Notice of Meeting

HEALTH & WELLBEING BOARD

Tuesday, 22 November 2016 - 6:00 pm
Conference Room, Barking Learning Centre, 2 Town Square, Barking, IG11 7NB

Date of publication: 14 November 2016

Chris Naylor
Chief Executive

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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
Cllr Bill Turner	(LBBD) Cabinet Member for Corporate Performance and Delivery
Anne Bristow	(LBBD) Strategic Director for Service Development and Integration and Deputy Chief Executive
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)
Bob Champion	(North East London NHS Foundation Trust)
Dr Nadeem Moghal	(Barking Havering & Redbridge University NHS Hospitals Trust)
Sean Wilson	(Metropolitan Police, Interim Borough Commander)
Ceri Jacob (Non-voting member)	(NHS England London Region)

AGENDA

Vision & Priorities (Oct '16)

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 held on 27 September 2016 (Pages 3 - 12)**

BUSINESS ITEMS

4. **Mental Health Strategy (Pages 13 - 58)**

5. **Children and Young People Mental Health Transformation Strategy (Pages 59 - 91)**

6. **Learning Disability Partnership Board Strategic Delivery Plan Update (Pages 93 - 107)**

7. **Health and Wellbeing Outcomes Framework Report - Quarter 2 2016/17 (Pages 109 - 152)**

8. **Safeguarding Boards Annual Reports 2015/16 (Pages 153 - 265)**

9. **Sustainability and Transformation Plan Update (Pages 267 - 329)**

STANDING ITEMS

10. **A&E Delivery Board (formerly Systems Resilience Group) - Update (Pages 331 - 335)**

11. **Sub-Group Reports (Pages 337 - 341)**

12. **Chair's Report (Pages 343 - 347)**

13. **Forward Plan (Pages 349 - 358)**

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

15. **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.***

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

(i)

(ii)

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London Borough of Barking & Dagenham
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Our Vision for Barking and Dagenham

One borough; one community; London's growth opportunity

Our Priorities

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

Well run organisation

- A digital Council, with appropriate services delivered online
- Promote equalities in the workforce and community
- Implement a smarter working programme, making best use of accommodation and IT
- Allow Members and staff to work flexibly to support the community
- Continue to manage finances efficiently, looking for ways to make savings and generate income
- Be innovative in service delivery

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MINUTES OF
HEALTH AND WELLBEING BOARD

Tuesday, 27 September 2016
(6:00 - 8:23 pm)

Present: Cllr Maureen Worby (Chair), Dr Waseem Mohi (Deputy Chair), Cllr Sade Bright, Anne Bristow, Cllr Laila M. Butt, Cllr Evelyn Carpenter, Frances Carroll, Matthew Cole, Ceri Jacob, Tracy Goddard-King and Bob Champion

Also Present: Cllr Bill Turner and Stephen Norman

Apologies: Conor Burke, Dr Nadeem Moghal and Sean Wilson, Sarah Baker, Louise Mitchell and Terry Williamson

32. Extension of the Meeting

At 7.58 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.

33. Declaration of Members' Interests

There were no declarations of interest.

34. Minutes - To confirm as correct the minutes of the meeting held on 26 July 2016

The minutes of the meeting held on 26 July 2016 were confirmed as correct.

35. Joint Strategic Needs Assessment (JSNA) 2016 - Key recommendations

Dr Fiona Wright, Consultant in Public Health at LBBD, presented the report, the aim of which was to give assurance to the Board that it had discharged its duties in relation to the JSNA. It also aimed to summarise the approach taken and key findings in the current context and to share the key findings and next steps. The presentation highlighted three key approaches to reducing health inequalities and the key plans and strategies for the borough. The Board's attention was also drawn to the context of the JSNA in regards to key plans and strategies for the LBBD, notably the Joint Health and Wellbeing Strategy. The JSNA provided a 'snapshot in time' of the Borough's health and wellbeing needs and inequalities. There was continued concern on a number of key health issues, details of which were set out in the report and presentation. Fiona particularly drew attention to life expectancy and healthy life expectancy rates in the Borough, as these indicated that healthy life expectancy was the lowest in London, with healthy life expectancy in women being particularly low. The Borough also has a comparatively young population and would need to prepare for the projected increase of more than 70,000 residents by 2031

Fiona also drew the Boards attention to a number of key points including:

- Over a quarter of 4 to 5 year olds are overweight and a third have tooth decay.
- The second highest rate of teenage conception in London

- The second highest proportion of young adults not in education or training (NEETS)
- The highest rate of pregnant smokers and lower than average percentage of mothers that breast feed.
- Heart disease most common cause of premature death.
- Cancer being the most common cause of death. Lung cancer was the most common cancer, with 9 out of 10 lung cancer deaths being related to smoking. Improving cancer screening coverage was clearly important.
- Issues that affect older generation such as depression and falls: that had resulted in nearly 400 emergency admissions to hospital.
- Domestic violence and homelessness on their negative effects on physical and mental health and health inequalities.

In response to a question from Cllr Carpenter, Cabinet Member for Educational Attainment and School Improvement, Matthew Cole advised that there had been improvements in many areas but we were not improving as fast as other London boroughs. The Sustainability and Transformation Plan (STP) would be prioritising some issues to enable targeted resources by partners; this would in effect create a smaller number of key priority areas.

The Chair reminded Partners that the JSNA needs to be more clearly shown in the strategies they develop and to be more explicit in why they are concentrating on specific issues.

Cllr Turner, Cabinet Member for Corporate Performance and Delivery, pointed out that there are differences in demographics between areas and that it would be helpful to break down the information at sub borough level. Cllr Turner also raised the effect that constantly changing demographics would have on the trends and how change could give a false perspective of performance. The Chair pointed that localities would be key. Matthew Cole advised that work was underway already for the data to be split at locality level and in effect they would have mini JSNAs for those areas.

In response to a question from a member of the public about training for GP surgeries to promote screening, it was noted that whilst the CCG do not commission training they would promote screening and that the programmes are well resourced and some GPs performance need to improve their performance. Dr Mohi commented that whilst there are incentives performance is down to individual doctors and performance needs to be raised to achieve consistency across the Borough.

Healthwatch said that a recommendation had been made by them in regards to toothbrushes being taken into nurseries to encourage tooth brushing, but the £15,000 funding had not continued. It was noted that Matthew Cole was working on a strategy on oral health, including prevention and this would come to the Board in due course. Ceri Jacobs, Director Commissioning Operations NCEL, NHS England, advised that she would raise the issue of dentistry prevention with her colleagues at NHS England.

Discussion was held on the end of life or hospice care. Dr Mohi advised that most end of life care is undertaken by a referral by the hospital consultant. It was noted that St Francis Hospice was currently looking to expand its home support provision

as many people would prefer to die at home and more needs to be done to allow that choice. Fiona advised that further details on end of life care were within the JSNA report.

The Chair raised her concern on the confusion that seemed to have appeared recently in regards to commissioning responsibility and performance and professional standards. This was noted by NHS England.

The Board agreed the recommendation of the report to:

(i) Consider the implications of the findings of the JSNA in the development of strategies of partnership organisations and commented accordingly;

(ii) Support the commissioning of services by Partner organisations that align with the JSNA findings and the Joint Health and Wellbeing Strategy (JHWS);

(iii) Assess the impact of the JSNA on the Delivery Plan of the JHWS by March 2017; and

(iv) In-line with statutory requirements, require the Public Health Department to lead an update and refresh of the JSNA in 2017 to inform commissioning in 2017/18.

36. Healthwatch Barking and Dagenham Annual Report 2015/16

Francis Carol, Chair of Healthwatch Barking and Dagenham, presented their Annual Report for 2015-16, which outlined the work undertaken by the Healthwatch team and volunteers during that period. The report also highlighted the challenges, consultations and interactions with the public, which had brought to light the public's experiences and opinions, which were then fed back to both health and social care services commissioners.

The Board's attention was drawn to a number of activities, including:

- Enter and view and project work. A total of 34 recommendations had been included in the Healthwatch project reports and 26 of those had been accepted. Lack of funding was given for the reason for some recommendations not being accepted and a response was still awaited on a number of other recommendations.

  Details were set out in the report on the visits to Morris Ward, Park View and Five Elms GP Practice and the project in regards to BHRUT Phlebotomy, which had resulted in improved marketing and communications on service availability and the overall patient experience,

- A number of projects are undertaken in association with other three local Healthwatch Groups. The Chair indicated that she was pleased to see this development and commented that this could help reduce pressure across the Healthwatch teams and allow for more time on local focus.

- Work with Partners on a number of Boards and Sub-Groups

- Work with the BHRUT and CCG in regards to urgent and emergency care. This had included over 1,000 face-to-face contacts /interviews with people about their views of on urgent and emergency care, in order to ascertain both their knowledge of other alternative health options and also why they had chosen to attend A&E rather than use other options. The results had been fed back to the BHRUT Systems Resilience Group and were being used to in the development of a new care model.

- A total of 508 individual enquirers had been helped, including signposting many of them to services.

- Homeless Health would be the next major project for Healthwatch.

In response to a question from Cllr Turner, Healthwatch advised that they are working on engagement with the harder to reach sections of the community and gave the example of the work they were currently undertaking to improve engagement with young people on health issues in association with the BAD Forum.

The Board:

(i) Received the Healthwatch Annual Report 2015-2016 and noted the work and impact that Healthwatch had had in the last year; and

(ii) Thanked Healthwatch and its volunteers for the valuable work they do.

37. Healthy Weight Strategy

Matthew Cole, Director of Public Health, presented the report and explained how the Strategy set out plans and action to be taken over the next four years to tackle one of significant health challenges the Borough faces. Matthew went on to explain how those lifestyle changes set out in the strategy could have a positive impact in improving healthy active life results across all age ranges.

In response to a question from Cllr Carpenter it was noted that schools were involved in the Health School Award Plan at Bronze, Silver and Gold levels and the Borough also had the highest uptake of Healthy School Awards in London. Public Health also fund aspects of PHSE in schools to encourage children to make better lifestyle choices. The Healthy Weight Alliance was also a pivotal part of the partnership working to improve long-term health of residents.

Cllr Turner raised the issue of encouraging healthy shopping through the use of regeneration and community initiatives to encourage private enterprise to offer healthy options, rather the more prevalent high sugar, high fat options that many sell. Matthew Cole advised that there may be some potential initiatives and support that could be provided through the food hygiene and licensing and officers would look into the options.

The issue of positive body image and mental health was also discussed. Concern was raised in regard to the officious and unfriendly prescribed wording that must be used in the letter sent to parents under the National Child Measurement Plan. This issue had been raised with NHS England by a number of agencies, including LBBD and other councils. In addition, the BMI used in those measurements were

Caucasian and other races may have a different BMI base, which could give a misleading result to parents and health professionals. Ceri Jacob noted the points and agreed to raise them with colleagues at NHS England.

Melody Williams, NELFT, advised that many parents when advised that their child is over average BMI react positively and ask for advice.

Dr Andy Heeps, BHRUT, advised that the Food Court at Queen's Hospital had been revamped and more healthy options, including a healthy option vending machine, were now available. A greengrocer concession had also recently opened at the main entrance and this was had been positively received and was being well frequented. King George Hospital food areas would be the next to be revamped.

Following discussion about how to get healthy lifestyle and eating information absorbed by parents and children and it was felt that joint campaigns could be the way forward. Anne Bristow, Strategic Director Service Improvement and Development, LBBD, suggested that officers consider how to target information to children on various initiatives, for example a book mark could be provided with healthy eating information on it, which would meet the aims to inform on healthy options and encourage children to read.

The Board:

(i) Received and commented on the Strategy in regards to the potential to encourage healthy food choices in commercial outlets;

(ii) Noted that consideration would be given on how to target information to children on various initiatives.

(iii) Approved the Healthy Weight Strategy 2016-2020.

38. Health and Wellbeing Outcomes Framework Report - Quarter 1 2016/17

Matthew Cole, presented the report, which in response to comments at earlier Board meetings was in a new layout style, and provided the quarter 1 performance and update on health and wellbeing in the Borough. The report highlighted areas that had improved and also indicated areas that required improvement.

The Board discussed a number of issues including, the poor performance in regards to Health Checks, care home placements and vaccination rates.

In response to a question from Cllr Turner, Matthew Cole provided information on the national initiative to ensure that all pregnant women receive a Whooping Cough (Pertussis) vaccination. Matthew said this initiative had been well received by pregnant women and had a good take-up rate locally. There had been one death locally from Whooping Cough. Dr Heeps, BHRUT, explained that maternity services vaccinations are given by GPs not at the hospital. Matthew Cole advised that he believed that a business case had been approved to allow the vaccinations at any maternity service health point, including the hospital, and he would check on this and report back to the Board in due course. Anne Bristow suggested that Partners needed to investigate ways to improve the provision of vaccination services to pregnant women, so they were provided in a patient centred way. Cllr

Turner supported the suggestions and said that it was important that vaccination services are provided by all GPs, as well as being offered at other health points.

The Chair raised the issue of additional support for the CCG in view of the additional work pressure the CCG would have following recent CQC inspections. Ceri Jacobs explained the governance role of NHS England, the support provided to Primary Care and that there were also NHS England medical directors available to support the CCG. Sharron Morrow, Chief Operating Officer, Barking and Dagenham CCG, explained that a committee had been set up to look at performance issues and to develop improvement / actions plans and how the CCG input into those plans as well as looking at poor health presentation through promotion. Dr Mohi provided information on the logistical and business planning work that was being undertaken with local GPs.

BHRUT gave an update on the 18 week Referral to Treatment (RTT) position and it was noted that the number of patients who have waited a long time had reduced by 67% since 3 April 2016. The target for operating theatre productivity had been exceeded, but there is a very significant challenge to return to meeting the RTT standards in a sustainable manner. This would involve carrying out around 5,000 operations and 93,000 outpatient appointments over an 18 month period. A management and assurance process was now in place to achieve a return to RTT standard, this included meeting with NHS England and the BHR System Resilience Group.

BHRUT assured the Board that the clinical reviews of those patients waiting over a year indicated that there were no cases where there had been clinical harm due to the length of time they had waited. The clinical review tool/programme had been so successful that it would continue to be used. Work was also being undertaken to identify capacity gaps in order that service provision would match demand.

BHRUT would continue outsourcing to independent providers, whilst BHRUT had revamped their letters, BHRUT felt they had always made it clear in their letters to patients that even if they are attending private facilities they are NHS patients and the treatment would be totally free.

Cllr Carpenter welcomed the detail provided in Dr N Moghal's letter of 16 September 2016, which included the number of LBBD residents on the waiting list by speciality, but was concerned that with 11,333 people on the list it could take two to three years to get through the backlog. BHRUT responded that they were now coping with the current demand and were also making in-roads into the backlog. Dr Heeps advised that not all discipline would need surgery and there were some conditions where they could initially be dealt with by GPs.

The Chair was concerned that pressures at A&E would be increased as people chose to go to A&E because of long waits for referred treatment, especially if they were in pain. BHRUT advised that the demand pathways are in line with national practice. Whilst some patients would turn up at the door of A&E, this pressure would be reduced by providing accessible and well signposted alternative pathway choices.

Ceri Jacobs advised that BHRUT actions and strategies were now being held up by NHS England as a good example to other health trusts who have got into difficulties on how make the necessary improvements.

In response to a number of questions from Cllr Turner, Anne Bristow advised that the trend lines would be included in future reports for information only, as the detail should be dealt with by the LBBD Health and Adult Services Select Committee (HASSC).

The Board:

(i) Received and commented on the report and noted:

(a) The current position of BHRUT's Action Plan in regards to the 18 week Referral to Treatments standards and the situation in regards to the individual medical disciplines as set out in Dr Moghal's letter of 16 September 2016;

(b) The use of clinical harm reviews as a tool to prioritise patients and the assurance from BHRUT that the recent reviews of those patients waiting to be seen / treated had indicated that there were no cases of harm found;

(c) The roles of the NHS England and CCG in commissioning, governance and the monitoring of GP and other primary care services;

(d) The LBBD Health and Adult Services Select Committee is already scrutinising issues of concern around Referral to Treatment and the Committee's work programme was on the Council's website; and

(ii) Partners agreed to investigate ways to improve the provision of vaccination services to pregnant women, in particular Whooping Cough (Pertussis).

39. Sustainability and Transformation Plan Update

Sharon Morrow presented the report, which provided a further update on the development of the North East London Sustainability and Transformation Plan (NEL STP) and drew the Boards attention to the public facing summary of progress attached as Appendix A to the report. Work was now progressing to bring the five year plan into reality and to align with the pilot and devolution programmes.

Sharon advised that the NEL STP was due to be submitted on 21 October 2016. Work that still had to be done included mitigating the financial risk and strengthening the local Primary Care and Mental Health needs, following recent CQC inspections and government reports. In addition, a number of work streams and prevention priorities proposals were being developed across NEL. Sharon indicated that the proposals would be presented to Partners in October.

Anne Bristow raised concern about the mix and plans that were evolving as they did not give any assurance about local needs being met, in addition, the governance process that had worked well locally had also not been mirrored in the NHS system nationally. The Chair raised the governance issue of one local council Chief Executive representing all eight local authorities and said this was not feasible because of differing local demographics, health demands and

priorities. Ceri Jacobs advised that NHS England recognised that action and decision needed to remain at local level, for example through commissioning, and felt that the workshops planned for October would provide a good platform for discussing such concerns.

The Board:

(i) Received the report on the progress to date, set out in Appendix A to the report, and noted:

(a) The Plan was scheduled to be submitted on 21 October 2016;

(b) Work was to be undertaken on mitigation of the financial risks, local primary care issues and, in view of the recent reports, the strengthening of the mental health sections; and

(ii) Noted that NHS England recognised the need for local needs to be met and LBBD's concern in regards to proposed governance issues, such as all eight local authorities being represented by one council's Chief Executive, and that NHS England had suggested this could be considered at the Local Government Association workshops in October 2016.

40. Improving Post - Acute Stroke Care (Stroke Rehabilitation)

Sharon Morrow presented the report and reminded the Board that the Barking and Dagenham, Havering and Redbridge CCGs had undertaken consultation on the proposals to reconfigure the stroke rehabilitation pathways. This had included a number of public engagement / drop in sessions and presentations were also made to both the LBBD Health and Wellbeing Board and HASSC. The results of the consultation process were detailed within the report and its appendix.

Sharon stressed that the overall the response to the proposed new service model had been positive and advised that the business case had been approved by the CCG in July. The CCG Governing Body had approved the plan to commission a combined Early Support Discharge and Community Rehabilitation Service covering the Barking and Dagenham, Havering and Redbridge boroughs and centralise stroke inpatient unit / beds at King George Hospital. Plans were being drawn up to implement these changes.

The Board:

(i) Commended the CCG on the public consultation process they had undertaken in regards to this service:

(ii) Noted the outcome of the consultation and the decision of the CCG Governing Body to approve the business case for the stroke rehabilitation service.

41. Systems Resilience Group - Update

The Board received and noted the report on the work of the System Resilience Group (SRG), which included the issues discussed at the SRG meetings held on

25 July and 22 August 2016.

42. Sub-Group Reports

The Board noted that no Sub-Groups had met since the last Health and Wellbeing Board.

43. Chair's Report

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

- World Mental Health Day
- Learning Disability Week
- New A&E Delivery Boards
- News form NHS England
  - Funding to set up centres of global digital excellence.
  - NHS learning from 'Pokémon GO'.

44. Forward Plan

The Board noted the draft November 2016 edition of the Forward Plan.

45. Fire Fatality in Lower Board Street, Dagenham

The Chair agreed that a verbal report could be considered at the meeting under the provisions of Section 100B(4)(b) of the Local Government Act 1972 as a matter of urgency in order to share the information at the earliest opportunity with Partners of a death resulting from a fire.

Stephen Norman, Borough Commander, London Fire Brigade, provided a verbal report on a fatal fire that had occurred in Lower Board Street, Dagenham, on 25 September 2016.

Stephen advised that the property was the home of three people, two of whom had been present when the fire had started, namely the mother and son. The son had a disability that affected his mobility significantly. It was understood that the mother had settled her son in bed, then went downstairs to prepare food and that the fire had started some time after that. Fire crews from Dagenham and Wennington had been dispatched and arrived in 6 minutes 4 seconds. Sadly the son died as a result of the fire.

The formal investigation was now underway and the Brigade were also working with the Council to see if there was anything that could have been done to prevent the death or if there was any learning that could be used for the future.

The Board:

(i) Received the verbal report from Stephen Norman, Borough Commander, London Fire Brigade, in regards to a fatal fire death of a vulnerable person; and

(ii) Noted that further details and would be provided to Partners following the completion of the formal investigation.

46. NELFT CQC Inspection

The Chair agreed that a verbal report could be considered at the meeting under the provisions of Section 100B(4)(b) of the Local Government Act 1972 as a matter of urgency in order to share the results of the CQC Inspection of NELFT at the earliest opportunity with other Partners.

Bob Champion, Executive Director of Workforce & Organisational Development read out a statement from John Brouder, Chief Executive NELFT, in regards to the Care Quality Commission's (CQC) Inspection of NELFT that had taken place over the 4 to 8 April 2016 and 14 April 2016. The CQC Inspection report was published on their website today (27 September 2016).

A total of 14 core services had been inspected by CQC and of those nine had been rated as 'Good' and four as 'Requires Improvement' and one as 'Inadequate'. This had led to an overall CQC rating of 'Requires Improvement' for the Trust (the full statement is available at NELFT Statement).

In response to a question Bob advised the Board that Brookside had been shut to look at improving the environment and general refurbishment had now been undertaken. The opportunity had also been taken to undertake retraining of staff.

The Chair commented that she was disappointed that there was no longer any part of the NHS that did not have a problem and of which it could be said that it was working well for residents of the Borough.

The Board:

(i) Received the verbal report from Bob Champion, Executive Director of Workforce & Organisational Development, NELFT on the CQC Inspection of NELFT, which had been published today; and

(ii) Noted that NELFT had received an overall rating of 'Requires Improvement' and that a more detailed report in regards to the report and the Action Plan for Improvement would be presented by NELFT in due course.

HEALTH AND WELLBEING BOARD

22 November 2016

Title:	Mental Health Strategy 2016 – 2018
Report of the Strategic Director, Service Development and Improvement	
Open Report	**For Decision**
Wards Affected: All wards	**Key Decision: No**
Report Author: Lewis Sheldrake Prevention Manger, Integration and Commissioning	**Contact Details:** Tel: 0208 724 8109 Email: Lewis.Sheldrake@lbbd.gov.uk
Sponsors: Conor Burke, Accountable Officer, Barking and Dagenham Clinical Commissioning Group Anne Bristow, Strategic Director, Service Development and Improvement	

Summary:

In 2015 the Health and Wellbeing Board agreed that a clearer strategy for the development of mental health support was needed, given the complex and challenging position of health and social care services and the need to respond to a range of initiatives intended to create positive change in mental health.

This Strategy provides a focus for action on the areas that are most important in creating this positive change in the next two years. It aligns with, but provides a specific Barking and Dagenham perspective on, the wider planning processes that are underway across North East London as part of the development of the Sustainability and Transformation Plan for the area.

The Mental Health Strategy 2016 – 2018 has been developed on the back of a wide range of stakeholder engagement activities. All of the engagement carried out identified four key priorities which are the focus for this Strategy.

The four priorities are as follows:

- Priority one: preventing ill health and promoting wellbeing
- Priority two: housing and living well
- Priority three: working well and accessing meaningful activities
- Priority four: developing a new model of social support

The Strategy has been through an extensive consultation process between July and November 2016. Feedback on the Strategy from service users, providers, public and professionals has been largely positive. The apparent consensus is that the Strategy focuses on the right areas and that the key theme of prevention is a welcome focus.

This is an evolving Strategy which will be periodically reviewed and adapted to meet the changing landscape of the local health and social care economy, within the context of the council's transformation programme and the NHS Five Year Forward View, realised

through the local Sustainability and Transformation Plan. This will be reflected through the actions and targets laid out within the Strategy.
Recommendation(s) The Health and Wellbeing Board is recommended to note the content of this report, the Mental Health Strategy 2016 – 2018 and agree the proposed next steps
Reason(s) The Mental Health Strategy 2016 - 2018 supports and aligns with the Council vision of **'*One borough; one community; London's growth opportunity'*** and the key priorities of the Council, including 'enabling social responsibility'. The Strategy supports the ongoing work with the local community to help create a Borough that supports wellbeing, promotes independence and encourages residents to lead active lifestyles as far as they possibly can. The Strategy shows how local services are working to improve the mental health and wellbeing of the population, and get better outcomes for people with mental health problems.

1. Introduction

1.1 In 2015 the Health and Wellbeing Board agreed that a clearer Strategy for the development of mental health support was needed, given the complex and challenging position of health and social care services and the need to respond to a range of initiatives intended to create positive change in mental health.

1.2 This Strategy provides a focus for action on the areas that are most important in creating this positive change in the next two years. It aligns with, but provides a specific Barking and Dagenham perspective on, the wider planning processes that are underway across North East London as part of the development of the Sustainability and Transformation Plan for the area.

2. Background

2.1 The Strategy has been developed on the back of a wide range of stakeholder engagement activities.

2.2 A Mental Health Needs Assessment was undertaken by consultants commissioned through the Public Health service and reported to the Health and Wellbeing Board in July 2015. The needs assessment included data review, policy analysis and work with service users and carers to inform a set of recommendations for the development of future services.

2.3 The Mental Health Subgroup considered the needs assessment described above, together with:

- The Crisis Care Concordat;
- The Health & Wellbeing Strategy;
- The CCG's work on developing a framework to guide its commissioning intentions for mental health services;

- A range of national policy documents, which informed the needs assessment work;
- The Care Act 2014, in view of the effects on mental health services, particularly with regard to personal budgets

2.4 Following consideration of the needs assessment, it was agreed that a wider view was going to be required to support the development of a clear Strategy around mental health. A Mental Health Strategy Map was developed as a first representation of the priorities that arise from the work that the Mental Health Subgroup had considered to provide a starting point for discussion.

2.5 A set of three mental health engagement workshops were subsequently conducted in summer 2015. The theme for these workshops included 'My Life, My Home, My Care', with one session on each of those themes with the intention to get consensus on the principles that should underpin a local approach to mental health services.

My Life - Helping people stay healthy, resilient and engaged in their communities when mental health issues develop, improving awareness of mental health problems and challenging stigma associated with mental illness, supporting integration, employment and training of people with mental health problems.

My Home - Providing the right support to enable people to live as independently as possible and facilitating greater choice in the kinds of accommodation and support available in Barking and Dagenham.

My Care - Rethinking ways of organising services to become more flexible, responsive and user-led; prioritising prevention, resilience and personalisation approaches whilst ensuring that statutory duties are delivered.

2.6 Attendance at the engagement workshops was good and the sessions formed a good basis to develop the Strategy further. Some key themes which emerged included peer support, reducing stigma / awareness raising, prevention and employment.

2.7 Having collated the work from the engagement activities detailed above, a draft outline for the Mental Health Strategy 2016 – 2018 was developed in consultation with the Commissioning Director, Adults' Care and Support and the Deputy Chief Operating Officer of the Clinical Commissioning Group.

2.8 The outline for the Strategy was developed in alignment with the council's transformation programme and in the context of the NHS Five Year Forward View for Mental Health.

2.9 Further discussions were held with a number of different stakeholders that were representative of the key themes that emerged from the engagement activities. This included colleagues within Housing Strategy, Regeneration, Sports and Leisure and Community Safety.

2.10 This process led us to determining the overall vision and scope for the Mental Health Strategy 2016 - 2018, along with the narrative and content of the four key priorities detailed in Section 4 below to produce the first draft of the Strategy for consultation.

3. Vision and Scope of the Strategy

3.1 The vision for the Mental Health Strategy 2016 – 2018 is for people to be active citizens; able to live a meaningful life and make positive contributions to the community they are part of. Services and support must focus on promoting wellbeing and enabling people who have experienced a mental health problem to be independent. We would like to see more people choosing the support they want and a greater range of services to choose from. We want to support people to achieve their aspirations such as returning to work, living well in suitable accommodation and keeping active.

3.2 Given the fact that mental health affects everybody, this Strategy links with a range of other strategies which are monitored by other groups, including subgroups of the Health and Wellbeing Board. A number of work streams reflected in this Strategy interface with elements of the Better Care Fund programme locally, including specific schemes on Dementia and Carers.

3.3 The Strategy is predominately focused on adults, but highlights the significance of promoting and protecting the emotional health and wellbeing of children and young people to prevent mental health problems in adulthood. Actions to do this are being taken forward through the Barking and Dagenham Children and Young People's Mental Health Transformation Plan, which includes consideration of improved transitions to adult services.

4. Priorities

4.1 All of the engagement carried out identified four key priorities which are the focus for this Strategy. The four priorities are those issues that need to be addressed in a strategic way, taking both a longer-term view as well as identifying immediate actions that are needed.

4.2 This is an evolving Strategy which will be periodically reviewed and adapted to meet the changing landscape of the local health and social care economy, within the context of the council's transformation programme and the NHS Five Year Forward View, realised through the local Sustainability and Transformation Plan. This will be reflected through the actions and targets laid out within the Strategy, which will in turn become more specific and measurable.

4.3 The actions within the Strategy have been developed through the consultation process and will ultimately form part of the action plan for the Mental Health Subgroup for 2016 – 2018.

4.4 Each priority is structured as follows:

- Assessing the situation
- Existing strengths
- Actions needed

4.5 Priorities one to three provide a focus for strategic work that is intended to respond to the main themes that have emerged from the recent mental health needs assessment and stakeholder engagement. These priorities take account of the complex and challenging position of health and social care services and the need to respond to a range of initiatives intended to create positive change in mental health.

4.6 The fourth priority of developing a new model of social support has been included as it was recognised throughout the engagement process that mental health services are going to need to be delivered differently in the future. This was driven by the financial challenges facing public services and the increased focus on prevention and early intervention.

4.7 There is an emphasis in the Strategy on encouraging people to take responsibility for their own wellbeing. This is demonstrated by actions which focus on enabling people to access safe self-help resources which in turn promote independence. This is aligned with Community Solutions which will be an early resolution and problem-solving service to help residents to become more self-sufficient and resilient. Community Solutions 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 partners in the voluntary and statutory sectors to deliver early intervention and preventative support.

4.8 The key theme of prevention runs throughout the Mental Health Strategy and the borough's Prevention Approach is an inherent aspect of our overall future ambition. The growing prevention agenda promotes the development of a more resilient community, where individuals are empowered and supported to take positive steps towards managing their own wellbeing.

4.9 A summary of the priorities are as follows:

Priority one: preventing ill health and promoting wellbeing

4.10 This priority recognises that mental well-being is fundamental to a good quality of life and the wellbeing of individuals, families and communities. It reflects that we need to develop resilience in our community so that people can draw on their own and their community resources in achieving positive mental health and managing the difficulties they might face in their lives. We need to ensure that everyone has timely access to all of the right care and treatment that can help them maximise their own health and wellbeing.

Priority two: housing and living well

4.11 This priority acknowledges the importance of having a stable, secure, safe and comfortable home in promoting wellbeing and protecting against mental ill health. It recognises we need to take a strategic approach to enabling people to live as independently as possible in their own accommodation, as well as providing a greater range of choice of both accommodation and support. One of the key focuses of this priority is to improve the pathways into a greater variety of accommodation for people who are discharged from hospital and other institutional settings.

Priority three: working well and accessing meaningful activities

4.12 This priority focuses on ensuring that everyone has the chance to benefit from the expected growth and increased prosperity in the borough, and to be fully engaged in, and contribute to, their local community. This includes enabling people to access employment, educational and training opportunities as well as undertaking caring roles and volunteering. One of the key actions within this priority is the re-modelling and re-tendering of our current mental health related employment and vocational support contract with an aim to increase numbers of people with mental ill health securing long term competitive employment.

Priority four: developing a new model of social support

4.13 This priority provides a focus on more creative, innovative ways to co-produce a new system of mental health care and support, including maximising the benefits of creating a digital front-door to advice and support. The role of social work and social care in this new model needs to be developed further, to allow the particular skills of social workers to be used to their full benefit in creating a sustainable and responsive approach in the borough. It also reflects the ambitious transformation programme taking place across BHR, supported by a bid for devolved powers from central Government, which will give us the best opportunity in a generation to tackle the significant health and wellbeing challenges that we face.

4.14 As part of the future design of the council, Community Solutions will take a holistic approach to providing early intervention and support and will develop responses that will incorporate links to mental health support as required. The new service will be developed to encourage self-help and where necessary provide residents with the most appropriate support based upon their circumstances.

5. Consultation

5.1 The first draft of the Mental Health Strategy was presented to the Mental Health Subgroup on 18 July 2016. The Strategy was well received and actions were agreed to ensure a thorough and robust consultation process.

5.2 Areas of consultation included the following:

- Learning Disabilities Partnership Board
- Children and Maternity Subgroup
- Employment and Opportunity Forum
- NELFT MH and LD Community of Practice
- Cllr Worby - Cabinet Member for Social Care & Health Integration and Chair of Health & Wellbeing Board
- Cllr Fergus – Mental Health Champion

5.3 In additional to the above, the Strategy was consulted with the following Service User forums:

- Patient Experience Partnership
- Richmond Fellowship - Working Together Group
- CCG Patient Engagement Forum

5.4 Feedback and comments from the first phase of the consultation process were collated and reviewed. A meeting was held with the Chair of the Mental Health Subgroup on 01 September 2016 to finalise the action plan and agree any amendments following the consultation process.

5.5 Following the input from the areas detailed in Sections 5.2 and 5.3, an updated iteration of the Mental Health Strategy 2016 – 2018 reported to the Mental Health Subgroup on 05 September 2016.

5.6 The Strategy was subsequently uploaded to Barking and Dagenham's Consultation Portal with the link communicated widely, including via Barking and Dagenham

Council for Voluntary Services and also as part of the engagement activities for World Mental Health Day on 10 October 2016.

5.7 The public consultation closed on 31 October 2016 with four people having commented on the Strategy via this channel.

6. Feedback from consultation process

6.1 Feedback on the Strategy from service users, providers, public and professionals has been largely positive. The consensus is that the Strategy focuses on the right areas and that the key theme of prevention is a welcome focus. A summary of the feedback can be found at Appendix B.

6.2 Some feedback has queried why the Strategy does not explicitly address issues and risk factors affecting specific age groups, such as older people. A decision was taken in the development phase to ensure that the priorities within the Strategy are applicable to all adults, and include overarching principles which are applicable to everybody, irrespective of age or health conditions, e.g. self-help and self-management.

6.3 Other feedback from the consultation process commented on the benefits of having a Mental Health Strategy which strongly interfaces with a range of other areas and strategies to ensure mental health is placed high on the agenda and works towards achieving parity of esteem.

7. Next Steps

7.1 The proposed next steps for the Mental Health Strategy 2016 - 2018 are as follows:

- Deliver upon the action plan, monitored and supported through the Mental Health Subgroup

- Establish and enhance links with other strategies to support the principle of parity of esteem for mental health

- Continue to develop the Mental Health Strategy 2016 - 2018 to align with and support the implementation of the Growth Commission and Ambition 2020 along with the NHS Five Year Forward View for Mental Health.

- Completion of a suicide audit and the development of a local suicide prevention plan in line with Public Health England's ongoing programme of work to support the government's suicide prevention strategy. The local plan will link with the Mental Health Strategy 2016 – 2018.

8. Mandatory Implications

Joint Strategic Needs Assessment

8.1 This programme will further the findings of the JSNA with regards to addressing mental health needs in Barking and Dagenham.

Health and Wellbeing Strategy

8.2 This Strategy will further and support the following priorities in the Joint H&WB Strategy:

- Increase the life expectancy of people living in Barking and Dagenham
- Close the gap between the life expectancy in Barking and Dagenham with the London average.
- Improve health and social care outcomes through integrated services.

Integration

8.3 Integrated commissioning and provision within Barking and Dagenham and across the wider health and social care system is at the heart of the Mental Health Strategy 2016 – 2018. The strategy aligns with integration priorities that have been identified as part of the BHR system wide approach to Mental Health and developed through the work on devolution. It also reflects the mental health priorities identified as priorities within the work to develop the North East London Sustainability and Transformation Plan. These priorities have been developed to reflect the national Five Year Forward View for Mental Health, ensuring that there is a link through from nationally identified priorities through to borough and locality level delivery. The development of the Strategy has been supported through the Mental Health Subgroup of the Health and Wellbeing Board whose membership consists of a wide range of partner organisations from across the local health and social care economy including representatives from Service User groups.

Financial Implications

8.4 Financial implications to follow

Legal Implications

8.5 Legal implications to follow

Background Papers Used in the Preparation of the Report:

- Joint Strategic Needs Assessment 2015 - https://www.lbbd.gov.uk/council/statistics-and-data/jsna/overview/
- Joint Health and Wellbeing Strategy 2015 – 2018 - https://www.lbbd.gov.uk/wp-content/uploads/2014/11/JHWS_A4_30-9-15_RF.pdf
- NHS Five Year Forward View - https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

List of Appendices:

Appendix A – Mental Health Strategy 2016 – 2018

Appendix B – Consultation feedback summary

Mental Health Strategy for Barking and Dagenham

2016 - 2018

Barking and Dagenham
Health and Wellbeing Board

Contents

Foreword 1

Mental Health is everybody's business in Barking and Dagenham.

Councillor Maureen Worby – Chair of Health & Wellbeing Board

It is estimated that one in four of us will experience a mental health problem each year. It is also estimated that about one in six of the adult population will have a significant mental health problem at any one time.

Physical and mental health are closely linked – people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England – often referred to as 'parity of esteem'. The Royal College of Psychiatrists has proposed one of the simplest and most influential definitions of 'parity of esteem': "Valuing mental health equally with physical health". We are committed to achieving this in Barking and Dagenham.

This strategy has been developed against the backdrop of immense financial challenges for both the council and NHS. The NHS 5-Year Forward View estimates that the cost of poor Mental Health to the economy is estimated to be around £100 billion annually – roughly the cost of the entire NHS.

Our Council vision is ***'One borough; one community; London's growth opportunity'*** and one of the key priorities of this vision is 'enabling social responsibility'. We are committed to working with the local community to help create a Borough that supports wellbeing, promotes independence and encourages residents to lead active lifestyles as far as they possibly can. This means that wherever possible we need to ensure there are support mechanisms to enable our residents to live more independently, whilst still offering a safety net of support for our most vulnerable.

Barking and Dagenham is one of the growth areas in London, it is an exciting, dynamic, multi-cultural area, with some great services and opportunities. However, people living here also face a number of historical challenges in terms of housing, employment and health outcomes, as well as dealing with the impact of more recent austerity measures and reductions in public expenditure.

The council's approach is to bring new life to the borough and to maximise the benefits of the new homes and jobs that economic growth will bring. We want to make sure that everyone living in Barking and Dagenham has an opportunity to contribute to the increasing prosperity and success of the borough. This means that we want to support individuals and community groups to build resilience and to protect and develop community assets. The report of the Barking and Dagenham Independent Growth Commission; *No-one left behind: in pursuit of growth for the benefit of everyone* explains this approach in further detail.

Working with local people to shape mental health services

Dr Waseem Mohi – Chair of Barking and Dagenham Clinical Commissioning Group

Your mental wellbeing is just as important as your physical health and as commissioners it is our duty to make sure you get the care and support you need.

Supporting people with mental health problems continues to be a priority for your local NHS clinical commissioning group (CCG). Through the local services we commission we already support thousands of people in the borough to feel better, or to live independent, healthy lives through managing their mental illness. However there is more we want to do to improve services and health outcomes for those with mental health problems. We want to build on these services and work with local people, and those who use them, to help shape them for the future. It is our aim to create flexible, tailored care and support that meets the needs of local people for years to come.
There are many things that can affect our mental wellbeing which is why we are working with the council, and other partners, to help create resilient communities and prevent people from experiencing mental ill health were possible. If people do need care and support it is our aim to ensure the right services available to those who need them, and it is clear and easy to get help. Through this strategy, and working with partners across the health and social care economy we aim to see more people choosing the support they want and a greater range of services to choose from.

Improving the health outcomes for those with mental health issues is something we all want for the people of Barking and Dagenham. As the mental health lead for the CCG it's something I'm committed to achieving.

Your local CCGs has undertaken a lot of work over the last year to help more people use the borough's mental health services. As well as working with GPs to achieve this, we have engaged with local people who are experiencing mental health issues to co-create a new campaign to raise awareness of one of our support services, Talking Therapies, which providers support for those who are experiencing work stress, money worries, trouble sleeping or feeling low.

I've been visiting every practice in the borough to speak to my GP colleagues about the importance of identifying patients who could benefit from mental health support. We've already seen more people using services as a result, but we're not stopping there. Through this strategy we will continue to build on this and ultimately improve the wellbeing of people in Barking and Dagenham.

Dr Raj Kumar – Mental Health Lead for Barking and Dagenham Clinical Commissioning Group

Background and introduction 2

Why have a strategy for mental health?

In 2015 the Health and Wellbeing Board for Barking and Dagenham agreed that a clearer strategy for the development of mental health support was needed, given the complex and challenging position of health and social care services and the need to respond to a range of initiatives intended to create positive change in mental health. This strategy, endorsed by key stakeholders, provides a focus for action on the areas that are most important in creating this positive change in the next two years. It aligns with, but provides a specific Barking and Dagenham perspective on, the wider planning processes that are underway across North East London as part of the development of the Sustainability and Transformation Plan for the area.

Where has this strategy come from?

The Mental Health Subgroup of the Health and Wellbeing Board has a remit to bring together people responsible for commissioning and providing mental health services with service users, voluntary sector colleagues and Healthwatch to work together to improve mental health outcomes. Further information about the group and the Health and Wellbeing Board can be found in Section 9.

A Mental Health Needs Assessment was undertaken by consultants commissioned through the Public Health service and reported to the Health and Wellbeing Board in July 2015. The needs assessment included data review, policy analysis and work with service users and carers to inform a set of recommendations for the development of future services.

Through the Mental Health Subgroup, a scoping exercise was then conducted in partnership with key stakeholders to draw up a mental health strategy map. This captured what matters most to service users and their carers, and provided direction for services to ensure their delivery.

A range of subsequent stakeholder engagement workshops followed. This engagement revolved around the three themes of ***My Life, My Home, My Care***, as described in brief below.

My Life - Helping people stay healthy, resilient and engaged in their communities when mental health issues develop, improving awareness of mental health problems and challenging stigma associated with mental illness, supporting integration, employment and training of people with mental health problems.

My Home - Providing the right support to enable people to live as independently as possible and facilitating greater choice in the kinds of accommodation and support available in Barking and Dagenham.

My Care - Rethinking ways of organising services to become more flexible, responsive and user-led; prioritising prevention, resilience and personalisation approaches whilst ensuring that statutory duties are delivered.

Mental Health Needs Assessment | Mental Health Strategy Map | Mental Health Engagement Workshops

All of the engagement carried out identified **four key priorities** which are the focus for this strategy.

PREVENTING ILL HEALTH AND PROMOTING WELLBEING

HOUSING AND LIVING WELL

MENTAL HEALTH STRATEGY 2016 - 2018

WORKING WELL AND ACCESSING MEANINGFUL ACTIVITIES

DEVELOPING A NEW MODEL OF SOCIAL SUPPORT

The four priorities are those issues that need to be addressed in a strategic way, taking both a longer-term view as well as identifying immediate actions that are needed. This strategy focuses on these four priority areas, whilst recognising that a number of other important issues are already being addressed by the Mental Health Subgroup and its members, for example through the Crisis Care Concordat. The fourth priority of developing a new model of social support has been included as it was recognised throughout the engagement process that mental health services are going to need to be delivered differently in the future. This was driven by the financial challenges facing public services and the increased focus on prevention and early intervention.

Who is the strategy mainly concerned with?

The 2015 refresh of Barking and Dagenham's Joint Health and Wellbeing Strategy outlined our top priorities for improving the health and wellbeing of all the people who live and work in the borough. Mental wellbeing is often omitted from consideration and recent policy directives have demanded parity of esteem with physical health. This is driven by the fact that people with poor mental health have below average physical health and higher rates of the diseases associated with premature mortality.

Our vision and outcomes for our Mental Health Strategy can only be achieved through a change in the way we do things in Barking and Dagenham. This will involve change for residents by taking on more responsibility for their own health and wellbeing supported by those planning and delivering local services.

This is an evolving strategy which will be periodically reviewed and adapted to meet the changing landscape of the local health and social care economy, within the context of the council's transformation programme and the NHS Five Year Forward View, realised through the local Sustainability and Transformation Plan. This will be reflected through the actions and targets laid out within the strategy, which will in turn become more specific and measurable.

The priority areas in this strategy mainly affect adults with mental health problems, including adults that might have "common" mental health problems such as anxiety and depression as well as mental health problems that are regarded as more severe and enduring. The strategy also aims to prevent mental health problems and includes recommendations to prevent suicide, and is for all adults in the borough.

We further recognise the mental health needs of older people are also a key requirement within Barking and Dagenham and their needs are inherent within the four priorities set out within this strategy.

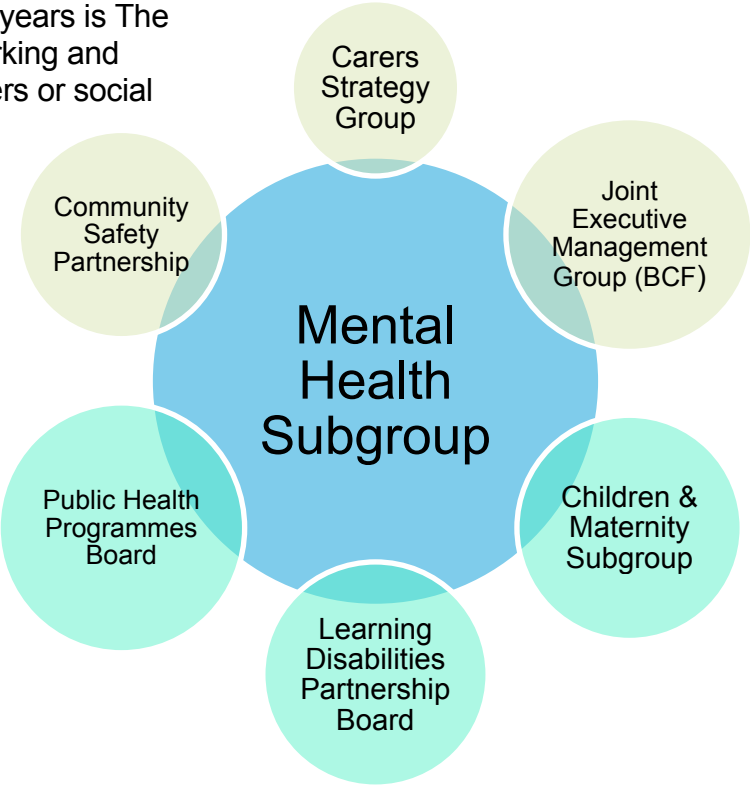
Links to other areas

Given the fact that mental health affects everybody, this strategy links with a range of other strategies which are monitored by other groups, including subgroups of the Health and Wellbeing Board. This strategy doesn't focus on the specific needs of people with learning disabilities, autism, or dementia.

There is a strategy in place for people with autism Adult Autism Strategy 2015-2017 London Borough Barking and Dagenham. The Learning Disabilities Partnership Board sets the strategic direction for learning disabilities services and services for people with autism in the borough.

A number of work streams reflected in this strategy interface with elements of the Better Care Fund programme locally, including specific schemes on Dementia and Carers. The Better Care Fund (BCF) programme has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with 'wraparound' fully integrated health and social care, resulting in an improved experience and better quality of life . The Better Care Fund is 'overseen' by the Integrated Care subgroup, but at a more detailed operational level, both finance and performance are managed by the Joint Executive Management Group. The mental health scheme of the BCF aligns with the sections of this strategy which focus on employment and accommodation, and will enable the delivery of some of the specific targets.

Promoting and protecting the emotional health and wellbeing of children and young people is crucial to preventing mental health problems into adulthood. Actions to do this are being taken forward through the Barking and Dagenham Children and Young People's Mental Health Transformation Plan, which includes consideration of improved transitions to adult services. An example of an service which supports people through the transition years is The Listening Zone. This is a counseling service for young people aged 14 to 21 who live or study in Barking and Dagenham. Young people can self-refer or referrals can be made by doctors, school nurses, teachers or social workers.



The Care Act places duties on local authorities to promote the physical, mental and emotional wellbeing of carers and their participation in work, education and training. Barking and Dagenham has produced Caring Together: A Carers' Strategy for Barking and Dagenham 2015-2018 which sets out the vision of a carer-conscious community in Barking and Dagenham and shows how carers will be supported.

Current provision of drug and alcohol services will develop and change over the next two years and improvements to the way services are organised for people who have a "dual diagnosis" of substance use and mental health problems will be considered as part of our strategy to develop a new model of social support. Additionally, Barking and Dagenham is the London site for Public Health England's Addiction to Medicines (ATM) pilot which aims to support areas to develop services for this cohort. The Community Safety Partnership oversees a range of areas where mental health is particularly significant including, Drug and Alcohol Services, Hate Crime, Domestic Violence and Offender Management.

Key theme of Prevention

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The theme of prevention runs through the mental health strategy and each of the four priorities will reflect the borough's Prevention Approach. The Care Act 2014 provided a new emphasis and role for local authorities and statutory agencies (principally the NHS) to actively promote wellbeing and independence rather than respond only in a crisis. The Act introduces the wellbeing approach and places duties on the Council to ensure that it:

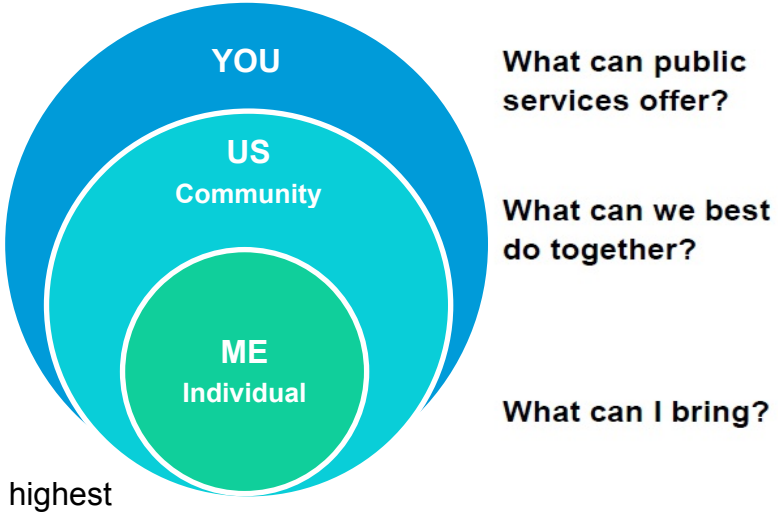
- provides good advice and information as early as possible to support individuals
- helps people retain or regain their skills and confidence and
- works with people to prevent, reduce or delay the impact of needs wherever possible

The London Borough of Barking and Dagenham developed a local prevention framework which promotes a strengths-based approach to assessing needs and supporting people. The three guiding principles of the prevention framework are that it is only effective when **individuals**, **communities** and **public services** work together.

This is aligned with one of the key priorities for Barking and Dagenham to enable social responsibility by encouraging residents to do as much as they can for themselves. This means that individuals, with support from communities and local networks, will be primarily responsible for making their own decisions about their personal life choices and for seeking the advice and information they need to achieve the outcomes they desire.

Improved social responsibility relies on good community and individual resilience, supported by an effective infrastructure and access to a range of appropriate, high quality local services. This work has started with the development of community hubs and empowerment of local people through better use of local assets such as children's centres, libraries, leisure centres and neighbourhood networks.

Prevention is also one of the four priority themes in the Joint Health and Wellbeing Strategy 2015 – 2018. In this context, prevention is described as: *Supporting local people to make lifestyle choices at an individual level which will positively improve the quality and length of their life and overall increase the health of the population.*



The Five Year Forward View for Mental Health describes the impact of mental illness and of the stigma often associated with this, and calls for a far more proactive and preventative approach from the NHS. People with lived experience of mental health problems, carers and health and social care professionals told the Taskforce that prevention was a top priority.

The growing prevention agenda promotes the development of more resilient community, where individuals are empowered and supported to take positive steps towards managing their own wellbeing. This also supports sustainability for public services to ensure that individuals with the highest levels of need will continue to receive support from statutory agencies such as the NHS and, for those who meet the national eligibility criteria, from the local authority. The report of the Barking and Dagenham Independent Growth Commission; *No-one left behind: in pursuit of growth for the*

benefit of everyone elaborates further on how the traditional role of the Council as the provider is evolving so that it is doing less itself, and enabling others to do more.

Mental Health in Barking and Dagenham 3

We take our definition of mental health from the World Health Organisation: "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community". Our strategy follows the WHO in recognising that mental health and mental illness (or mental health problems or mental disorders) are not opposites. The absence of a mental disorder does not necessarily mean the presence of good mental health, as there may be significant numbers of people who would not meet the description of wellbeing above, but do not have a diagnosable mental "disorder". Also people living with mental illness can live satisfying, meaningful, contributing and healthy lives.

Councillor Edna Fergus – Member Champion for Mental Health

Our ability to attain good mental health and our likelihood of developing mental health problems is affected by a range of social, economic and environmental factors, and these include the conditions of daily life from before birth, during early childhood, at school age, during family building and working ages, and at older ages. In Barking and Dagenham some of these factors are risk factors, rather than preventative factors, which means there are likely to be relatively high mental health needs locally, as explained in the borough's Mental Health Needs Assessment 2015.

National policy seeks to achieve "parity of esteem" for mental health and physical health, including achieving new standards in access and waiting times for mental health services. Barking and Dagenham Clinical Commissioning Group has invested additional funds in Talking Therapies and Early Intervention in Psychosis Services, provided by NELFT, in order to increase the capacity of these services to provide more people with evidence-based interventions.

There are a range of services for people experiencing mental health problems in Barking and Dagenham, some of these are directly accessible – like IAPT/Talking Therapies, others can be accessed through GPs. NELFT provide community, inpatient and specialist mental health services locally and the Care and Support Hub provides further information on these. The Emergency Duty Team provides urgent care for vulnerable people, including the provision of Mental Health Act assessments and Mental Health Direct is available to callers 24 hours a day.

We're in!
The mental health challenge
Local councils championing mental health

Barking and Dagenham has prioritised mental health as a borough, through signing up to the Mental Health Challenge and nominating a council Member Champion for mental health; Cllr Edna Fergus.

Vision and Aims 4

Vision: We want people to be active citizens; able to live a meaningful life and make positive contributions to the community they are part of. Services and support must focus on promoting wellbeing and enabling people who have experienced a mental health problem to be independent. We would like to see more people choosing the support they want and a greater range of services to choose from. We want to support people to achieve their aspirations such as returning to work, living well in suitable accommodation and keeping active.

Mission Statement: By 2018, we will ensure that when people first experience mental health problems they will get timely access to evidence-based interventions. We will take steps to address the inequalities that people with mental health problems experience and move towards parity of esteem for mental health and physical health. The borough will develop an approach to the delivery of support that maximizes prevention - particularly digital channels - and empowers residents to identify and meet their own needs wherever possible. Our personalised, place-based approach will build our community assets to develop supportive neighbourhoods where mental health is not stigmatized.

Aims:

Prevent ill health and promote wellbeing - by raising awareness of mental health issues, promoting positive steps for individuals and communities to build resilience and by ensuring that everyone has timely access to the right care and treatment.

Housing and living well - to enable people to live as independently as possible in their own accommodation whilst improving the pathways into a greater variety of accommodation for people who are discharged from hospital and other settings.

Working well and accessing meaningful activities - to ensure that everyone has the chance to benefit from the expected growth and increased prosperity in the borough, and to be fully engaged in, and contribute to, their local community.

Develop a new model of social support - by building on the strong tradition of integrated health and social care in the borough we will develop a new model of mental health care and support with prevention at the heart.

Priority One: Preventing ill health and promoting wellbeing 5

Assessing the situation

Our first priority is the prevention of mental ill health and the promotion of wellbeing. Mental well-being is fundamental to a good quality of life and the wellbeing of individuals, families and communities. Its impact is felt across education, employment, criminal justice, participation in public life, social behaviour, physical health, recovery from mental and physical illness, and life expectancy.

Underpinning the mental health strategy is the need to address inequalities and the associated stigma. Populations at most risk from social exclusion are more at risk of developing mental health problems, including those with limited opportunities for employment; women; racial and ethnic minority groups; refugees; sex workers; people living with disabilities, addictions or chronic illnesses; homeless people; and older people living in isolation or on reduced income.

Promoting mental health and well-being in later life will benefit the whole of society by maintaining older people's social and economic contributions, minimising the costs of care and improving quality of life. Evidence about the factors that affect mental health and well-being has increased. Activity to promote good mental health and well-being in later life should be integrated into current developments locally.

Promoting and protecting the emotional and mental wellbeing of children and young people is crucial in reducing risk factors of mental ill-health in adulthood and is the main aim of our Children and Young People's Mental Health Transformation Plan which interfaces with this strategy. This is particularly important as mental health conditions tend to affect people early in the life course, with 50% of cases occurring by age 14.

We recognise that preventing suicide and deliberate self-harm as severe outcomes of mental ill health is vitally important. We want to ensure that in addition to promoting wellbeing that we have in place systems that can highlight not only where and when individuals are 'at risk' but also reducing this risk and the impact of the wider effects of suicide in community networks. It also means taking steps to maximise everyone's opportunity to live as full and healthy a life as possible. This is especially important for people who have serious mental health problems who are at much greater risk of physical health problems such as heart disease and cancer, to the extent that they are at risk of dying, on average, 15 to 20 years earlier than people without serious mental health problems.

The New Economics Foundation has assessed the latest scientific evidence and created a set of simple actions to improve wellbeing in everyday life. By adopting the **Five Ways to Wellbeing** you can increase your life expectancy by up to 7.5 years.

Five Ways to Wellbeing

Connect...

Be active...

Take notice...

Keep learning...

Give...

The Five Ways to Wellbeing are evidence based ways to help you improve your mental wellbeing. We want to encourage individuals, communities and organisations to adopt the Five Ways to Wellbeing. This means more individuals, communities and organisations building 5 actions into their everyday lives to improve their wellbeing.

Existing strengths

Barking and Dagenham Council has recently won its bid to help set the national pace for healthy living, as part of the NHS 'Healthy New Towns' programme. Long-term development work, over a fifteen year period, will focus on Barking Riverside, and will have a wider impact locally and throughout the country. This initiative will see the council and its partners apply the latest health and social care research and practice in the planning and development of the built environment to create a mentally and physically healthy community. Residents will be asked to take part in a unique 'co-production' partnership, through a Community Interest Company. This approach will support the realisation of two of the council's key priorities by enabling social responsibility and encouraging civic pride from the outset.

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Barking and Dagenham is already signed up to the Mental Health Challenge. The Challenge has been set by seven mental health charities who are working together to improve mental health across England. As part of the Challenge, the borough has a nominated Member for Mental Health, Councillor Edna Fergus. Cllr Fergus, as Member Champion, is responsible for advocating for mental health issues in council meetings and policy development and also reaching out to the local community through schools, businesses and faith groups to raise awareness and challenge stigma.

The Council received a national Mental Health First Aid Champion Award in 2014 for 'demonstrating exemplary leadership in increasing mental health literacy in their community' as more than 1000 front line staff from across a range of organisations in Barking and Dagenham received Mental Health First Aid training between 2013 and 2015. This is an educational course which teaches people how to identify, understand and help a person who may be developing a mental health issue. In the same way as we learn physical first aid, Mental Health First Aid teaches delegates how to recognise those crucial warning signs of mental ill health.

The council commissions the Big White Wall, a digital mental health and wellbeing service that provides anonymous help and support to its members at whatever time that suits them. Members can talk to others in the Big White Wall community who share similar experiences and engage with counselors online as well as finding out about topics ranging from anxiety and depression, to coping with redundancy and alcohol problems. They can also find out more to help them understand their worries and concerns and how to move forward, and to express

Big White Wall™

how they feel creatively by making ‘Bricks’ on The Wall.

Many people with long-term physical health conditions such as diabetes, dementia and cardiovascular diseases, also have mental health problems. These can lead to significantly poorer health outcomes and reduced quality of life. The government’s mental health outcomes strategy No Health Without Mental Health placed considerable emphasis on the connections between mental and physical health, and gave new responsibilities to Improving Access to Psychological Therapy (IAPT) services for supporting the psychological needs of people with long-term conditions or medically unexplained physical symptoms. Voluntary sector organisations are also often well placed to work at the intersection between individuals’ mental, physical and social needs, including through the provision of support groups and peer-delivered services.

In order to meet new access and waiting time standards for mental health services, Barking and Dagenham Clinical Commissioning Group has invested additional funding in Talking Therapies (IAPT) and in Early Intervention in Psychosis services, provided by North East London Foundation NHS Trust. This means that more people are able to rapidly access the evidence-based interventions that can help them feel better, and, for some people, prevent them becoming more unwell.

As part of the future design of the council, Community Solutions will take a holistic approach to providing early intervention and support and will develop responses that will incorporate links to mental health support as required. The new service will be developed to encourage self-help and where necessary provide residents with the most appropriate support based upon their circumstances. Community Solutions means that the customer will be an equal partner with the Council in improving their outcomes. They will experience more holistic services both online and in person, and will receive outreach support where needed.

Actions needed

Future efforts need to include raising awareness of mental health issues, tackling stigma associated with mental illness, reducing risk factors for mental ill-health, and ensuring there is rapid access to evidence-based interventions for people who can benefit from them

We need to develop resilience in our community so that people can draw on their own and their community resources in achieving positive mental health and managing the difficulties they might face in their lives. We need to ensure that everyone has timely access to all of the right care and treatment that can help them maximise their own health and wellbeing.

Number	Focus Area	Success Measure	By when	By whom
1	Raising awareness of mental health issues and challenging stigma	Support the embedding of the council's Mental Health Member Champion Hold activities and events to promote mental wellbeing during Mental Health Week/on World Mental Health Day including the Five Ways to Wellbeing.	31 March 2017 10 October 2016/17/18	Integration and Commissioning LBBD / CCG/ NELFT
2	Supporting individuals and the community to help themselves and each other through digital well-being approaches and through education and training	Barking and Dagenham residents will be able to continue to access the Big White Wall - unlimited places available per month accessible via residents' postcodes Identify additional funds for a new programme of Mental Health Awareness Training Ensure safe information and self help resources relating to Mental Health are accessible via the Care and Support Hub	31 March 2017 31 March 2018 31 December 2016	Public Health Mental Health Subgroup Integration and Commissioning
3	Ensuring rapid access to evidence based interventions; Talking Therapies (IAPT) and Early Intervention in Psychosis services	Talking Therapies (IAPT): NHS Barking and Dagenham CCG is required to deliver two mental health standards related to IAPT; 15% of adults with anxiety and depression will have timely access to IAPT services with a recovery rate of 50%. Talking Therapies (IAPT): 75% of people with anxiety or depression needing access to IAPT will be treated in 6 weeks of referral and 95% by 18-weeks Early Intervention in Psychosis: Treatment with a NICE approved care package within 2 weeks for more than 50% of people experiencing a first episode of psychosis	31 March 2017 31 March 2017 31 March 2017	CCG and NELFT CCG and NELFT CCG and NELFT

4	Promoting health and wellbeing for people with mental illness	Physical Health checks to be undertaken for people with MH issues to address the higher associated risk around conditions such as diabetes and cardiovascular disease.	31 March 2018	NELFT/Public Health/GP/Leisure
5	Taking a partnership approach to reducing suicide	A completed suicide review to understand who is at risk of committing suicide and where and when suicide could happen Create a suicide prevention plan that will include interventions based on the suicide review for high-risk locations and high-risk groups of people in Barking and Dagenham which will be presented to the Mental Health Subgroup of the Health and Wellbeing Board	31 December 2016 31 July 2017	Public Health Public Health
6	Promote the Five Ways to Wellbeing	Promotion through: • Online Care and Support Hub • Mental Health Awareness raising events, e.g. World Mental Health Day • Social Media, e.g. Council's Facebook • Inclusion in other strategies as appropriate • Other routes as opportunities present themselves.	31 March 2018	Integration and Commissioning / NELFT / CCG / Public Health / Marketing and Communication Team
7	Improve the physical health of people with severe and enduring mental health problems to address premature mortality.	To ensure implementation of NICE guidance to promote physical health monitoring people living with severe and enduring mental illness	31 March 2017	NELFT / CCG

8	Increasing support for General Practice to support GPs in managing people with mental health to stay well and not enter secondary care	Development of GP Primary Care Workers	31 December 2018	NELFT/ CCG
9	Establish Healthy Ageing programmes in partnership with other agencies.	Development of Healthy Aging Programmes	31 December 2017	LBBD/CCG

Priority Two: Housing and Living Well 6

Assessing the situation

Have a secure, safe and comfortable home is enormously important in promoting wellbeing and protecting against mental ill health. However mental health problems can make it difficult to sustain secure accommodation; sometimes interfering with our ability to pay rent, manage a household or get on with our neighbours. This means people with mental health problems are at a higher risk of vulnerability and homelessness. Providing people with support to sustain their tenancy is therefore very important. Furthermore, having insecure or inappropriate accommodation can have a negative impact on mental health and make it more difficult for people to recover and live independently.

Barking and Dagenham has seen a fall in owner occupation and council ownership in the last fifteen years, and a huge growth in the private rented sector. There has been a 383% increase in homelessness since the advent of welfare reform in 2012. High rents and "non-decent" stock in the private sector exacerbate the problems for people who are effectively excluded from home ownership – the so-called "generation rent". The impact of the Welfare Reform and Work Act 2016 and the Housing and Planning Act 2016 provide further challenges for the borough in terms of reduced incomes and availability of affordable accommodation. These factors affect all residents in the borough, with some specific issues affecting people with support needs relating to their mental health.

Barking and Dagenham block contracts three supported living projects for people with mental health needs, providing between 12 hours of support a day and two projects which provide lower levels of floating support (typically two hours a day). A greater range of options is needed to meet the different support needs that people have. The need for mental health accommodation for specific cohorts is growing and the lack of 'step-down' properties in social or private rented stock for clients ready for independent living means they cannot be moved on, which creates bottlenecks for other clients. The borough's adult commissioning team and NELFT are undertaking a review of their current approach to mental health commissioning and housing-related provision.

With all of the current contracts in relation to this service type coming to an end in 2016/17, this provides the opportunity to re-design the service as a whole to meet the needs of the borough. In order to do this successfully work will be undertaken to ensure that the current and future need for mental health supported living is understood.

Existing strengths

Barking and Dagenham has strong strategies and ambitious plans to address the housing needs and aspirations of a dynamically changing population

through the Growth Strategy 2013-2023 and the Housing Strategy 2012-2017. The council has embraced the need to provide a wider range of housing choice for local people and to place Barking and Dagenham as a destination of choice for working households while simultaneously furthering physical, social and economic regeneration. This includes a place shaping approach, such as the Healthy New Town initiative at Barking Riverside, building new stock and renewing and regenerating major estates.

Our strategic approach aims to address the housing needs and aspirations of a dynamically changing population, embracing the need to provide a wider range of housing choice for local people and other Londoners struggling to get a foot on the housing ladder. We have implemented this regeneration strategy by delivering homes for working households who may not be able to access home ownership and who may have changeable tenure needs over the next few years, including supplying and delivering new homes through innovative approaches such as a private company owned by the council. Indeed we are London's growth opportunity with sufficient land and plans in place to build over 35,000 new homes in the next 15-20 years. These homes will be high quality homes of mixed tenure helping to improve the environment and attracting new investment and money flows into Barking and Dagenham. The borough is also improving the quality of the private rented housing sector through a borough-wide Private Rented Property Licensing scheme. All landlords and/or property managing agents letting a property in the London Borough of Barking and Dagenham need to apply for a licence for each property that is let out. This scheme will improve the quality of private rented homes and will reduce anti-social behaviour associated with poorly managed rented properties.

Barking and Dagenham has a relatively high proportion of adults in contact with mental health services in stable accommodation (as reported in the adult social care outcome framework when compared with similar local authorities) and needs to continue to ensure that this good performance is maintained. Barking and Dagenham has a draft Homelessness Strategy to tackle homelessness. The council has deployed a broad range of preventative interventions to alleviate the risk of homelessness through debt advice, assisting with rent deposits, resolving housing benefit problems, family mediation and preventing house repossessions. These interventions have helped to sustain tenancies and accommodation, minimising the number of households who would otherwise trigger an obligation to be housed under the statutory homelessness route.

Actions needed

Housing is at the heart of the Council's drive to improve the quality of life for residents and to create thriving communities and attractive places – homes and places where people positively choose to live. In addition to this we need to take a strategic approach to supporting people to live as independently as possible in their own accommodation, as well as providing a greater range of choice of both accommodation and support.

We want to provide support to people to maintain their own tenancies in Barking and Dagenham wherever possible. We will also provide more individualised and personal accommodation support for people with mental health problems, through extending the "floating" support that is available, to enable people to move on from supported accommodation as and when they are ready to do so, and not have to remain in accommodation with more support than they need for longer than they need to. We want to improve the pathways into a greater variety of accommodation for people who are discharged from hospital and other institutional settings, and for people with offending histories.

Number	Focus Area	Success Measure	By when	By whom
1	Work with housing market to increase numbers of people living independently with mental health problems	Work with private sector landlords to identify a minimum of five units for rent Support individuals into shared ownership owner-occupation	31 March 2017 30 September 2017	Housing Housing
2	Provide greater range of accommodation support available for people in contact with mental health services	Retendering of floating support service. Commissioning team to work with Housing and NELFT to ensure support for people in contact with mental health services receive support to help maintain their tenancies. Maintain the high proportion of adults in contact with mental health services who are in stable accommodation (79.3% in 2014/15 compared to similar local authorities average of 76%)	31 December 2017 31 March 2017	Integration and Commissioning / Housing / NELFT Housing / NELFT
4	Improve the pathways into a range of different kinds of accommodation when people leave hospital or require step-up from community. (Including independent, residential homes, nursing homes, supportive accommodation, sheltered housing and specialist provision).	Reduce Delayed Transfers of Care and hospital avoidance Establish a robust mental health accommodation step down and step up pathways	31 March 2018 31 March 2018	LBBD / CCG / NELFT LBBD / CCG / NELFT
5	Enhance the arrangements for partnership working between health and social care by agreeing a funding formula for people with complex needs and require joint funding between health and social care, particularly those who are subject to section 117 of the Mental Health Act.	The existing formula will be reviewed and agreed by Health and Social Care	31 December 2017	LBBD / NELFT / CCG

Priority Three: Working well and accessing meaningful activities 7

Assessing the situation

Having strong social networks and meaningful activity are important factors in protecting and promoting our mental wellbeing. A regular income that provides for our needs can bring independence and personal satisfaction. Employment, education and training are all important components in achieving financial independence, finding personal satisfaction and in developing social networks. Conversely, job stress, under-achievement in school or college, and financial worries can harm our mental health. Many people have caring responsibilities and/or work in the home, rather than in paid employment. Others will be retired from the workplace. Some people will find significant barriers to entering into employment and therefore enjoying the benefits it can bring. Barking and Dagenham faces a number of challenges in developing a prosperous local economy, due to the decline of the traditional manufacturing industry in the borough, low average household income, below average adult skills and higher than average unemployment.

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Barking and Dagenham has the third highest proportion of claimants of any borough in London receiving Employment and Support Allowance (ESA) or Incapacity Benefit (IB) behind only Islington and Hackney. Figures for February 2016, show there to be 8,200 claimants of ESA or IB, which accounts for 6.6% of working age people. This compares to an average rate of 5.1% across London. Of Employment and Support Allowance claimants, mental and behavioural disorders is listed as the principal reason with 43.5% of all ESA claimants being recorded as claiming for this reason.

Our strategy is to find ways to support people to manage the stresses of working, student or caring life and to maximise the opportunities for people to contribute fully to their local community, whether through employment, volunteering or fulfilling caring and parenting roles. Our Children and Young People's Mental Health Transformation Plan includes actions to support people in schools so this strategy focuses on adult education and employers and finding ways to provide better support to people in the workplace to help them manage stress and to notice and manage any problems early on that might, unchecked, lead to losing employment, income or opportunities. This will include ensuring that employers and employees are aware of the provision of Talking Therapies in Barking and Dagenham.

We also want to ensure that people with mental health problems are given the appropriate support in the workplace. We know that many people work in the home, with caring responsibilities, again these people might benefit from Talking Therapies and being connected with other people in their local community to prevent isolation. Caring Together: A Carers' Strategy for Barking and Dagenham 2015-2018 sets out how the council can support people in this position. During the stakeholder engagement that was carried out before this strategy was devised, we heard clearly from people who use mental health services how much they valued peer support and need to identify ways to facilitate this approach in Barking and Dagenham.

Recognising the contribution that people can make to society, no matter what their age, will assist in the promotion of good mental health and well-being

for all. Most of us want to remain active and involved and continue to contribute to society in later life, as feeling needed and wanted according to Age UK, helps to promote mental health and well-being. Older people have a lifetime of knowledge and experience to share, but are often faced with barriers to participation.

Participation can be in the sphere through employment, volunteering, education and learning, or through personal interests, hobbies and everyday activities that keep us feeling stimulated and engaged, and give us a sense of meaning, purpose and responsibility.

Existing strengths

Barking and Dagenham has significant housing and employment growth potential, this is articulated in the borough's Growth Strategy 2013-2023. In a strategic location, with good transport links, business support and strong school performance, Barking and Dagenham is set to become more prosperous over the next two decades. Over 10,000 new homes are planned to be built over the next 15 years at Barking Riverside Healthy New Town, which is one of the most ambitious and important new developments in the UK. Care City, the Barking based health, social care and regeneration innovation centre, is the lead partner.

Care City is a centre for healthy ageing innovation, research and education. It is based in Barking and works across the four north east boroughs, with reach into Essex. Founded by NELFT and the London Borough of Barking and Dagenham and launched in January 2016, Care City was awarded NHS England's Innovation Test Bed status in February 2016. Care City aims to deliver measurable improvements in healthy ageing for our local population and act as a catalyst for regenerating one of London's most deprived regions.

It will do this through:

- COMMUNITY: To create an asset based approach to partnership and participation, and promote healthy ageing across the community
- INNOVATION: To stimulate continuous improvement and innovation across the local health and social care system.
- RESEARCH: To advance the application of cutting-edge research into practice by bringing research to local people, and facilitating new models of research.
- EDUCATION: To increase resilience across the system's workforce by inspiring new entrants from our local population, facilitating life-long learning and generating future leaders

Work Programme provision has been the principle source of support to people who have been long-term unemployed, including Incapacity Benefit (IB) and Employment Support Allowance (ESA) claimants since 2011. The scheme specifically attempted to incentivise increased levels of support to the people through differential payments that also targeted sustained employment outcomes. A new ESA claimant is typically referred onto the programme after 3 months of claiming as part of the Work-Related Activity Group (WRAG).

There are two Jobcentre Plus (JCP) Disability Employment Advisors who work with any JCP customers with a disability or those in need of additional support. This client group includes a number of ESA claimants who have completed the Work Programme, those who are waiting to be assessed, some who are in the Support Group but would like some form of employment support and those who are in the Work Related Activity Group. The Work Choice programme is a voluntary support scheme available to individuals who have more complex health conditions and whose needs cannot be met by other programmes. Individuals do not have to be claiming any benefits but almost six-in-ten nationally are claiming Jobseekers Allowance.

Richmond Fellowship is commissioned by the Council to deliver mental health related employment and vocational support in the borough. Referrals are received via the Community Recovery Teams (CRT) for individuals with a more severe and enduring mental illness and via Barking and Dagenham Access and Assessment Team (BDAAT) for service users who have less serious illnesses. A high number of these clients are receiving ESA/PIP.

Individuals referred to the service are given 1:2:1 individual tailored support to enable them to overcome barriers and achieve their desired vocational goals including involvement in social activity, education & training and voluntary or paid work. The current contract is included in the scope of the Better Care Fund (BCF) and is jointly funded by the London Borough of Barking and Dagenham and the Barking and Dagenham CCG.

The Council has a dedicated Job brokerage service – Job Shops - located across three sites offering employment support across the Borough and has helped over 3,000 people into work since April 2013. This voluntary service is open to workless residents of the Borough and is focused on supporting residents into sustainable employment. It provides career information, advice and guidance, employability skills development, short training courses and "better-off" calculations through one-to-one appointments and group sessions. Post-employment support is also available for up to six months. The service has a dedicated job broker supporting those with a disability or health condition and there is a developing programme of work with Jobcentre Plus, Richmond Fellowship and the Talking Therapies Service.

There is a robust volunteer programme across the Children's Centre network . The programme consists of a 5 week 'Me and My Community' course, accessing a DBS certificate and a placement within a children's centre or with partner agencies. The target for Children's Centres is to have 7 volunteers working within each centre at all times. The benefits of this programme is that parents and carers are able to access positive activity, helping those who have been away from the job market for a period of time to build self-esteem, motivation, confidence and skills required for the current job market. Many participants do move into jobs, but there are also opportunities for those unable to work where they are able to access a variety of training courses, personal development and social networking.

The Economic Wellbeing team (EWB) is active across the children's centre network. Its focus is on debt management, financial stability, employment, training, education and volunteering. The team supports residents with pre-employment skills through a variety of positive activities delivered via one to one work or group sessions. Support is provided with building confidence, self-esteem and motivation, plus employability skills that include developing interview skills, work experience, volunteering, CVs, job search, careers guidance, sector training, and personal development. Residents who access these services tend to be people who are the furthest away from the labour market and need specialist support with their economic wellbeing.

An Access to Work grant is available to those that have a disability, physical or mental health condition that require adjustments to be made within the workplace to support their ability to do the role and sustain employment. Adjustments to equipment or fixtures and fittings as well as transport to and from the place of employment can also be covered. Referrals can be by the individual directly or through JCP. Additionally, there are two key publicly funded support programmes, designed to help people to stay in work which complement employers' occupational health schemes where they exist.

Fit for Work is a free service that helps employees stay in or return to employment by offering Occupational Health support and by offering advice to organisations and GPs. It offers a way for employers to offer phased returns to employment and focus on what an individual can do rather than what they cannot do.

The council's extensive volunteering programme has seen volunteers provide 32,481 hours of support to services in 2015/16, including 25 trained Health Champions who work to spread positive health messages and signpost residents to appropriate services.

Actions needed

We want to ensure that everyone has the chance to benefit from the expected growth and increased prosperity in the borough, and to be fully engaged in, and contribute to, their local community. This includes enabling people to access employment, educational and training opportunities as well as undertaking caring roles and volunteering. There is a clear need to ensure that locally funded provision builds on and adds value to the mainstream offers of support available through government-funded programmes.

The Community Solutions model will incorporate a broad range of factors which impact upon the wellbeing of our residents. The promotion of positive mental wellbeing will be a key part of the approach to providing early intervention and support. The new service will be developed to encourage self-help and enable residents to take positive steps to live healthy and independent lives.

There is to be a re-modelling and re-tendering of our current mental health related employment and vocational support contract with an aim to increase numbers of people with mental ill health securing long term competitive employment . This is to be in the shape of an Individual Placement Support (IPS) model, meaning anyone with a severe and enduring mental health need who wants to work will be eligible for employment and will gain the support to do so. There will be an integrated approach to recovery from mental ill- health to the final destination of sustained wellbeing which includes may include employment, independent living, maintaining friendships and many other things defined by the individual.

As part of this process we will assess best practice models from other leading boroughs and evaluate the success of some recent pilots to ascertain the best supported employment option for the residents of Barking & Dagenham. Analysis of referral activity, referral sources, pathways and movement between programmes is also being undertaken, as will consult with service users and carers to inform proposals. There will also be collaboration with NELFT and CCG colleagues, Job Centre Plus and Community Solutions to ensure a strategic approach to the integration of the new service model.

Number	Focus Area	Success Measure	By when	By whom
1	Improving the support to people in employment and education through working with employers and colleges	Employers signing up to Disability Confident or Workplace Healthy Charter. Employer awareness/use of Fit for Work Service & Access to Work	31 March 2018 31 March 2018	LBBD / DWP LBBD / DWP
2	Re-commission the existing vocational support offer to develop the provision of individualised placement support for people in contact with mental health services	Increase in number of adults in contact with mental health services who are in paid employment. To perform at same level as that of similar local authorities (2014/15 3.7% to that of similar local authorities 4.5%) Adult Social Care Outcome Measure	31 March 2018	Integration and Commissioning
3	Explore the use of increased peer support for people in contact with mental health services	Explore peer support models in other boroughs to identify best practice and suitable examples applicable in LBBD	31 March 2017	Integration and Commissioning
4	Commissioning of Work & Health Programme to replace existing Work Programme provision	Improved outcomes and performance for ESA claimants as compared to the Work Programme.	31 December 2017	LBBD / DWP
6	Partners of the Mental Health Subgroup to actively seek and promote employment, volunteering and training opportunities for people with mental ill health	Placements within each organisation	31 March 2018	Mental Health Subgroup
7	Mental Health Sub-Group to receive regular reports and updates from the Barking & Dagenham Employability Partnership on employment initiatives/programmes	Improved communications between health & employment partners leading to narrowing of employment rate gap	31 March 2018	Mental Health sub-group / Barking & Dagenham Employability Partnership

8	Development of improved voluntary sector support for people with mental health problems in Barking & Dagenham	An established model and implementation	31 December 2018	LBBD / CCG / NELFT / CVS / Voluntary Sector
9	The opportunity for older people to engage in meaningful activity and make contributions to society in both public and person life and to combat loneliness.	Develop community based projects that will involve older people	31 December 2017	LBBD / CCG and partner organisations

Priority Four: Developing a new model of social support 8

Assessing the situation

Priorities one to three in this document provide a focus for strategic work that is intended to respond to the main themes that have emerged from the recent mental health needs assessment and stakeholder engagement. These priorities take account of the complex and challenging position of health and social care services and the need to respond to a range of initiatives intended to create positive change in mental health. At the same time as councils are facing severe financial pressures, people's needs and expectations demand a positive response. National policy to achieve parity of esteem for mental health and physical health provides a welcome focus on improving mental health services, including setting out access and waiting time standards for mental health services for the first time. Across Barking & Dagenham, Havering and Redbridge we have embarked on an ambitious transformation programme, supported by a bid for devolved powers from central Government, which will give us the best opportunity in a generation to tackle the significant health and wellbeing challenges that we face.

Priorities one to three attempt to address some of the immediate issues that will improve our strategic response to mental health, priority four aims to provide a focus on more creative, innovative ways to co-produce a new system of mental health care and support by 2018, including maximising the benefits of creating a digital front-door to advice and support. The role of social work and social care in this new model needs to be developed further, to allow the particular skills of social workers to be used to their full benefit in creating a sustainable and responsive approach in the borough. There are innovative models of support in place in other parts of the country that can help inform our thinking about how to develop our approach in Barking and Dagenham.

Grounded in an approach to locality working, our proposals for an Accountable Care Organisation, if successful, will bring greater coherence and focus to our transformation plans for mental health, planned care, primary care, and urgent and emergency care. We would have a greater emphasis on reducing the costs of expensive acute care and investing in prevention activity, all under the management of a single organisation taking responsibility for the health, and health and care services, of the 750,000 people in Barking & Dagenham, Havering and Redbridge. Our immediate work to develop new models of mental health care and support will take us towards this new, ambitious vision of health and wellbeing for our residents. Decisions on an Accountable Care Organisation will be taken during 2017 by the eight health and social care organisations that would take part (three local authorities, three clinical commissioning groups, two NHS trusts).

Ensuring new models of health and social care delivery and innovation, through Care City NHS Innovation Test Bed will be integral to the approach for developing the Barking Riverside Healthy New Town. This includes applying the latest learning on 'age-friendly' built environments and public spaces, and ensuring the area is livable and inclusive for all ages. Additionally, through service redesign, the Community Solutions approach will provide early intervention for all residents as they interact with the council.

Existing strengths

Barking and Dagenham has developed integrated working between health and social care for adults of all ages over the last few years, with a cluster-based model of integrated case management for adults that incorporates community health services, social services and primary care services. Recent additional investment by Barking and Dagenham Clinical Commissioning Group into Talking Therapies and Early Intervention in Psychosis -services means that more people are able to access evidence-based psychological interventions in a timely way. Barking and Dagenham has a well-established mental health sub-group of the Health and Wellbeing Board that brings together people with a responsibility for mental health care in the borough to work together to improve outcomes, this group has overseen the development of the local Crisis Care Concordat Action Plan.

Our mental health social workers have advanced skills, not only in their role in addressing the legal and statutory requirements upon them and protecting people from harm but in their ability to work holistically with people and others in their social network in order to develop their social capital.

Actions needed

We will build on the strong tradition of integrated health and social care in the borough; developing the assets we already have in our statutory workforce and the voluntary sector, to continue to develop our approach to mental health care and support. We will seek to develop our mental health social workers, to integrate their working more effectively with the approach taken to adult health and social care. We will improve access to social support through Community Health Champions and Community Solutions, and will ensure that these new approaches will work across adult health and social care to develop community assets and to improve access to services when needed. Through the personalisation agenda, we will ensure that people will be able to make choices about their care, including through personal budgets.

Number	Focus Area	Success Measure	By when	By whom
1	Developing the role of the mental health social worker in Barking and Dagenham	To develop a programme of social work development activity for mental health as part of the borough's wider approach to social work practice development.	31 July 2017	Adults' Care and Support / NELFT (sec 75) Social Care Lead for Mental Health
2	Ensuring Community Solutions embrace mental health and wellbeing in their approach	Developing MH expertise in Community Solutions to ensure robust signposting to NELFT services.	30 September 2017	Director ComSol, LBBD
3	Developing the role of the Community Health Champions to support mental wellbeing	Training of Community Health Champions	31 December 2016	Volunteer Manager, Heritage Services

4	Further development of mental health in the locality approach and new models of integration between adult health and social care and mental health social work	New integration options developed and considered including engagement with residents and service users.	31 March 2017	Adults' Care and Support / NELFT
5	Developing an outcomes-based approach to mental health commissioning	Agreement of key outcomes	31 March 2018	CCG, NEFLT, LBBD commissioning
6	Integration of mental health and substance use support as required	An agreed approach to developing dual diagnosis services	31 December 2017	CCG, NEFLT, LBBD commissioning
7	Care and support, should be evidenced based, timely, providing choice and delivered within the remit of least restrictive practice, offering people choice dignity and respect.	• Outcome measures • Use of Personalisation • Service User Survey	31 December 2018	All care providers
8	Providers of care should be of a high quality, safe and delivered by suitably trained staff	• Monitoring • Reduced complaints • Increased compliments	31 December 2018	Commissioners / Regulators
9	Develop a peer support model, which promotes recovery, wellbeing and opportunity for community engagement.	An agreed model and implementation	31 December 2017	Commissioners

Implementation 9

Working together has developed this strategy, and will underpin the approach we take to improving it and seeing it delivered in 2016/17 and beyond.

This strategy has been developed for the Health and Wellbeing Board for Barking and Dagenham, by the Mental Health Sub-group. This Health and Wellbeing Board was established on 1 April 2013 under the provisions of Health and Social Care Act 2012 and is chaired by the Cabinet Member for Social Care and Health Integration, Councillor Maureen Worby.

The Health & Wellbeing Board is primarily responsible for promoting the health and wellbeing of residents, and promoting integration amongst local health, health-related and social care services. It is ultimately responsible for the delivery of the commitments in this strategy.

It is supported by five sub-groups, working on Mental Health, Children & Maternity Services, Integrated Care, Learning Disability and Public Health Programmes. They will all be expected to contribute to the delivery of this strategy and its on-going development through shaping the understanding of needs and putting in place plans to deliver the needs of the respective care groups for which they are responsible.

Key aims of the Mental Health sub-group are:

- To have oversight of, and foster improvements in, mental health in its totality from the social determinants of mental health, ill-health prevention and screening, to detection, treatment and care of mental health conditions.
- To report on local work programmes and service developments.
- Agree partnership approach through the engagement of key stakeholders, including specialist providers, the voluntary sector, service users/patients, acute sector, carers and GPs and partners.
- To ensure patients and carers are involved in all needs assessment, service commissioning and provision undertaken
- To work collaboratively with the other HWBB sub groups and Children & Maternity Groups on joint pieces of work.

Membership of the Mental Health Sub-Group comprises representatives from a wide range of stakeholders including service users and carers.

This strategy will be monitored by the Mental Health Sub-Group who will make an annual progress report on implementation to the Health and Wellbeing Board.

How you can tell us what you think 10

The publication of this strategy is not the end of the process. It needs to be delivered and, as the work rolls out, there will be opportunity to further develop our understanding of what is needed.

It's important we hear from as many people as possible when planning work of this nature. If you have views that you would like to contribute to the future development of mental health services, please contact us.

You can email us at adultcommissioning@lbbd.gov.uk

You can write to us at
Mental Health Strategy
Integration & Commissioning
Barking Town Hall
1 Town Square
Barking
Essex IG11 7LU

There will be a number of public events, as well as provider and service user forums, during the first year of the strategy – keep an eye out for details and come and talk to us there.

References

11

Adult Autism Strategy 2015-2017 London Borough Barking and Dagenham

LBBD Mental Health Needs Assessment 7 July 2015

Joint Health and Wellbeing Strategy 2015 to 2018

Developing a Mental Health Strategy HWB paper 7 July 2015

Mental Health Services in Barking and Dagenham Setting the scene, shaping the vision 7 July 2015

Barking and Dagenham Children and Young People's Mental Health Transformation Plan

Adults in contact with mental health services who are in paid employment

Adults in contact with mental health services who are in stable accommodation

Barking and Dagenham Prevention Framework

Care Act 2014

Future in Mind

The Five Year Forward View for Mental Health

Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives 2012

https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england

Guidance for Developing a Local Suicide Prevention Action Plan: Information for Public Health Staff in Local Authorities October 2014

https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

(Draft) Homelessness Strategy 2016 - 2021

Caring Together: A Carers' Strategy for Barking and Dagenham 2015-2018

Social work for better mental health- A strategic statement

Crisis care concordat action plan and Crisis care concordat website

No Health without Mental - 2011

Appendix B

Consultation Feedback Summary

1. Introduction

1.1 The first draft of the Mental Health Strategy was presented to the Mental Health Subgroup on 18 July 2016. The Strategy was well received and actions were agreed to ensure a thorough and robust consultation process.

1.2 Subsequent iterations of the Strategy were consulted with the following areas:

- Learning Disabilities Partnership Board
- Children and Maternity Subgroup
- Employment and Opportunity Forum
- NELFT MH and LD Community of Practice
- Cllr Worby - Cabinet Member for Social Care & Health Integration and Chair of Health & Wellbeing Board
- Cllr Fergus – Mental Health Champion

1.3 In additional to the above, the Strategy was consulted with the following Service User forums:

- Patient Experience Partnership
- Richmond Fellowship - Working Together Group
- CCG Patient Engagement Forum

1.4 The Strategy was uploaded to Barking and Dagenham's Consultation Portal with the link communicated widely, including via Barking and Dagenham Council for Voluntary Services and also as part of the engagement activities for World Mental Health Day on 10 October 2016.

1.5 The public consultation closed on 31 October 2016 with four people having commented on the Strategy via this channel.

2. Feedback

2.1 Feedback and comments on the Mental Health Strategy 2016 – 2018 were provided via a range of different means. The list below is intended to provide a rounded summary of the key themes which emerged through the consultation process.

2.2 All feedback received throughout the consultation process was considered to inform the latest version of the Mental Health Strategy 2016 – 2018. A number of suggestions were directly incorporated into the Strategy or were reflected through amendments. Other points were referred to the most relevant service areas.

2.3 As expressed in Section 10 of the Strategy, its publication is not the end of the process. The Strategy will be periodically reviewed and adapted to meet the changing landscape of the local health and social care economy. This will be reflected through the actions and targets laid out within the Strategy.

Summary - Patient Experience Partnership	
Comment	**Action / Feedback**
The “five ways to wellbeing” are very good. Promoting them will be helpful. They complement the “eat five a day” for physical health.	Noted.
I think there needs to be more on physical health. Exercise is good but it’s only part of the solution. A lot of service users ignore their physical health; from simple things like eye tests right through to the more serious things. Some GP’s also ignore physical health when dealing with mental health.	More has been included in Priority 1 on this. Particularly with reference to people with long-term physical health conditions such as diabetes, dementia and cardiovascular diseases, who may also have mental health problems. Reference is also made to the government’s mental health outcomes strategy No Health Without Mental Health which placed considerable emphasis on the connections between mental and physical health.
It’s good to see that suicide is being addressed in this strategy.	Noted.
Priority Three, the title is good as it suggest that work is not the be all and end all; that meaningful activities are equally as important. All too often employment is over emphasised and that can make service users who haven’t reached that point feel diminished in some way.	Noted.
Bearing that in mind the Focus Areas (priority 3) could do a lot more to reflect the broad range of meaningful activities; for example developing social networks and being a Carer. There’s a big emphasis on employment here it needs to be balanced with other meaningful activities.	Priority 3 has been rewritten and reflects more of the services available in the borough. The work of the Richmond Fellowship, for example, supports individuals to enable them to overcome barriers and achieve their desired vocational goals including involvement in social activity, education & training and voluntary or paid work.
I think it’s good that this strategy will be reviewed with service users and residents.	Noted.
I think it’s very good that all the different agencies are getting	Noted

together to do something about mental health.	
People with mental health problems often struggle with managing their finances and with looking after their home environment. There needs to be more support in these areas.	The Council's Commissioning team will work with Housing and NELFT to ensure support for people in contact with mental health services receive support to help maintain their tenancies through the retendering of the Floating Support service
There needs to be more about challenging stigma, awareness raising and education about mental health. You also need to do something about the media.	We will be holding activities and events to promote mental wellbeing during Mental Health Week/on World Mental Health Day including the Five Ways to Wellbeing which will work to tackle stigma. We will also be promoting positive messages through our marketing and communications team via social media.
Reducing isolation is very important.	This is address in Priority 3 within the MH Strategy and is part of the Council's wider focus on how digital solutions can reduce isolation.
Suicide: How can you prevent someone from killing themselves unless they're on a section in hospital?	Public Health are conducting a suicide review to understand who is at risk of committing suicide and where and when suicide could happen. A suicide prevention plan will be developed that will include interventions based on the suicide review for high-risk locations and high-risk groups of people in Barking and Dagenham.
There needs to be more about social support, friendship building, confidence etc.	The local Prevention Approach works to promote social support, along with the Councils priority to enable social responsibility
I enjoyed reading it.	Noted
I strongly agree that having a "safe, secure and comfortable home" is of paramount importance to good mental health.	Noted

Summary - Working Together Group, Richmond Fellowship	
Comment	**Action / Feedback**
It's good that the Council are doing something about mental health.	Noted.
We'd like meaningful volunteering, part time work initiatives, part time job trails that don't affect benefits.	Referred to Regeneration Manager, Employment and Skills. Additionally, this feedback will be considered as part of the mental health vocational support retender.
To get back to work I'd need even more training in confidence building, stress management and other things like interview skills.	Referred to Regeneration Manager, Employment and Skills. Additionally, this feedback will be considered as part of the mental health vocational support retender.
Employers need to know about Mental Health First Aid	Referred to Regeneration Manager, Employment and Skills and discussed through Mental Health Subgroup. Additionally, this feedback will be considered as part of the mental health vocational support retender.
We need training in computers.	Future options to enable residents to improve their computer skills are currently in development. Dagenham Library currently offers residents with support as a UK Online Centre.
I don't know anything about the Care and Support Hub (or Band together).	Referred to Information and Advice Manager, Integration and Commissioning
How about the final destination of recovery is sustained Wellbeing? That would include employment, independent living, caring for others, maintaining friendships and many other things. And after all, the goals of recovery need to be defined by the individual who's recovering not by someone else for them.	Section in Strategy amended to read "…sustained wellbeing which includes may include employment, independent living, maintaining friendships and many other things defined by the individual.

Summary - Joint Children's Commissioner, Clinical Commissioning Group	
Comment	**Action**
It mentions that it does not focus on Children and Young People but the NHS Five Year Forward View does refer to this throughout so the Strategy seems less complete without this element. It may be better to bite the bullet and state that any MH strategy cannot be aged limited – all this issues around My Life; My Home etc impact across all ages.	Both the CAMHS TP and the MH Strategy are in their infancy and will need to be developed further to account for the evolving landscape of health and social care. Future intention may be to bring the two areas together are a 'life course' strategy.

Summary - Patient Experience Forum	
Comment	**Action / Feedback**
Is the strategy going to look at improving access/services for those in full time work (evening and weekends), lots of great services only available during working hours weekdays often at the exact same time and date so no flexibility.	Talking Therapies have increased their accessibility. Additionally, all NELFT services are exploring the feasibility of amended working hours to improve accessibility.

Summary - Healthwatch	
Comment	**Action**
The picture of the clasped hands doesn't work for me as I don't make the connection between it and the mental health strategy.	Image changed and approved by Mental Health Subgroup.

On page 4 there is no direct reference to the mental health needs assessment used on page 5 – perhaps that could be mentioned to bolster the link between the 2 for those who may not know?	This has since been amended to reflect the MHNA.
The impact of physical health issues on mental health well being could be raised as an area to focus on too; perhaps highlighting the numbers of individuals with physical health conditions that access talking therapies as a preventive/supportive measure.	The use of Talking Therapies, particularly for those with LTC's has since been included.

Summary - Mental Health and Employment Forum	
Comment	**Action**
Insufficient acknowledgment of people past retirement age and those too unwell to consider employment	The strategy is for all adults, including those past retirement age. This priority recognises that employment may not be realistic for all, hence the focus on meaningful activities.
Various services and their resources are omitted.	This entire has since been rewritten with the assistance of the Regeneration Manager, Employment and Skills.

HEALTH AND WELLBEING BOARD

14 June 2016

Title:	**Children and Young People's Mental Health Transformation Plans 2016 Refresh**
Report of the Children and Maternity Group	
Open Report	**For Decision**
Wards Affected: None	**Key Decision:** No
Report Author: **Gemma Hughes,** **Deputy COO B&D CCG**	**Contact Details:** Tel: 020 3644 2380 E-mail: gemma.hughes6@nhs.net
Sponsor: **Conor Burke, Chief Officer, B&D CCG**	

Summary:

Barking and Dagenham CCG produced Children and Young People's Mental Health Transformation Plan (CYP MH TP) in 2015, which was approved by NHSE and published in December 2015.

The plans responded to the Children's Mental Health Taskforce report, **Future in Mind**, published in March 2015 and set out how the CCGs would use their allocation of CYP MH Transformation Funds.

The plans were produced by the joint CCG and local authority children's commissioner and were approved by the Health and Wellbeing Board. NHSE requested that these plans are refreshed and resubmitted by 31 October 2016. This paper provides an overview of the refreshed plans for Barking and Dagenham.

Recommendation(s)

The Health and Wellbeing Board are asked to:

- Note the progress made to date on delivery the CYP MH TP and the new challenges that have arisen
- Note the contents of the refreshed plans

Reason(s)

75% of mental health problems in adult life (excluding dementia) start by the age of 18 and if left untreated can develop into conditions that require regular care. The Barking and Dagenham CAMHS needs assessment (2016) reported that there are a growing number of children in the borough who are at risk of developing mental health conditions and current services are not keeping pace with demand. The CYP MH TP sets out a five year plan to build capacity and capability across the system and develop more responsive and preventative approaches to build resilience and provide early intervention. Central to

this is the redesign of services around the thrive model of care which is being taken forward through the development of the wellbeing hub. This is expected to be in place early in the new year.

1. Introduction and Background

Barking and Dagenham CCG produced a Children and Young People's Mental Health Transformation Plans (CYP MH TP) in 2015, which was approved by NHSE and published in December 2015.

The plan responded to the Children's Mental Health Taskforce report, *Future in Mind*, published in March 2015 and set out how the CCG would use its allocation of CYP MH Transformation Funds.

The plans is available at:

http://www.barkingdagenhamccg.nhs.uk/Downloads/Our-work/CAMHS/Barking-and-Dagenham-CAMHS-report-v2-December-2015.pdf

The plan was produced by the joint CCG and local authority children's commissioner and was approved by the Health and Wellbeing Board.

NHSE have requested that the plan is refreshed and resubmitted by 31 October 2016. The refresh of the CYP MH TP is attached as Appendix 1

2.0 Purpose of the refreshed plans

1.1 The refreshed plans provide an opportunity to:

- Take account of new information available since the plan was written in 2015
- Remind stakeholders of the vision set out in previous plans
- Provide an update on progress and engagement in the last year
- Provide an update on changes occurring in the local environment during 2016
- Identify new challenges
- Provide refined commissioning plans for 2017/18 that respond to these factors as well as setting out how new national "must dos" will be balanced with local priorities.

2.2 The refreshed plan does not change the strategic direction set out in the plan produced one year ago, nor does it change the vision that we are working towards. It should be read as an updated version of this plans which continues with much of the activity that has been delivered in the previous year, builds on learning gained from this work and adapts to changes in the environment.

2.3 Since the LTP was published in December 2015, the CCG has been able to develop a deeper understanding of the population needs and local priorities. This has enabled the development of plans to improve emotional health and resilience in CYP at risk of developing a mental health conditions as well as improving access to services for those that are diagnosed with a mental health condition.

3.0 Allocation of CYP MH Transformation Funds and proposed expenditure

3.1 The CCG will receive a recurrent allocation of CYP MH Transformation Fund in 2017/18 and a small uplift. The full allocation, including the recurrent funding, for Barking and Dagenham is £522,000.

3.2 This fund is already committed to priority work streams as agreed in the previous years' plan and the proposed expenditure plan is summarised below.

Priority work stream	**Related target**	**Proposed activity**	**B&D spending plan**
Perinatal	Increase in women accessing specialist services	Increase in capacity if funds available	Dependent on transformation fund availability
Eating disorders	Access and waiting times	Increase in capacity as per previous investment, developing access / integrate with SPA	No additional investment (previous investment is recurrent)
Early intervention in psychosis (EIP)	Access and waiting times	Increase in capacity and stretch waiting time target	No additional investment (previous investment recurrent)
Wellbeing hub	Increase in access and CYP IAPT compliance	NEFLT additional practitioners (Single Point of Access and CYP IAPT)	£146,000
		Crisis support	£195,000
		Looked After Children practitioner	£58,000
		Digital support	£40,000
		Schools training	£21,000
		MH social worker	£40,000
Enabler: engagement		Support to local Youth Forum / Parliament	£2,000
Enabler: implementation support		Contribution to programme management across BHR	£20,000
Contingency			
Total			**£522,000**

It should be noted that these plans enable the continuation of existing commitments.

4.0 Governance and engagement

6.1 Engagement has taken place throughout 2016 on the CAMHS needs assessment and our transformation plans, including with the Barking and Dagenham Youth Forum and Young Inspectors Specific. A workshop was held in October to inform the refresh of the plan with representation for health, education and social care and the findings included in the refreshed plans. The joint children's commissioner has engaged directly with children's services and education colleagues in the council about the content of the plan. Members of the Mental Health Delivery Group for BHR CCGs (including NELFT and local authorities) were invited to comment on the draft plans.

4.0 Mandatory Implications

4.1 Joint Strategic Needs Assessment

A CAMHS needs assessment was commissioned in 2016 which supplements the Barking and Dagenham Joint Strategic Needs Assessment (JSNA). Barking and Dagenham has higher rates of diagnosable mental health problems when compared to the England average and the number of children with a diagnosable mental health problem will increase by 2020. Some groups of children and young people are more at risk of experiencing mental health problems, including those living in poverty, looked after children and young offenders.

4.2 Health and Wellbeing Strategy

The programme will support health and wellbeing throughout all stages of life to:

- Reduce inequalities
- Promote choice, control and independence
- Improve the quality and delivery of services provided by all partner agencies

4.3 Integration

The paper makes clear reference to and proposals in respect of both to the joint commissioning – a requirement of the Children and Families Act 2014 – and to the development of the Accountable Care Organisation.

4.4 Financial Implications

A budget of £522,000 has been identified to support the delivery of the LTP in 2017/18.

4.5 Legal Implications

None

Public Background Papers Used in the Preparation of the Report: None

List of Appendices:

Appendix 1 – Barking and Dagenham Children and Young People's Mental Health Transformation Plan Updated October 2016

Barking and Dagenham

Children and Young People's Mental Health Transformation Plan

Updated October 2016

Table of Contents

Executive summary

This document provides a refresh of the Children and Young People's Mental Health Transformation Plan in Barking and Dagenham. The plan, produced in December 2015, was developed in partnership between the CCG and the London Borough of Barking and Dagenham and our local providers and stakeholders. The plan set out how the CCG would use the additional allocation of Transformation Funding to launch whole system change for children and young people's emotional and mental health.

Since the plan was approved by the Health and Wellbeing Board, we have seen both considerable progress in terms of delivery of the plan, and increasing and new challenges to which we have had to respond. Our vision, for all children and young people to enjoy good emotional wellbeing and mental health, remains. Our ongoing engagement with stakeholders, and our deepening understanding of our local resident's needs (as for example set out in the 2016 Barking and Dagenham Children and Young People's Mental Health needs assessment) validates this vision and reinforces the importance of this transformational work.

Having already ensured that we have a common vision across the three CCGs and boroughs of Barking and Dagenham, Havering and Redbridge, and working collaboratively with our neighbouring CCG and borough of Waltham Forest, we are extending our collaboration in 2016/17 across the STP area of north east London and in partnership with NHSE in relation to the commissioning of specialist services.

This document provides an update on delivery, describes some new challenges and requirements, and sets out a refined set of priority workstreams along with our commissioning plans to deliver these.

We always welcome comments and discussion on our plan and would be happy to hear from you. You can contact the CCG on b&dccg.bdccg@nhs.net

1. Introduction

The Mental Health Five Year Forward View Implementation Plan set out the requirement for Children and Young People's Mental Health Local Transformation Plans to be expanded, refreshed and re-published by 31 October 2016. This document is the October 2016 refresh of the Barking and Dagenham Children and Young People's Mental Health Transformation Plan that was first produced in December 2015. This document updates, rather than replaces the previous plan, which is available at

http://www.barkingdagenhamccg.nhs.uk/Downloads/Our-work/CAMHS/Barking-and-Dagenham-CAMHS-report-v2-December-2015.pdf

The plans respond to *Future in Mind*, the national report, produced by the Children and Young People's (CYP) Mental Health and Wellbeing Taskforce in early 2015.

The purpose of this document is to:

- Refresh the previous plan to take account of new information available, including the Barking and Dagenham needs assessment produced in 2016[1]
- Remind stakeholders of the vision set out in previous plans
- Provide an update on progress and engagement in the last year
- Provide an update on changes occurring in the local environment during 2016
- Identify new challenges
- Provide refined commissioning plans for 2017/18 that respond to these factors as well as setting out how we will meet the new national "must dos" and balance these with local priorities.

2. Strategic alignment

Barking and Dagenham CCG already work with Redbridge and Havering CCGs under a single Chief Officer and shared management structure. A common vision for the Barking and Dagenham, Havering and Redbridge (BHR) footprint was shared in the previous plans, though with local variation to meet the different specific needs and priorities in each borough. BHR CCGs also work closely with Waltham Forest CCG to commission specialist services, including for example community eating disorders and early intervention in psychosis services, across a wider geographic footprint, allowing for greater economies of scale as well as consistency of offer.

This refreshed transformation plan is now also aligned with the north east London sustainability and transformation plan (STP). Workstreams relating to perinatal mental health, collaborative commissioning models for children and young people inpatient (tier 4) services, 24/7 crisis care for children and young people (CYP) and management of child sex abuse are currently being planned at STP level. Significant progress has been made in CYP mental health transformation. However, variation in performance (e.g. bed usage, placements) still exists across north east London and sustainably meeting the Five Year Forward View objectives requires transformation across the system. The local transformation plans for children's mental health services draw on *Future in Mind* and are focused on delivery of the Five Year Forward View targets. The STP work will ensure that mental health is a key component of all STP plans and not a stand-alone programme of work.

[1] https://www.lbbd.gov.uk/wp-content/uploads/2016/08/CAMHS_Needs_Assessment_web.pdf

3. Vision

3.1 Barking and Dagenham Vision

Our vision for children and young people in Barking and Dagenham has not changed since December 2015. It remains that our vision is for all children and young people to enjoy good emotional wellbeing and mental health.

Our vision is that children and young people in Barking and Dagenham are empowered to be resilient and able to cope with the challenges of everyday life. We envisage mental health being seen as 'everyone's business' and that people within a child's sphere of influence understand their role in promoting good mental health.

We want children, young people, their parents, and all professionals who work with them to be aware of local services and of how to access extra support where there are identified additional needs. Further, where those needs are indicative of underlying mental health conditions, support must be easily accessed and interventions be timely, evidence-based, and delivered by friendly, caring professionals.

We envisage services that are flexible and integrated, responding to varying levels of need including the additional needs of vulnerable children and young people, including looked-after children, children needing post-traumatic recovery support, and children and young people with special educational needs and disabilities.

Our intention is to deliver seamless, integrated services that are flexible and graduated in their response to need. The support of CYP MH transformation funds will enable us to accelerate improvements, building capacity and capability and exploring new ways of working.

Barking and Dagenham Children and Young People's Mental Health Transformation Plan 2015

3.2 Barking and Dagenham ambition 2016-2020

The Transformation Plan published in 2015 set out our aspirations to develop a sustainable whole system approach to building resilience and better emotional wellbeing and mental health in children and young people. This approach aspires to draw on and enhance the assets found in our local community and services, in particular in health services, the council, schools, the third sector and youth justice. We are currently evolving from the traditional tiered approach to a seamless pathway into and out of four quadrants of service delivery, based on the Thrive model. Our ambition is to achieve the target of 35% of children and young people with diagnosable conditions accessing evidence-based treatment by 2020/21; to ensure that all children and young people with diagnosable conditions are encompassed within this approach and; to build resilience and promote prevention universally. The model is described briefly below and in diagrammatic form in Figure 1.

Figure 1: Thrive/Quadrant approach

Quadrant 1: Building resilience; preventing ill health and promoting wellbeing by working with parents, children and young people, schools, early help provision and other universal services to support emotional needs, provide early help and practical support.

Quadrant 2: Helping children, young people and families to cope; to practically build resilience, highlighting risk and protective factors and providing access to digital support, parental learning, online counselling and direct and timely access for routine assessment and treatment if needed.

Quadrant 3: More intensive support and specialist treatment; readily available from a single point of access for all needs, with integrated pathways into and out of specialist services including eating disorders, and with specific pathways in place for vulnerable children including looked after children and those in contact with the justice system.

Quadrant 4: Support and intensive interventions in a crisis; available when needed, fully integrated into other pathways, working towards a 24/7 offer and seeking to outreach and reduce need for higher levels of intervention.

4. Progress during 2015/16

4.1 Baseline

The case for change that underpins this plan was set out in the previous plan published in December 2015 which provided our baseline in terms of staffing, finance and activity (see pages 19 to 20 in the 2015 plan http://www.barkingdagenhamccg.nhs.uk/Downloads/Our-

work/CAMHS/Barking-and-Dagenham-CAMHS-report-v2-December-2015.pdf.) We have using these baseline data, along with our population data, to develop a working model to plan demand through the quadrants described above. We have modelled the demand that we expect to see through each quadrant and have ascertained the additional activity that will be expected to deliver the target of 35% of children and young people with diagnosable conditions accessing evidence-based treatment by 2020/21. The next step in this process is to map out the workforce required to deliver this activity and to test the model during 2016/17.

4.2 Progress on delivery

Overall we have seen significant progress on delivery of the transformation plans produced in December 2015. The CYP MH transformation funds allocated to the CCGs have enabled investment in new staff and services as well as the piloting and testing of new innovative approaches including digital support. We now have a deeper understanding of our population need and local priorities and are developing a range of enabling strategies to support the continued delivery of our plans. We have been able to extend and develop partnerships locally, as well as collaborative working across and beyond Barking and Dagenham, Havering and Redbridge, into the north east London STP footprint. We have progressed work with our main service provider, NELFT, incorporating our joint vision into the 2016/17 contract and are developing our contractual framework for 2017-19 to further support delivery. We have also made significant progress in developing our outcomes framework and mapping out our benefits realisations framework. Finally we have been able to secure significant additional funding for BHR from our successful Vanguard bid.

In summary, in Barking and Dagenham in 2016/17 an additional transformation fund of £444,000 was made available plus an allocation of £111,358 for eating disorders. This has delivered the additional staffing, training and piloting of new services and models as summarised in the table below.

Workstream area	**Activity delivered**	**Organisations involved**
Resilience and promoting prevention	Thrive Training delivered	Barking and Dagenham schools
	Positive Parenting (Triple P) programme delivered	NELFT and LBBD
	Additional 1 WTE social work post agreed to work on provision of Social, Emotional and Mental Health in schools	LBBD and schools
Vulnerable children pathways	Additional 1 WTE social work post to work with LAC	NELFT
Maximising digital support and guided self-support	Pilot started of online counselling service	Third sector, schools, GPs, LBBD
Wellbeing Hub	Redesign and review work started, additional staffing agreed of 3 WTE therapists	NELFT
Crisis care	Successful Vanguard bid for additional £847,000 for BHR	NELFT, BHRUT, BHR

	and mobilisation of new model of care	CCGs
Community Eating Disorder Service	Additional investment agreed to increase service capacity by 7.6 WTE across the 4 boroughs	Barking & Dagenham, Havering, Redbridge and Waltham Forest CCGs and NELFT
Early Intervention in Psychosis service	Additional investment agreed (outwith Transformation Funds) to increase service capacity by 16.5 WTE across the 4 boroughs	Barking & Dagenham, Havering, Redbridge and Waltham Forest CCGs and NELFT
Outcomes Framework	Outcomes framework commissioned	NELFT, third sector, LBBD, BHR CCGs

Further details of these areas of progress for Barking and Dagenham are provided below, and were reported to the Health and Wellbeing Board in July 2016[2].

In Barking and Dagenham the Children and Young People's Mental Health Transformation Plan has supported the development of the London Borough of Barking and Dagenham's Social, Emotional, Mental Health and Behaviour Guidance, which aims to build on the current PSHE work to promote mental health and wellbeing, with a focus on supporting whole school programmes as part of the local integrated offer.

Building Resilience and Promoting Prevention
As part of the delivery of the CYP MH TP in 2016, the CCG has jointly commissioned with London Borough Barking and Dagenham the following resilience programmes:

- Thrive training – this early intervention person centred approach to children and young people with mental health issues is being developed in Barking and Dagenham schools. To date it has been adopted by the Thomas Arnold school in Barking and Dagenham, with 35 practitioners trained to date. This will be developed further in the borough during 2017 and linked to the wider i-Thrive developments.
- The Positive Parenting Programme (Triple P) – this programme aims to build resilience and support children and young people with emotional and mental health challenges, lead to increased parental confidence, skill and knowledge in supporting child and family emotional resilience and ultimately result in fewer problems being experienced, better outcomes and less need for specialist support. Five members of staff from Barking and Dagenham additional resourced provision are included in this programme currently, with a further seven staff from the Interact service that works across Barking and Dagenham, Havering and Redbridge. This will mean that 20 people across BHR will be trained on the Triple P programme (four from Redbridge and four from Havering).

The CCG and LBBD have created a new mental health professional post to work directly on provision of Social, Emotional, and Mental Health with identified schools in the borough, this is an additional 1.0 Whole Time Equivalent (WTE) member of staff.

Better support for looked after children and those leaving care

[2] http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MId=8815&Ver=4

A further 1.0 WTE new Mental Health Social Worker post has been created within NELFT to provide dedicated Senior Triage and Social Work support to Looked After Children from Barking and Dagenham with mental health needs as part of the single point of access/wellbeing hub development.

Developing a Wellbeing Hub
Progress is being made on developing the wellbeing hub, this includes the extension of capacity in services described above, and in particular has led to the agreement of a contract variation with NELFT to recruit additional staff that will include additional psychological wellbeing practitioner posts plus 3 additional therapy staff as indicated by the outcome of the Fundamental Service Review that is in in train, and to expand the Single Point of Access. These developments are being made in line with the agreed wellbeing hub development framework which is attached in Appendix A.

Eating Disorders service
BHR CCGs worked with Waltham Forest CCG to agree additional investment in the child and adolescent community eating disorders service provided by NEFLT to fund an additional 7.6 WTE staff. This 4-borough service, based in Barking and Dagenham, has recruited additional staff to greatly increase its capacity to provide evidence-based interventions to more young people. The service is also now reporting regularly on access and waiting times in preparation for the new access and waiting times standards[3] that will be required in 2017-2019.

Urgent and emergency care vanguard
Since the development of the CYP MH TP, NHSE invited all 8 urgent and emergency care Vanguard sites (part of a national programme to test out new models of care) to bid for a £5 million pot of funding to test to out the best way of providing urgent and emergency support for young people in crisis, in particular to provide better support to young people attending A&E after self-harming. The Vanguard sites were asked to put in expressions of interest, showing how they would be testing out new models of care in line with their local transformation plans. BHR CCGs, working with NELFT, rapidly developed a BHR wide bid to the value of £846,627 as part of our local Vanguard. This funding has now been approved and is being used to mobilise this new model of care, which will be evaluated in 2017.

Early Intervention in Psychosis
BHR CCGs, working with Waltham Forest CCG, made significant additional investment in the Early Intervention in Psychosis service in 2015/16 from their wider mental health parity of esteem investment funds (not from within the CYP MH Transformation Fund allocation). This investment was made to increase the capacity of the existing service (by a total of 16.5 WTE clinical posts for the 4 boroughs) so that it could meet the population need for the service, based on prevalence estimates, and to do so within the new access and waiting time standards for Early Intervention in Psychosis, so that more than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral. The standard is '2-pronged', both conditions must be met i.e. a maximum 2-week wait from referral to treatment *and* treatment delivered in accordance with NICE guidelines. The standard applies to, and is monitored for, people of all ages, with the EIP service working specifically with people between the ages of 14 and 35 years old. People either older or younger than these ages experiencing first episode of psychosis will be seen by the appropriate service within the same timeframe.

[3] https://www.england.nhs.uk/wp-content/uploads/2015/07/cyp-eating-disorders-access-waiting-time-standard-comm-guid.pdf)

BHR CCGs have also developed a primary care psychosis pathway which was finalised in September 2016 and is being disseminated to GPs to facilitate rapid recognition of first episode psychosis and rapid access to EIP.

Outcomes framework
BHR CCGs have commissioned CORC (Commissioned Outcomes Research Consortium) to work with NELFT and the CCGs to support the development of an emotional and mental wellbeing outcomes framework that covers all aspects of the CYP MH Transformation including universal, targeted and specialist services. This will support our aspiration to ensure all services provided under the emotional and mental wellbeing hub are outcomes focused, holistic, and accessible and built around the needs of children, young people and their families and informed by their views. The intention is that these outcomes will cover strategic, service and operational outcomes, to see to what extent the plans have been able to: for example, build resilience, provide extra and early Help, and improve wellbeing and crisis care. The intention is to support the shift in thinking needed from understanding how a service operates (what it does) to the good that it accomplishes (what it achieves). Ideally this will lead to the development of a shared set of principles, with data, outcome measures and service standards that align across the whole system (NHS, public health, social care, youth service, education, voluntary and community sector) to deliver improvements in child mental health outcomes.

This work will report in 2017 and will inform the development of outcomes based commissioning.

4.3 Innovations

In 2015/16 we have started to test out some innovative approaches including digital support and a new model of home treatment. These are described in brief below.

Maximising use of Digital Resources & Guided Self Support
An online counselling service (Kooth) is currently being piloted in Barking and Dagenham (and in Redbridge) with schools identified by the Inclusion Team. This service has been co-produced with the Barking and Dagenham Youth Forum who will be involved in the evaluation of the service, which will inform future commissioning decisions around online support and digital resources. The pathways and links to the service are being developed in discussion with GPs, the Youth Forum, Local Authority and other partners.

Vanguard pilot of crisis care
A new model of care which is an extension of the home treatment team model is currently being tested. This builds on learning locally about how best to provide care for CYP and will integrate with the wider urgent and emergency care offer including mental health liaison services. The evaluation of the new model, due in Spring 2017, will inform future commissioning decisions.

4.4 Engagement

We continue to engage widely with all our stakeholders on refining and implementing our transformation plans.

Engagement has taken place throughout 2016 in Barking and Dagenham, including as part of the needs assessment process. This has highlighted the need to continue to focus on meeting the needs of looked after children in Barking and Dagenham and to continue to work closely with, and through, education and schools. Specific engagement has taken place with the Barking and Dagenham Youth Forum on 18 April 2016, which was attended by the Lead Member for Mental Health and the Public Health lead and led to the Youth Forum agreeing to

participate in the shaping of the online service and the future engagement with schools and GPs. In Barking and Dagenham we have well-established mechanisms of engaging with stakeholders on matters relating to Children and Young People though the Children and Maternity sub-group of the Health and Wellbeing Board, as well as the Barking and Dagenham Youth Forum and a range of family, parent and carer groups. The Young Inspectors are a particular source of engagement and scrutiny of services by young people.

The Barking and Dagenham CCG Patient Engagement Forum is a lively group which has had excellent representation from the Barking and Dagenham Youth Forum when discussing a range of commissioning strategies.

We held a series of engagement workshops as part of the refresh of the Transformation plans in each of the three BHR CCGs/boroughs which brought together representatives from health, education and social care. There was an overwhelming agreement that the transformation plan was long overdue and the focus on Children and Young People's Mental Health was very welcome. The core themes that emerged from these workshop were similar across BHR, and did align, in most cases with the existing transformation plans. There were however some additional areas of focus for Barking and Dagenham that delivery of this refreshed plan will need to address, these are summarised below:

- Collaborative Commissioning between Health, Education and Social care was needed.
- Early intervention for supporting children in schools that are displaying emerging behaviour difficulties to stop the escalations
- Support for out of Borough Looked After children as well as those in Borough
- Developing early screening approach for LAC to identify those at risk and putting in some targeted interventions to stop them becoming LAC.
- Develop more evidence based Foster Carer training and support packages
- A clear and robust approach to Crisis care and avoidance of hospital admission
- Improved access to Psychological therapies for all not just those in tier 3.
- An ambition to provide 24/7 Crisis support
- Look to develop technology as an enabler for both staff and service users.
- Workforce planning to encompass all agencies to ensure a whole system approach
- A focus on proper service user engagement to inform the transformation and design of work going on.

We also held a BHR workshop on the development of the wellbeing hub in March 2016 which provided an opportunity for stakeholders to share views on how the development of the hub could improve access and address existing problem areas.

5. Changing environment and new challenges

5.1 Local challenges

Our transformation plans are being delivered in a changing environment which presents new challenges. Our plans have to adapt to these. This includes decisions made by other partners which will affect the provision of services for children and young people. Decisions that will have a direct impact on service provision are summarised below, however these are being made within an overall context of reducing expenditure throughout social care in light of decreasing resource allocation.

In Barking and Dagenham the local authority has had to find significant savings, this has led to a decision by the Public Health Programme Board to disinvest in the children's centres primary care mental health workers by £150,000. Other factors that could affect the delivery of the Transformation Plan include the proposed review of the speech and language community network, and additional investment that is being sought from health for the multi-agency safeguarding hub.

A new, unexpected challenge that emerged in 2016/17 was the temporary closure of Brookside Adolescent Inpatient Unit between April and October 2016 due to concerns about staffing capacity and the environment. Although this service is commissioned by NHSE, a joint approach between NHSE, the BHR CCGs and NELFT was taken to put in place an alternative offer to young people and their families during this period and to develop a new model of care. This new approach includes the provision of a young people's Home Treatment Team to support young people in their own homes, and facilitating hospital admission when required. This approach, alongside full refurbishment, has allowed the unit to re-open and will be taken forward through new collaborative commissioning arrangements that will be developed between BHR CCGs and NHSE (see section 6.5 below for more details).

5.2 Population needs

London Borough of Barking and Dagenham completed a child and adolescent mental health needs assessment in 2016[4]. This provided additional information on need in the borough and identified areas where a better response to the needs of children and young people could be developed. The needs assessment shows that in Barking and Dagenham the prevalence of some disorders is higher than the national average and that the risk and vulnerability factors associated with mental illness are apparent in the borough, including numbers living in poverty and numbers of lone parent households. Children that are at particular risk of developing mental health and emotional problems include Looked After Children, those in contact with the Criminal Justice System, those with a learning disability, children whose parents have mental health problems and children living in situations of domestic violence.

The needs assessment sets out recommendations to improve the response to children and young people in Barking and Dagenham, including the need for an increased emphasis on prevention and promotion – as found in the Thrive model – and building of resilience and emotional wellbeing. These recommendations have shaped this plan, and have influenced in particular the work planned to improve pathways for vulnerable children.

[4] http://moderngov.barking-dagenham.gov.uk/documents/s104536/BACKGROUND%20DOC%20-%20CAMHS%20NEEDS%20ASSESSMENT.pdf

5.3 Health inequalities

This plan is intended to help mitigate against the impact of health inequalities by building resilience to deal with the risk factors that are experienced by our local population, by promoting protective factors, by facilitating better access to help when needed through the Thrive model and by improving pathways for the most vulnerable children.

5.4 New guidance and targets

The NHS Operational Planning and Contracting Guidance 2017-2019[5] sets out national "must-dos" which include the following that are particularly relevant to this plan:

- More high quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018.

- Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE recommended package of care within two weeks of referral.

- Commission community eating disorders so that 95% of children and young people receive treatment within four weeks of referral for routine cases, and one week for urgent cases.

- Increase access to evidence-based specialist perinatal mental health care, in line with the requirement to meet 100% of need by 2020/21 and ensure that care is in line with NICE recommendations.

Improvements to crisis care are also expected, as set out by the Healthy London Partnership in: *Improving care for Children and Young People with mental health crisis in London: Recommendations for transformation in delivering high quality accessible care.*

6. Priority work streams

Our priority workstreams aim to balance the need to continue to support effective areas of service provision and recent transformation changes with those service areas that are more challenged. We have made progress in 2015/16 on delivering activities that build resilience and work across the whole system (quadrants 1 and 2), and in commissioning additional capacity in specialist services including eating disorders and early intervention in psychosis (components of quadrant 3). We have also had to undertake some rapid work to put in place our Vanguard pilot and to respond to the inpatient closure noted above (Quadrant 4). As such, we need to prioritise work in 2016/17 on further development of the integrated inpatient pathway and ensuring we have a robust plan for delivery of CYP IAPT and facilitating better access via quadrant 3 in particular.

We have refined our priority workstreams to 5 key service delivery workstreams and 5 enablers. These are described below.

[5] https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

6.1 Priority workstream 1: perinatal services

We currently have a renowned service model for community perinatal mental health in north east London, provided by NELFT across Barking and Dagenham, Havering, Redbridge and Waltham Forest. However, the service is under-capacity to meet current need, meaning that the service tends to focus on the severe end of need and has less capacity to support women with mild to moderate needs. In order to provide the full range of NICE compliant interventions and to meet the projected demand caused by the rising birth rate in north east London, additional staffing will be required. BHR CCGs have worked with NEL CCGs to create a NEL wide bid for transformation funds (c £2.2m) that would enable services to be developed to sufficient capacity to provide access to specialist perinatal mental health service for an additional 2000 women in NEL by 2020. We are currently awaiting to hear about the outcome of this bid.

6.2 Priority workstream 2: eating disorders services

BHR and WF CCGs invested their additional allocation in child and adolescent community eating disorders services in 2015/16, with this investment recurring in 2016/17 and into the next contracting round. This enabled the service to increase their capacity significantly, by 6.6 WTE clinical staff (and 1 WTE non-clinical) equating to an additional 158 cases. This will also enable the service to provide the full range of interventions required by the new access and waiting time standards for community eating disorders services. However there remains insufficient capacity in the service to meet the entire projected population need to 2020/21. Further work is planned to agree how to manage these pressures and also how to integrate the eating disorders offer into the development of the wellbeing hub and the single point of access.

Barking and Dagenham CCG partners with Havering, Redbridge and Waltham Forest CCGs to commission the community eating disorders service. We are monitoring baseline performance as shown in table below, Barking and Dagenham has achieved 100% of urgent cases seen within 1 week in Q2 2016/17 and routine cases seen in 4 weeks. In Q1 there were no urgent cases for Barking and Dagenham and 60% of routine cases were seen within 4 weeks.

		Q1 2016/17	Q2 2016/17
CYP with eating disorders (urgent cases) - 1 week wait	Barking & Dagenham	0%	100%
CYP with eating disorders (routine cases) - 4 week wait	Barking & Dagenham	60%	100%

6.3 Priority workstream 3: EIP

Significant additional investment was made in 2015/16 to meet expected prevalence and waiting time standards for EIP including access to NICE recommended treatment for internal and external referrals. No additional investment in the service is planned in 2017-19 however extension of the current waiting time target to meet 53%, on the trajectory to 60% by 2020/21 will be sought via the service development and improvement plan, as will consideration of further integration in the wellbeing hub to ensure that there is a fully integrated pathway for all CYP. The EIP service is provided by NELFT for the 4 neighbouring boroughs of Barking

and Dagenham, Havering, Redbridge and Waltham Forest and is for people aged 14-35 years. We have agreed with NELFT that people younger or older than these ages will be provided with the same access standard of treatment, and will be supported by the most age-appropriate service.

Performance for Barking and Dagenham against the 50% target this year is shown below. A review process is in place if the target is breached to understand reasons for the breach and to address these.

Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
60.0%	66.7%	66.7%	81.8%	76.9%	87.5%

6.4 Priority workstream 4: Wellbeing hub

The wellbeing hub encompasses a range of improvements that, over time, will result in a comprehensive offer that will in effect, lower thresholds for services and ensure a timely response for all. We have recently completed demand and capacity modelling that allows us to plan for the current and future predicted need in the local offer. This has been modelled across BHR as well as being available on a borough by borough basis and guides us to how we will our target of increasing access to evidence-based services to 32% by 2018 and then to 35% by 2020/21. There are 6 key components that we will be working on in 2016/17:

- **Developing the single point of access** – Ensuring all referrals are rapidly managed and get the most appropriate response
- **Improving the crisis response -** This will involve taking forward the outcome of the Vanguard pilot, incorporating the recommendations from the Healthy London Partnership, and achieving better standards of care and where possible accelerating plans to pump-prime crisis, liaison and home treatment interventions suitable for under 18s, with the goal of minimising inappropriate admissions to in-patient, paediatric or adult mental health wards and working towards a 24/7 offer.
- **CYP IAPT -** We will be seeking from our provider a clear plan to be fully IAPT compliant by 2018 and to ensure full membership and participation in CYP IAPT and its principles including routine outcome monitoring and improvement. We are also currently assessing how we can make use of the additional national funding to address waiting times and improve CYP IAPT. This funding, which will be non-recurrent and available in 2016/17 will be released to support CCGs to continue to invest in training existing staff through the CYP IAPT training programme, including sending new staff through the training courses. CYP IAPT collaborative are recruiting to training places now, so we are currently identifying with their partners the staff to send on training course and any additional resources required to release staff. We are committed in principle to offering this opportunity across the system, however need to do further work on assessing how to fund this.
- **Pathways for vulnerable children -** The LTP also aims to examine the pathways for vulnerable children and young people to mitigate the effect of any barriers to achieving good access and positive outcomes from services. Vulnerable cohorts identified are victims of Child Sexual Abuse (CSA); Looked After Children, children with learning difficulties/ASC; SEND and those in contact with the criminal justice system. NEL work is underway to work together to respond to Child Sexual Abuse (CSA) and to understand the financial support available through NHSE/MOPAC. As part of this BHR commissioners and local partners are initially scoping the setting up of a physical

or virtual 'hub' which brings together high quality medical and emotional support for the child and family from the first examination, and covers several CCG areas. This project is at an early stage and full cost implications need to be clarified and examined, however the process does allow BHR to look at the existing service offer and to consider issues of emotional support for CSA victims as part of the wellbeing hub including links to specialist CAMHS, local third sector agencies that provide services for children young people and families affected by child sexual abuse and the current role of adult mental health services. There will be a need to undertake local demand and capacity mapping, and an application has been made to the Social Care Innovation Fund for a grant to do the same in North East London (to be confirmed). It is proposed that this work is picked up as part of the FSR (Full Service Review) that will be completed this year in BHR. The second major issue is around the medical support provided to CSA victims; it is proposed in BHR that the medical support around CSA victims is contained within the Community Paediatrics SDIP groups that is looking at the whole service across BHR

- **Digital support -** We will be reviewing the outcomes of pilots undertaken in 2016 and make commissioning decision based on these.
- **Schools/SEMH -** We will review the outcome of work done in 2016 and build on this.

A summary of our proposed spending plans of the CYP MH allocation of £522,000 for 2017/18 is as follows:

Priority workstream	**Related target**	**Proposed expenditure/activity**	**Cost**
Perinatal	Increase in women accessing services	Increase in capacity if funds available	Depending on transformation fund availability
Eating disorders	Access and waiting times	Increase in capacity as per previous investment, developing access/integrate with SPA	No additional investment (previous investment is recurrent)
EIP	Access and waiting times	Increase in capacity and stretch waiting time target	No additional investment (previous investment is recurrent)
Wellbeing hub	Increase in access and CYP IAPT compliance	NEFLT additional practitioners (SPA and CYP IAPT)	£146,000
		Crisis	£195, 000
		LAC practitioner	£58, 000
		Digital support	£40, 000
		Schools training	£21, 000
		MH social worker	£40, 000
Enabler: engagement		Support to B&D Youth Forum	£2, 000
Enabler: implementation support		Contribution to programme management across BHR	£20, 000

6.5 Priority workstream 5: Inpatient services/collaborative commissioning

The temporary closure of the child and adolescent inpatient unit, Brookside, run by NELFT in May 2016 brought forward a review of the service model for tier 4 CAMHS. Clinical evidence supports a different model of care for those young people with emerging personality disorders that often manifest as admissions to CAMHS inpatient units through serious self-harm and risk. A new model of care which is an extension of the home treatment team model has been put in place. Further work needs to be done on integrating this with the Vanguard outcomes and to develop collaborative commissioning arrangements with NHSE

It is expected that this work will include developing a local integrated pathway for children and young people that includes admission avoidance, and appropriate and safe discharge, and that joins up with health and justice commissioners where relevant to ensure appropriate transitions between secure settings and liaison and diversion

As part of the work around the LTP the issue of co-commissioning specialist inpatient services has been outlined with CCG partners across the STP as follows:

- Each CCG will include plans to strengthen local pathways to improve crisis response in the same plan as future inpatient requirements, and include local good practice examples; this will be part of the FSR in B&D
- CCGs will propose further work within the STP footprint (with each other and with providers) and NHS England to identify the scope for intensive and crisis models to impact on acute admission, including data. This will build on the productivity and proves mapping approach undertaken in acute services and for Urgent and Emergency care Vanguards. Working with local authorities will be essential.
- The further work will include review of service models and activity data, and a response to the recommendation of the London Healthy Partnership guidance on CYP crisis published In October 2016.

7. Enablers

We also have clear plans to ensure that we have the right engagement and governance processes in place to support delivery of our plans. Other key enablers are links with health and justice, workforce planning and data.

7.1 Engagement

We will continue to develop our engagement mechanisms, with a strong focus on engaging directly with young people and their families and carers. We intend to consider how we can best support the Barking and Dagenham Youth Forum and other key groups locally.

7.2 Governance

Across BHR we have a Mental Health Delivery Board that provides strategic oversight of the BHR CCG mental health transformation programme including the CYP MH Programme. The Board is chaired by the BHR CCGs Executive Lead for mental health and has representation from the three local authorities, NHSE and NELFT. Reporting to this Board there is the BHR CCG wide CAMHS Transformation Board which oversees the delivery of the CYP MH Transformation Plan.

In Barking and Dagenham CYP MH is overseen by a well-established Children and Maternity sub-group of the Health and Wellbeing Board.

The BHR Integrated Care Partnership provides us with a mechanism to work collaboratively across health and social care in the BHR footprint. We are also connected to the wider NEL STP footprint through those emerging governance processes.

7.3 Health and Justice links

Barking and Dagenham have already made progress on securing dedicated CAMHS input to the Youth Justice Board through the provision of a seconded clinical psychologist and community nurse. Additional plans include those to develop a speech and language therapy project with the targeted children's service and to develop and coordinate this response further in partnership with the Youth Justice Board.

Barking and Dagenham will receive non-recurrent funding for 2016/17 to identify any current gaps in provision; it is intended that this be used to fully map the current offer for CYP in the justice system; from prevention, arrest, community supervision within the YOT, to remand and custody and the resettlement pathway from both Young Offenders Institutions and Secure Children's Homes.

Recurrent funding is expected be allocated to B&D up to 2019/20 and plans around the use of this money will include;

- Mapping consultation with key partners through the YOS-COG
- Looking at existing data and JSNA for this vulnerable cohort
- Liaison & Diversion Data; arrest rates for CYP in the borough; Conviction rates for CYP in the borough and type of offence
- Identifying Gaps
- Presenting Proposal and
- Joint Commissioning with CCG/YJB

7.4 Workforce plans

Developing our workforce is perhaps the single most important enabler to the delivery of CYP mental health transformation.

There are three workstreams underway that will underpin workforce development planning, and that will deliver a multi-agency workforce plan which will include plans to recruit and train the additional staff needed to deliver the ambitions set out in this plan.

Fundamental Service Review

Our programme of work has started with the instigation of a Fundamental Service Review (FSR) in conjunction with our main service provider, NELFT. This will provide greater clarity about:

- coverage of the service against population need
- how statutory obligations are fulfilled
- outcome measures and achievements against these
- pathways and interdependencies
- caseload management and productivity
- value for money.

The FSR is due to report in March 2017.

Capacity planning
We have undertaken capacity planning to map need against the service model we are development. This provides us with the framework needed to plan service capacity and workforce numbers.

Workforce needs assessment
To understand the workforce needs in transitioning from the tiered model currently in place to the Thrive model we seek to achieve through the transformation programme, we have started a workforce review. This has been commissioned from Anna Freud Centre for Children and Families and will encompass CAMHS and the wider system that works to support CYP.

There will be two phases to the review. The first phase will gather quantitative data (including numbers of staff, vacancies, banding, and skills) and qualitative data (e.g. how well staff skillsets are being used, and the balance of face to face time with CYP. A survey of the 'THRIVE-like' working practices (shared decision making, use of the THRIVE quadrants, when to stop treatment, enabling self-management, skills for assessment and signposting and enabling self-care and management) will be carried out to ascertain to what extent practitioners feel able to use these skills currently. Following completion of this phase (by December 2016) the second phase will start in January 2017 and due to complete by 31st of March 2017. This will focus on building capacity and competency to work in and deliver a THRIVE like system, using the data gathered in phase 1 to undertake a gap analysis and devise plans to develop the workforce, including identifying any changes to job plans or movement around the system, as well as training and development that can be provided by the I-THRIVE academy – linking in with the developments required in CYP IAPT.

7.5 Data

Providers are expected to submit full accurate data returns for all routine collections in the MHSDS and IAPT MDS. These requirements will be included in full in the 2017-19 contracting process. We are developing greater shared understanding of local activity and needs and will continue to refine our local models accordingly.

8. Impact and outcomes

It is important that as part of the Transformation Programme we develop clear benefits realisation metrics and an outcomes framework. The Benefits Realisation Matrix (see table below) is a key product of the programme documentation suite. The benefits realisation plan will be developed alongside the programme plan to ensure alignment. The metrics attached will be refined further by the programme manager via the Programme Board as further intelligence and baselines become available. At the end of the programme, as the changes become embedded into business as usual, the metrics within the BRM will form the basis for the benefits realisation report.

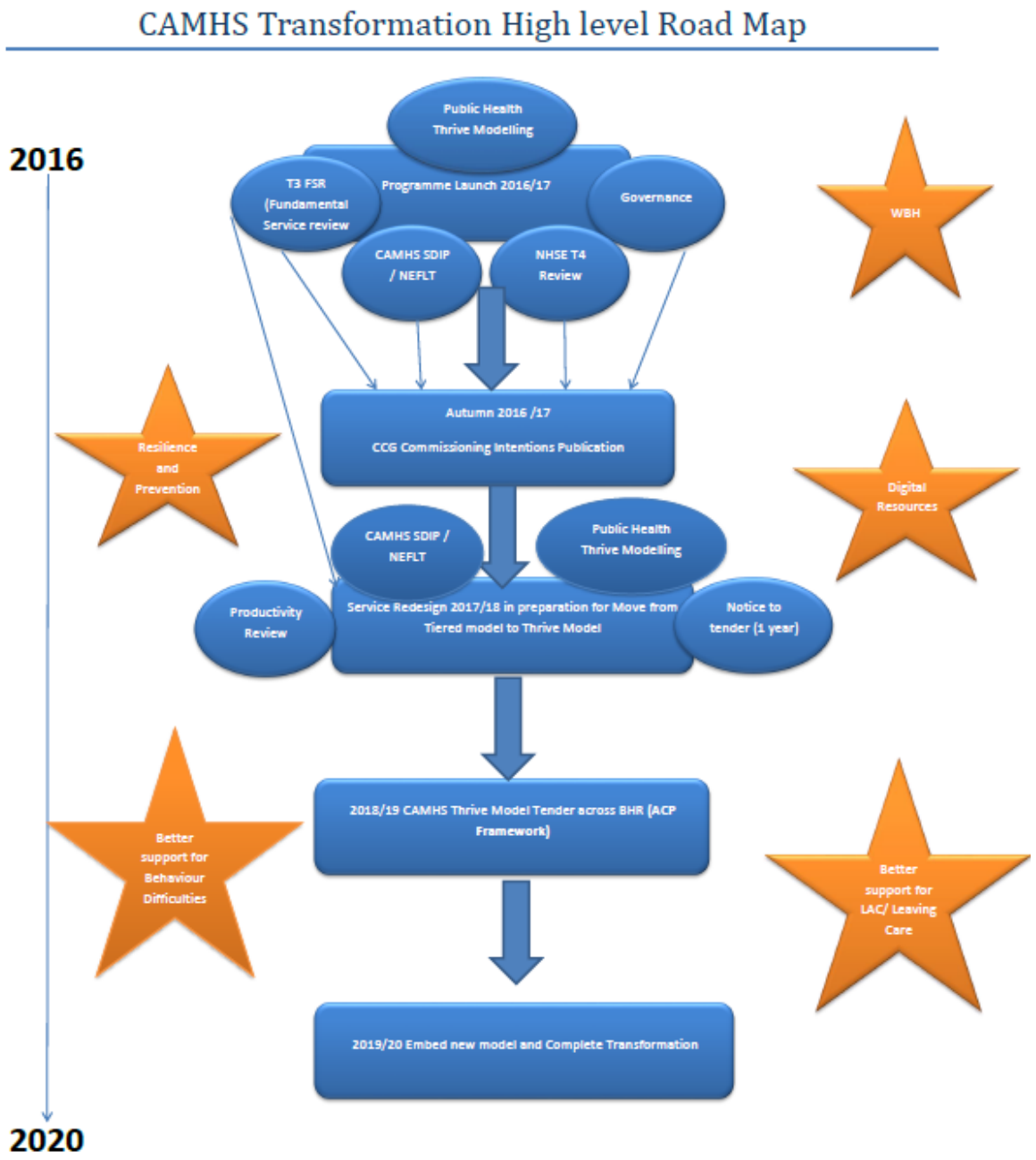
As noted above we have commissioned CORC (Child Outcomes Research Consortium) to develop an outcomes framework for the Transformation. Our aim is to use the outcomes developed by CORC in collaboration with the current providers to firstly feed into the wider outcomes for measuring the benefits of the programme once delivered but also to support the move from block contracting to outcome based commissioning.

Transformation Theme	Strategic Objectives	Who benefits	Type	Timescale	Measure
Wellbeing hub development	To have an integrated multiagency single door across BHR for children and young people accessible 27/7 and provides assessment at the lowest level for all referrals, signposting and case management.	CYP	Clinical benefit	2020	10% increase in CYP accessing support across all quadrants
Building Resilience and Promote Prevention	To have every professional involved in the support of children and young people to be capable of offering first line support for any child or young person no matter where they are in the system before referring to the WBH. To improve the ability of families and young people to cope within their home and school environments, despite having ongoing mental health and emotional well-being needs.	CYP	Clinical benefit	2020	60% of CYP with a need being supported outside of Quadrant 3 and 4.
Better support for CYP with behaviour difficulties	To have a coordinated system wide challenging behaviour support pathway that ensures that young people can stay in education whilst getting the right support by the right professionals	CYP	Clinical benefit	2018	% reduction in the number of exclusions
Transformation Theme	**Strategic Objectives**	**Who benefits**	**Type**	**Timescale**	**Measure**

Digital resources	To make mental health support more accessible for young people through development of a wide range of digital resources that can offer timely access to support no matter where the young person is.	CYP	Clinical	2020	10% increase in the number of young people accessing evidence based treatments
Crisis Support	To have a system capable of providing proactive and reactive support for children and young people in crisis no matter where they are 24/7. To provide appropriate alternatives to hospital admission through Home Treatment and Outreach support models develop robust and joined up transition support for 16-25 years' olds.	CYP	Clinical	2020	To provide early crisis support and outreach to 7,900 CYP per year across BHR by 2020.
Eating Disorders	To deliver evidence-based, high-quality care for eating disorders that can	CYP	Clinical	2020	Data collected in 2016 will inform trajectories for incremental percentage increases, with the aim of setting a 95% tolerance level by 2020. From 2016
CYP IAPT.	To make psychological interventions for Children and Young people more accessible, and delivered across all quadrants of the model	CYP	Clinical	2020	10% increase in the number of young people accessing evidence based Psychological treatments.

9. Implementation

We have a high level road map for implementation of the transformation across BHR, as set out in fig 2 below, detailed implementation plans are being produced by 2017/18 at a local level. Risks to delivery are reported through the Mental Health Transformation Programme risk register.



Appendix A. NELFT WBH Development Framework

	Transformation Work stream	Deliverable	Methodology	Who benefits	Timescale	Measure	Baseline
1a	**Better support for CYP with behaviour difficulties**	Build on the existing single point of access to receive professional referrals for children with additional emotional or mental health needs including those who would not currently be eligible for CAMHS. This includes a broader definition of crisis to include those that are not self-harming.	Develop a clear evidence based pathway for Behaviour difficulties with partners within the WBH	NELFT, Wider System, CYP	2016-2017	Behaviour Difficulty WBH pathway	Currently no defined pathway
1b	**Better support for CYP with behaviour difficulties**	Develop relationships and provide a named contact with all schools, children centre and other early years settings, GP practices, etc.	Develop school and Primary Care link workers within the WBH	CYP , schools, Primary care	2016-2017	Appointment of link workers	Currently not in place
1c	**Better support for CYP with behaviour difficulties**	Act as advisors and gatekeepers, redirecting back to universal services where appropriate, or providing the gateway to targeted early support or more specialist services	Development of this function within the WBH	CYP, schools, wider system , NELFT	2016-2017	Clearly defined role within the SOP	Currently not in place
1d	**Better support for CYP with behaviour difficulties**	To undertake an initial multi-disciplinary assessment including common assessment frameworks and agree the lowest level of	Development of this function within the WBH	CYP, schools, wider system , NELFT	2016-2017	Clearly defined role within the SOP	Currently not in place

		appropriate support for each child. This could include supervised self-management, telephone and online counselling, group therapy, behaviour pathway, or specialist treatment. Alternatives would be offered while on the waiting list if appropriate					
1e	**Better support for CYP with behaviour difficulties**	Have responsibility for case management and ensuring stepped care can occur so that children do not have to start again and be re-referred should their needs change while they are already in the system	Development of this function within the WBH	CYP, schools, wider system , NELFT	2016-2017	Clearly defined role within the SOP	Currently not in place
1f	**Better support for CYP with behaviour difficulties**	Provide and coordinate CAMHS key workers to supervise and provide strategic oversight for self-directed support that is actioned via the single route to care, such as telephone counselling and online CBT	Development of this function within the WBH	CYP, schools, wider system , NELFT	2016-2017	Clearly defined role within the SOP	Currently not in place
1g	**Better support for CYP with behaviour difficulties**	Work toward the ambition that support could be available 24/7, with intelligent staffing levels to reflect need over weekends and evenings	Development of this function within the WBH	CYP, schools. Wider system , NEFLT	2016-2017	Clearly defined role within the SOP	Currently not in place
1h	**Better support for CYP with behaviour difficulties**	Deploy higher grade, senior mental health specialist resources on the single route	Development of this function within the WBH	CYP, schools, wider	2016-2018	Clearly defined role within the SOP	Currently not in place

		to care in addition to other therapists and counsellors from the community voluntary sector.		system , NELFT			

	Transformation Work stream	Deliverable	Methodology	Who benefits	Timescale	Measure	Baseline
2a	**Enhanced SPA**	Build on the existing single point of access to receive professional referrals for children with additional emotional or mental health needs including those who would not currently be eligible for CAMHS	Development of this function within the WBH	CYP, schools, wider system , NELFT	2016-2017	Clearly defined role within the SOP	Currently not in place
2b	**Enhanced SPA**	Develop relationships and provide a named contact with all schools, children centres and other early years settings, GP practices, etc.	Development of this function within the WBH	CYP, schools, wider system , NELFT	2016-2017	Clearly defined role within the SOP	Currently not in place
2c	**Enhanced SPA**	Act as advisors and gatekeepers, redirecting back to universal services where appropriate, or providing the gateway to targeted early support or more specialist service	Development of this function within the WBH	CYP, schools, wider system , NELFT	2016-2017	Clearly defined role within the SOP	Currently not in place
2d	**Enhanced SPA**	To undertake an initial multi-disciplinary assessment including common assessment frameworks and agree the lowest level of appropriate support for each child. This could include supervised self-	Development of this function within the WBH	CYP, schools, wider system , NELFT	2016-2017	Clearly defined role within the SOP	Currently not in place

		management, telephone and online counselling, group therapy, behaviour pathway, or specialist treatment. Alternatives would be offered while on the waiting list if appropriate					
2e	**Enhanced SPA**	Have responsibility for case management and ensuring stepped care can occur so that children do not have to start again and be re-referred should their needs change while they are already in the system	Development of this function within the WBH	CYP, schools, wider system , NELFT	2016-2017	Clearly defined role within the SOP	Currently not in place
2f	**Enhanced SPA**	Deploy higher grade, senior mental health specialist resources on the single route to care in addition to other therapists and counsellors from the community voluntary sector.	Development of this function within the WBH	CYP, schools, wider system , NELFT	2016-2017	Clearly defined role within the SOP	Currently not in place

	Transformation Work stream	Deliverable	Methodology	Who benefits	Timescale	Measure	Baseline
3a	**Looked after children support**	Develop a new local pre-specialist behaviour pathway based on evidence based practice	Development of pathway for LAC	LAC	2016-2017	TBC	Develop baselines in 2016-17
3b	**Looked after children support**	Augment the planned multi-disciplinary behaviour team with dedicated CAMHS	Development of this function within the	CYP, schools, wider system , NELFT	2016-2017	Clearly defined role within the SOP	Currently not in place

		support	WBH				
3c	**Looked after children support**	Develop an integrated pathway to guided or supervised support for the programme through the single route to support and integrate with existing specialists where needs are identified	Development of the ICP within the WBH	LAC	2016-2018	TBC (outcomes to be established)	Establish baselines in 2016-2017
3d	**Looked after children support**	A dedicated clinician-led service for looked after children and care leavers	Development of this role within the WBH	LAC	2016-2017	TBC (outcomes to be established)	Establish baselines in 2016-2017
3e	**Looked after children support**	Case consultation on cases where looked after children present with multiple and complex needs	Development of this function within the WBH	CYP, schools, wider system , NELFT	2016-2018	Clearly defined role within the SOP	Currently not in place
3f	**Looked after children support**	Joint visits to encompass the emotional and psychological element to effectively assessing and understanding needs	Development of this function within the WBH	CYP, schools, wider system , NELFT	2016-2018	Clearly defined role within the SOP	Currently not in place
3g	**Looked after children support**	Assessment of sibling attachment relationships to consider placement needs	Development of this function within the WBH	LAC	2016-2017	Clearly defined role within the SOP	Currently not in place
3h	**Looked after children support**	Quick response to children in crisis	Development of the crisis function within the WBH	LAC	2016-2017	4 hour response time for LAC in crisis	Currently not in place
3i	**Looked after children support**	Flexibility in terms of where and when children are seen	Development of this function within the WBH	LAC	2016-2017	Clearly defined role within the SOP	Currently not in place

3j	**Looked after children support**	Supporting social workers' emotional resilience when working with complex cases	Development of this function within the WBH	LAC	2016-2017	Clearly defined role within the SOP	Currently not in place
3k	**Looked after children support**	Participating in and contributing to training and development of social work practitioners' understanding of emotional, mental and psychological needs	Development of this function within the WBH	LAC	2016-2017	TBC (outcomes to be confirmed	Baselines to be established in 2016-2017
3l	**Looked after children support**	Flexibility in working with carers and the professional network	Development of this function within the WBH	LAC	2016-2017	Clearly defined function within the SOP	Currently not in place
3m	**Looked after children support**	Offer advice and support to leaving care workers	Development of this function within the WBH	LAC	2016-2017	Clearly defined function within the SOP	Currently not in place
3n	**Looked after children support**	Improved liaison with CAMHS services for children placed out of borough.	Development of this function within the WBH	LAC	2016-2017	Clearly defined function within the SOP	Currently not in place

Narrative and development Approach

1. This framework represents our development map for the journey from where the SPA is currently at the moment to where it needs to be in order to deliver the outputs and outcomes for the WBH as outlined within the BHR CAMHS Transformation plans.
2. It is envisaged that there will be phased approach over the next 2 years in the delivery of this framework
3. The Fundamental Service Review of all current services which is part of the SDIP will provide insight into opportunities for operational redesign that can facilitate the delivery of a different way of working to allow implementation
4. The BHR CAMHS Transformation Group which is represented by all the three LAs and the CCG will take the lead in agreeing any outcomes that still need to be developed. The work that NELFT is undertaking with CORC will also inform this. This group will also feed into the Children's and Maternity Board, Mental Health Transformation Board and BHR Mental Health Executive
5. NELFT will contribute to this via the SDIP and also be co-opted members of the BHR CAMHS Transformation Group.

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HEALTH AND WELLBEING BOARD

22 November 2016

Title:	**Learning Disability Partnership Board – Update on Delivery**
Report of the Strategic Director, Service Development & Integration	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Karel Stevens-Lee, Joint Commissioning Manager	**Contact Details:** Karel.stevens-lee@lbbd.gov.uk; 020 8227 2476.
Sponsor: Anne Bristow, Strategic Director of Service Development & Integration	

Summary:

The Health & Wellbeing Board (HWBB) have delegated to the Learning Disability Partnership Board (LDPB) to oversee the improvement of services and support to people with a learning disability in Barking and Dagenham. It achieves this through the regular monitoring of an action plan which brings together the actions arising from strategies and self-assessment work for both learning disability services and autism, together with the work that is coming out of the nationally-driven Transforming Care Partnership programme.

This report provides an overview of progress in order to give assurance to the Health and Wellbeing Board (HWBB) on progress against the agreed workplan.

The last report was presented to the HWBB on 26 January 2016. At the meeting, the HWBB were presented with the delivery plan for the LDPB. The delivery plan is an evolving document, with actions added to it as new issues and national and local agendas arise. The delivery plan is reviewed at each of the LDPB meetings. This report summarises the work that has been undertaken since January 2016.

As a separate attachment, Members of the Board are also provided with a more detailed update on the Transforming Care Partnership work, which is being led across Barking and Dagenham, Havering and Redbridge under the nationally-driven TCP programme. This is also included in discussion at LDPB meetings to ensure that there is good borough engagement and to review fit against the wider plans for people with learning disabilities, autism and challenging behaviour.

The Health & Wellbeing Board are invited to note achievements against the plan, to review areas or services which require further improvement, and to review the actions agreed to progress any improvements.

Recommendation(s)

Members of the Board are recommended to:

(i) Comment upon the progress that has been made in implementing the delivery plan.

(ii) Comment upon the progress and actions made in implementing the Transforming Care Programme.

(iii) Request any further actions to be taken forward to maintain or improve services for people with learning disabilities and autism.

Reason(s)

The Learning Disability Partnership Board is a sub-group of the Health and Wellbeing Board. The HWBB tasked each sub-group to be responsible for reporting and implementing actions relating to national and local priorities, as well as sections of the Health and Wellbeing Strategy delivery plan that relates to its service area. This report provides assurance from the Learning Disability Partnership Board (LDPB) that the actions delegated to the LDPB from the HWBB are being delivered.

The Delivery Plan and Outcomes Framework of the Health and Wellbeing Strategy delegates the governance and scrutiny to the LDPB. These have been incorporated into the delivery plan attached, although these are also covered in the Learning Disability Self-Assessment Framework (LDSAF), Autism Self-Assessment Framework (ASAF) and the Transforming Care Programme.

1 Introduction

1.1 The Learning Disability Partnership Board (LDPB) meets on a bi-monthly basis and includes representatives from organisations who work across the local health and social care economy, from both the voluntary and statutory sectors, together with service users and carers.

1.2 The LDPB has three representative groups that support it: a Service User Forum, a Provider Forum and a Carers' Forum. These groups discuss and comment upon items that go to the LDPB, and escalate issues facing people with learning disabilities and autism to the Board. A representative from each of the representative groups sits on the LDPB and attends each of the meetings. There are currently two service user representatives and an informal carer representative on the LDPB.

1.3 A delivery plan has been created to track and monitor the progress being made against key national and local agendas for people with learning disabilities and autism, including:

- Learning Disability Self Assessment Framework (LDSAF);
- Autism Strategy;

- Autism Self Assessment Framework (ASAF)
- The Winterbourne View Concordat and the Transforming Care Partnership programme;
- Challenging Behaviour plan;
- Carers' Strategy.

1.4 The delivery plan is discussed at each LDPB meeting and updates to the plan are coordinated by the Joint Commissioning Manager for Learning Disabilities. The LDPB escalates any exceptional issues which require attention or investment by the HWBB via the sub-group reports to Health and Wellbeing Board meetings.

Update to the Autism Self-Assessment Framework

1.5 The borough has submitted its annual update to the Autism Self-Assessment Framework in October 2016, involving members of the LDPB in shaping the view against each of the domains. The final Autism SAF submission will be discussed at the next LDPB, importantly to reshape the action plans as necessary to ensure that improvement in services for people with autism continues. A future update to the Health & Wellbeing Board will summarise the resulting revisions to plans.

2 Priority areas previously discussed with the Board

2.1 In previous consideration of the action plan and the priorities for improvement, the Health & Wellbeing Board has highlighted the following as areas of concern:

- Numbers of people with learning disabilities in paid employment;
- Healthchecks;
- Screening for health conditions;
- Offender health and the criminal justice system;
- Housing needs for people with autism;
- Diagnostic pathway for people with autism.

2.2 The report presents updates on these priority areas, as follows. Further detail on the wider Transforming Care programme plan is included in Appendix 1.

Numbers of people with a learning disability in paid employment

2.3 Every year as part of our statutory performance returns, we report on the proportion of adults with a learning disability in paid employment. This measure is intended to improve the employment outcomes for adults with a learning disability, reducing the risk of social exclusion. There is a strong link between employment and enhanced quality of life.

2.4 During 2015/16, 13 people (3.5%) with a Learning Disability, who are in receipt of social care services, have been identified as being in paid employment. This figure puts us in the bottom quartile of our comparator group for other local authorities: the comparator group average is 6.9% and the London average is 6%.

2.5 The Health and Wellbeing Board requested for the LDPB to put a plan together, setting out how 50 service users can be identified, with an outcome of 40% of these service users (20) being successfully supported into employment. Employment can

be as little as 4 hours per week and can be short term (such as temporary work over the Christmas period).

2.6 The LDPB held a workshop in July 2016 which focussed on the barriers to employment and identified ways of improving and securing employment opportunities for people with learning disabilities & autism in Barking and Dagenham. The meeting was attended by a wider representation of service users, carers and providers focussing on employment. It was agreed that a coordinated approach was needed by partners to support people with learning disabilities into work and the following actions were generated from the workshop:

- Develop and implement a programme of raising awareness of disability for prospective, new employers of people with learning disabilities.
- Circulate and publicise on the Care and Support Hub general information about permitted earnings to service users, carers and employers.
- NELFT to run a development session about interviewing for people with learning disabilities.
- Officers to attend voluntary groups to talk about employment opportunities.
- Employers within the borough to be contacted about employing a person with a learning disability.
- Commissioners to work with the Business Enterprise Centre to explore how it can support this endeavour and how it can develop social enterprises/small businesses that will work with people with learning disabilities.

2.7 In early November it was reported that 100 NHS organisations across the country have pledged to employ more people with learning disabilities, as part of Mencap's drive for more work experience placements for people with learning disabilities. On signing up to the pledge, organisations receive a learning disabilities toolkit, developed by NHS England and NHS Employers to highlight good practice in LD employment. The pledge and the toolkit will be discussed at the LDPB meeting in November. In particular, BHRUT and NELFT will be encouraged, alongside other partners, to sign up to the pledge and create more work experience placements and job opportunities in their organisations, particularly as some of the biggest employers in the local area.

2.8 A task and finish employment project team has been formed to take forward improvements in employment opportunities. All of the actions above have been turned into an action plan and incorporated into the LDPB delivery plan for monitoring by the Board.

2.9 These actions are being pursued, and a number of internal discussions have taken place to engage employment support partners in discussion about how to better support people with a learning disability into employment. However, this has yet to deliver tangible results in terms of supporting people into a job. Therefore, there remains a need to ensure that this is surfaced explicitly at LDPB meetings so that outcomes are seen from this work.

Health checks for people with a learning disability

2.10 People with learning disabilities have poorer health than the general population and have a shorter life expectancy compared to the general population. Mental illness,

chronic health problems, epilepsy, and physical and sensory problems are more common amongst this group than they are within the general population.

2.11 To help address these health inequalities GPs are commissioned to offer an Annual Health Check to people with a learning disability in line with good practice set out in the Cardiff Health Check.

2.12 The report in January 2016 showed a significant reduction in the number of health checks recorded as being carried out by GPs, following changes to how payments were validated. The HWBB raised significant concern about this, noting a figure of just 25% of people with a learning disability on GP registers having had the health check. To achieve a positive 'green' rating in the annual self-assessment, ADASS and NHS England expect 80% performance, equivalent to 630 health checks in numerical terms.

2.13 Local data shows that, as of the 31 October 2016, the number of health checks has increased from 25% to 70% for this cohort, allowing adjustments for a small increase in the number of people with a learning disability on GP registers.

2.14 A significant programme of action has been undertaken to achieve this improvement, including:

- Communication, awareness raising and formal training with GPs and their practice staff, undertaken by the Joint Commissioner, the CLDT Lead Nurse and the CCG Practice Improvement Lead;
- Enhanced co-ordination and targeted support to practices through the CLDT, with better follow-up, validation and monitoring, which included improvements to the link between this work and the on-going partnership work between social care, primary care and community health services through the locality teams;
- A series of workshops with providers and service users on the need for, and process of, a health check, facilitated by the CLDT with the aim of empowering service users and carers to expect a health check routinely and to assist providers in identifying reasonable adjustments;
- Inclusion of health check promotion as a requirement in supported living contracts;
- Inclusion of health check monitoring in the Quality Assurance framework of the Council's commissioning function.

2.15 Alongside work on health checks, it is important to note that more than 90 percent of people registered with the CLDT have a Health Action Plan (HAP) in place.

2.16 Performance in heath checks and health action plans has been continuously monitored by the LDPB over the past six months, as well as by the Joint Commissioner, Practice Improvement Lead and CLDT. The improvement is still short of the required 80% and requires continued efforts ensure people with a learning disability receive a health check. The on-going challenge will be to embed this working relationship and evidence continuous improvement. Focus on this area will be supported by the inclusion of health checks for people with learning disabilities within CCG operating plan requirements for 17-19.

Screening programmes

2.17 As for the general population, people with a learning disability are entitled to supported access to screening programmes for major cancers, including breast, cervical and bowel cancer screening.

2.18 A local analysis in January 2016 suggested that breast and cervical screening performance was in line with expected performance, but that performance was below average for bowel cancer screening for people with learning disabilities.

2.19 The local data available as of September 2016 is reporting that:

- 26% of the eligible learning disability population have had a bowel cancer screening
- 31% of the eligible learning disability population have has cervical cancer screening
- 31% of the eligible learning disability population have had a breast cancer screening

2.20 The CLDT, Joint Commissioner and Practice Improvement Lead have worked with GPs to ensure that cancer screening is included within the health check process.

2.21 The CLDT and Joint Commissioner has been working with Public Health to understand specific issues around people with learning disabilities participating in screening and to implement some actions to address this, including:

- Working with GPs through the Cancer programme and LD health checks work to raise awareness of screening.
- Wider awareness raising with carers, service users and LD providers on the process and importance of screening.
- Working with screening providers to ensure appropriate information and appointment times are provided for people with LD.

2.22 These outcomes for cancer screening are positive and more than the required 23% of the learning disability population have received their screening. However, the CCG remains committed to improving on this number. Colleagues in Public Health are carrying out a review of cancer screening due for completion in April 2017 which will inform our next steps in ensuring that this performance continues in an upward trajectory.

Offender health and the criminal justice system

2.23 Whilst Barking and Dagenham does not have a local prison, nonetheless there are a number of important issues that touch on the lives of people with learning disabilities and autism around the criminal justice system. The LDPB has sought to ensure that Police, community safety and probation colleagues are invited into the partnership to maintain dialogue and to ensure that strategies are developed for the issues that arise.

2.24 This improved dialogue with criminal justice agencies has included engagement of the LDPB and its service user and carer sub-groups to with police colleagues to raise the awareness of learning disabilities. Greater engagement with frontline

police officers remains an action to be undertaken, and discussions are being initiated with the Borough Commander on how this might best be undertaken.

2.25 The Group Manager for Community Safety and Integrated Offender Management was a regular attender at the Learning Disability Partnership Board and, since this post was deleted in the Council's restructure, new mechanisms need to be established for maintaining a senior manager representation on community safety matters.

Housing needs for people with autism

2.26 The Council is developing an overarching needs analysis and strategy for meeting the housing needs of those with care and support needs and other vulnerabilities. This will include detail on how the Council will meet the housing and support needs of adults with autism, including how it will engage with ageing carers around the housing and support needs of their adult children with autism. This work has taken longer than the original timescale set, and is now being developed in parallel with the emerging transformation priorities for the Council that will deliver a range of new and expanded ways to meet local residents' housing needs. A draft of the strategy is expected by the end of March 2017.

2.27 The strategy will include work with the private sector housing market, the use of the Council's own housing stock, as well as new building developments and commissioning plans for supported living to meet expected needs. The LDPB and its subgroups will remain engaged in its development and have the opportunity to shape the final plans.

Diagnostic Pathway

2.28 The diagnosis of autism has at times been captured within the overall diagnosis of learning disabilities in the absence of specific autism assessment. A key driver of the success of the Autism Strategy is access improved diagnosis and information through diagnosis and assessment. The agreement within the Autism Strategy was for an autism diagnostic pathway to be provided by NELFT, including its implementation and publication.

2.29 NELFT has set up a Diagnostic Pilot Pathway across the four NELFT London Boroughs. This pathway was developed and agreed by the Trust / CCG to provide a diagnostic service. The local authority is working with NELFT to ensure the autism diagnostic pathway service is fully embedded and is accessible and publicised to service users, including publicity on the Council's Care and Support Hub. The CCG will be reviewing the diagnostic pathway across BHR and will determine next steps for the pathway once the pilot comes to an end.

3 Transforming Care Partnership

3.1 "Building the Right Support", published in October 2015, set out the national plan to develop community services and close inpatient facilities for people with learning disabilities and/or autism who display behaviour that challenges, including those with a mental health condition. This followed the scandal at Winterbourne View hospital, and widespread concern about the unnecessary detention of people with challenging behaviour in Assessment & Treatment Units. This was accompanied

by the publication of the national service model which describes the range of support that should be in place by no later than March 2019

3.2 Commissioners were required to establish a Transforming Care Partnership who would lead on the development of a three year transformation plan to deliver the system change. Locally, it was agreed that the transformation footprint for Transforming Care would be across Barking and Dagenham, Havering and Redbridge as there were already good commissioning relationships in place across health and social care which were critical to the delivery of the programme. The BHR Transforming Care developed a three year transformation plan (2016/17 to 2019/20) that was submitted to NHSE on 11 April and endorsed by the Governing Body in May 2016.

3.3 A key outcome of the plan is to reduce the number of beds commissioned for this cohort over three years, bringing the CCG commissioned beds within the national planning assumption of 10-15 beds/million population.

3.4 NHS Planning guidance for 2016/17-2020/21 identifies Transforming Care as one of the nine “must dos” for 2016/17 for every local system with a deliverable for 2016/17 to “increase people with learning disabilities/autism being cared for by community not inpatient services, including implementing the 2016/17 actions for Transforming Care”.

3.5 System success in delivering this requirement is reported through the CCG Improvement and Assessment Framework (IAF) 2016/17. The IAF reports CCG performance against a range of indicators, some of which are not fully in the control of the CCG. For these indicators, the CCGs are asked to focus on the strength and effectiveness of their system relationships and to use all the levers and incentives to allow them to make progress.

3.6 Currently there are 9 Barking & Dagenham patients in assessment and treatment units whose discharges into community support are being planned.

3.7 The detailed report at Appendix 1 gives an overview of the governance and progress towards meeting the requirements of the Transforming Care Programme. It continues to be discussed through the Learning Disability Partnership Board to ensure fit with borough priorities and to maintain the engagement of the local partners in the programme.

4 Mandatory Implications

4.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment has a strong learning disability analysis and the detail contained in this report aligns well with the strategic recommendations of the Joint Strategic Needs Assessment. The JSNA was refreshed in July 2016 to reflect the current analysis of learning disabilities and autism. The purpose of the ongoing JSNA process is to continually improve our understanding of local need, and identify areas to be addressed in future strategies for the borough.

4.2 Health and Wellbeing Strategy

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

4.3 Integration

The Learning Disability Partnership Board is a multi-agency Board with representation from the local authority, the CCG, NELFT, BHRUT Health watch and other partners across the health and social care economy and the voluntary and community sector. The Board also has representation from service users, carers and Providers of learning disability services. The Joint Commissioning Manager for Learning Disabilities is also a joint appointment between the Council and the CCG.

4.4 Financial Implications

Implications completed by: Katherine Heffernan, Group Finance manager

This report provides an update on the progress of the Learning Disability Workplan. There are no new direct financial implications arising from this report. The costs of the delivery plan itself will be managed within existing funds available through the Council and CCG base budgets and the Better Care Fund.

The report also provides an update on progress of the Transforming Care Partnership Programme. As noted in the appendix there are some financial risks associated with this programme. There is a risk to the overall system that additional costs may be incurred during the implementation period. This risk is largely mitigated by the funding of £0.624m over three years has been awarded from the national programme which should be match funded by the local CCGs. In addition there is a risk to the Local Authority position if they incur a larger share of costs of provision in future. This should be mitigated by close partnership working between health and social care authorities and transparency around funding and savings.

4.5 Legal Implications

Implications completed by: Dr. Paul Feild Senior Governance Lawyer

The Health and Wellbeing Board is established under Section 194 of the Health and Social Care Act 2012. The primary duty of the Health and Wellbeing Board is to encourage those who arrange for the provision of health or social care services to work in an integrated manner. This is further extended to include encouraging integrated working with those who arrange for the provision of health-related services (defined as services that may have an effect on the health of individuals but are not health services or social care services). There are no specific legal implications in this report as it is understood that:

- the Action plan is being developed with regard to all the relevant policies, the Care Act 2014, the associated regulations and guidance;
- the required actions as directed by the Winterbourne Concordat/Transforming Care Programme has been implemented;

- there is recognition of the need for continuous improvement and actions that have been met are monitored and where there is a specific need for improvement such actions are identified and measures devised and are in the process of implementation.

Public Background Papers Used in the Preparation of the Report: None

Other useful documentation:

Adult Autism Strategy, presented at the Health and Wellbeing Board on 9 December 2014: http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MID=7555

Review of Learning Disability and Autism Self Assessment Frameworks, presented at the Health and Wellbeing Board on 12 May 2015: http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MID=8156#AI55438

Learning Disability Partnership Board Strategic Delivery Plan Update, presented at the Health and Wellbeing Board on 26 January 2016: http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MId=8161&Ver=4

List of Appendices:

Appendix 1: Detailed update on delivery of the Transforming Care Partnership agenda

Appendix 1: Update on Transforming Care Partnership agenda

The purpose of this appendix is to update the HWBB on delivery of the Transforming Care programme plan and performance at September 2016. This paper provides an update on the delivery of the Barking Havering and Redbridge (BHR) Transforming Care Partnership (TCP) plan that was submitted to NHS England on 11 April 2016 and on performance at Month 5.

The BHR Transforming Care Partnership has agreed a three-year plan to put in place services that meet the national service model for people with learning disabilities and/or autism and behaviour that challenges, which is expected to reduce the number of inpatient beds required. A Transforming Care Partnership Board has been established across the BHR CCGs and local authorities to oversee delivery of the plan. The programme governance arrangements are managed within the BHR CCGs' mental health transformation programme.

Background/Introduction

Following the Panorama programme on Winterbourne View Hospital, the government produced a report and concordat that were to be implemented nationwide called 'Transforming Care: A National response to Winterbourne View Hospital (December 2012)'. The report clearly stated that local authorities and health services should identify those patients within a hospital setting with a learning disability who no longer require this level of care intervention and whose needs could be more appropriately met within a community setting, preferably in a location close to their family. In particular, it sets out that local authorities and Clinical Commissioning Groups (CCGs) work together to ensure that vulnerable people, particularly those with learning disabilities and Autism, receive safe, appropriate, high quality care. It states 'the presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people.'

"Building the Right Support" published in October 2015 set out the national plan to develop community services and close inpatient facilities for people with learning disabilities and/or autism who display behaviour that challenges, including those with a mental health condition. This was accompanied by the publication of the national service model which describes the range of support that should be in place by no later than March 2019

Commissioners were required to establish a Transforming Care Partnership who would lead on the development of a three year transformation plan to deliver the system change. Locally, it was agreed that the transformation footprint for Transforming Care would be across Barking and Dagenham, Havering and Redbridge as there were already good commissioning relationships in place across health and social care which were critical to the delivery of the programme. The BHR Transforming Care developed a three year transformation plan (2016/17 to 2019/20) that was submitted to NHSE on 11 April and endorsed by the Governing Body in May 2016.

A key outcome of the plan is to reduce the number of beds commissioned for this cohort over three years, bringing the CCG commissioned beds within the national planning assumption of 10-15 beds/million population (March 2015- 29/million population)

NHS Planning guidance for 2016/17-2020/21 identifies Transforming Care as one of the nine "must dos" for 2016/17 for every local system with a deliverable for 2016/17 to

“increase people with learning disabilities/ autism being cared for by community not inpatient services, including implementing the 2016/17 actions for Transforming Care”.

System success in delivering this requirement is reported through the CCG Improvement and Assessment Framework (IAF) 2016/17. The IAF reports CCG performance against a range of indicators, some of which are not fully in the control of the CCG. For these indicators, the CCGs are asked to focus on the strength and effectiveness of their system relationships and to use all the levers and incentives to allow them to make progress.

BHR Transforming Care Plan update

The CCGs received feedback on the partnership transformation plan in May which resulted in a revision to the year 1 trajectory for bed reductions. Analysis suggested that the initial trajectory in year 1 was ambitious and it was amended to forecast a reduction of four inpatient beds in year 1 compared to a reduction of 6 beds in the original plan. This took into account activities that were planned to take place in 16/17 that would impact on admissions. The revised trajectory was endorsed by the TCP Board on 20 June 2016.

The TCP plan and an easy read version of the plan was published on the CCG websites in June 2016.

- www.barkingdagenhamccg.nhs.uk/Our-work/transforming-care-partnership-plan.htm
- www.haveringccg.nhs.uk/Our-work/transforming-care-partnership-plan.htm
- www.redbridgeccg.nhs.uk/Our-work/transforming-care-partnership-plan.htm

The TCP Board has agreed a milestone action plan which will be used nationally to report progress against plans. NHSE will maintain oversight of progress against the milestones submitted, recognising that the milestone action plan is a live document that is subject to change.

Confirmation was received at the NHSE stocktake meeting on 28 July 2016 that the TCP Plan and milestone action plan had been approved.

TCP priorities for 2016/17

Whilst the TCP plan encompasses a range of actions to deliver the national care model over the next three years, the focus in 2016/17 is to develop local community services to provide greater support to admission avoidance. A review of admissions into inpatient beds and feedback from a stakeholder engagement event suggests that some admissions could have been avoided if there had been quick access to appropriate community based or respite provision, especially out of hours.

The BHR partnership has been successful in a bid to NHSE for transformation funding to pump prime transformation in community services. The proposal is to prevent unnecessary admissions to inpatients beds by a) enhancing the community support available to people who require more intensive home support when their behaviour becomes challenging b) ensuring that mental health crisis services respond to the needs of people with LD/autism of all ages in and out of hours c) developing skills in the community learning disability teams to manage people with more complex needs and d) enable follow up in community placements post discharge to ensure that accommodation is stable, preventing readmission.

The bid was for £624,950 over 3 years to be match funded by the CCGs. NHSE funding of £110,000 was released in July for year 1. Although there is a commitment to ongoing support for this programme, NHSE funding for future years has not been guaranteed.

A workshop with professionals was held on 19 July to engage with professionals on service redesign, which has informed the commissioner's plans to develop community outreach and crisis services. Further to this, the commissioners have written to NELFT inviting a proposal to extend the current Home Treatment Team (HTT) offer to include an outreach and crisis function for the learning disability cohort. Commissioners are working with NELFT, to deliver improvements in the crisis care pathway as part of the Crisis Care Concordat action plan and have invested in crisis services in 2016/17.

A business case will be required to secure funding for years two and three that demonstrates a shift in resources for inpatient to community care.

There has been a series of workshops with the Community Learning Disabilities Teams across all the regions on developing the "at risk register" and ensuring the community teams are familiar with the care and treatment reviews prior to admission.

Performance

The BHR partnership has planned to reduce the number of patients in inpatient beds from 26 (March 2016) to 22 by the end of the financial year. This includes beds commissioned both by the CCG and NHS England specialist commissioning. At the end of quarter 2 it is planned that no more than 25 patients (CCG – 17; specialised commissioning - 8) will be in an inpatient bed; current performance reports that commissioners are on plan to deliver this with 24 beds in current use (CCG – 16; specialised commissioning – 8). Table 1 outlines performance reported in August 2016.

Commissioners are focused on ensuring that patients receive Care and Treatment Reviews CTRs), in line with national guidance, and supporting discharge. 94% of patients whose care is commissioned by the CCG have had a CTR in the past six months and of these 47% have been assessed as ready for discharge and have a discharge plan.

Nine patients have been admitted into inpatient beds this financial year (5 - B&D; 2-Havering: 2-Redbridge). Some admissions have been recorded as patients who had not been previously recognised as BHR patients are added to the tracker (e.g. through the census survey). There have been some admissions however which potentially could have been avoided if better support was in place in the community and the transformation work that is being initiated with NELFT on crisis care is expected to impact on admission avoidance. NHSE specialised commissioning are undertaking a national exercise to repatriate patients across the country back to their responsible commissioner locality which will identify patients who were not previously on the BHR tracker.

Learning disabilities is one of the six clinical areas that CCGs are rated on in the CCG Improvement and Assessment Framework. Two measures are included: the inpatient rate per million GP registered adult population for the TCP area and the percentage of people with a learning disability who are on the GP register and receive an annual health check during the year. In the ratings that were published in September the BHR CCGs were rated as "requires improvement".

In respect of the first measure (inpatient rates), improvements will be delivered through the TCP plans that have been put in place and performance in August suggests that progress

has been made. Improvements in the percentage of learning disability health checks is being taken forward in the primary care workstream of the mental health programme, which will be reported at the November Governing Body meeting.

Table 1. BHR patients in inpatients beds – August 2016 (data source HSCIC)

		BHR CCGS	B&D	Hav	R'bg
Inpatients March 2016	Patient count as on March 2016 (CCG commissioned)	17	8	6	3
	Patient count as on March 2016 (NHSE commissioned)	9	1	2	6
	Total patient count as on March 2016 (CCG+NHSE)	26	9	8	9
Inpatients (CCG Commissioned)					
	Current inpatients at reporting month	16	11	3	2
	Q1 16/17 plan for inpatients	17	8	6	3
	Q2 16/17 plan for inpatients	**17**	**8**	**6**	**3**
	Variance from Q2 plan	1	-3	3	1
	% variance from plan	6%	-38%	50%	33%

Governance

The BHR TCP is a partnership of the three local authorities (LAs), the three clinical commissioning groups (CCGs), NELFT NHS Foundation Trust, NHS England (NHSE) Specialist Commissioning and people with a lived experience of using local services. A partnership board was established in December 2015 to take forward the development of the three year transformation plan. The CCGs are the lead organisation accountable for the delivery of the plan, working in partnership with local authorities.

The BHR Transforming Care Partnership Board agreed its membership and terms of reference in June 2016 to reflect the transition from planning to delivery. The BHR TCP programme board has overall responsibility for delivering the TCP plan on behalf of the partnership. Sharon Morrow, Chief Operating Officer B&D CCG is the senior responsible officer and chair of the partnership board; Barbara Nicholls, Acting Director for Adult Social Care London Borough of Havering is the social care lead and deputy chair of the partnership board. It is proposed that the Board reports to the CCG Governing Bodies and Health and Wellbeing Boards. Programme management arrangements have been established through the CCG transformation programme for mental health

A London Transforming Care Programme Board has been established to ensure effective oversight and assurance of delivery of Transforming Care priorities and targets across London, provide a regional leadership role and escalate issues and concerns. The BHR senior responsible officer attends the monthly meetings on behalf of the TCP Board.

The delivery of the TCP plan is monitored monthly by the NHSE London transforming care team and a more detailed quarterly review is provided to the national team.

North East London Sustainability and Transformation Plan (STP)

Transforming care for people with learning disabilities has been identified as one of the ten London priorities to be delivered through the STPs. The North East London STP has

described this as one of the 23 transformation programmes and a North East London senior responsible officer and delivery lead have been identified for this workstream. Work is progressing to develop the NEL STP delivery plan, building on the TCP plans that have been already been agreed at the BHR and Inner North East London partnership boards. Preliminary discussions across the two partnerships suggest that there are some common areas in the plans that would benefit from joint working.

Resources

Local TCPs (including NHSE specialist commissioning) are being asked to review the total sum of money that is spent as a whole system on people who fall into the TCP cohort, with a view to disinvesting in inpatient care and investing in community based solutions to deliver care in a different way and achieve better outcomes for the people who use services. The costs of future models of care are therefore to be met from the total current envelope of spend on health and social care services. NHSE estimates that nationally through the closure of inpatient services, this will 'release hundreds of millions of pounds for investment in better support in the community'.

NHSE has recognised that such a large transformation programme is likely to involve significant transition costs, including managing double running costs for a period of time as inpatient beds close, with new services coming on stream before funding can be released from the inpatient bed(s). To that end £30 million over three years has been made available nationally to support the transformation. As already noted, the BHR TCP has been successful in securing £624,950 non-recurrently for three years from the transformation funding available, which is to be match funded by BHR CCG's.

In addition, there is also £15 million capital funding over three years made available, with NHS England committing to exploring making more capital available following the next Spending Review.

There is concern, particularly from local authorities, about the financial risk associated with delivering the national requirements. Financial sustainability across the system is a key feature of the programme plan and concerns about sustainability are reflected in the programme risk register.

Risk

The TCP Board maintains a risk register which is reviewed at each Board meeting. At the September Board meeting the following risks were discussed;

- The need to develop community housing solutions to support this cohort of patients post discharge – Havering Council are hosting a pan-borough meeting in September to discuss this further
- Ensuring that all community teams actively develop and manage a register of people who are at-risk of admission – a risk assessment process is due to be signed off in September and rolled out to community team members
- Organisational capacity in CCGs and local authorities to undertake the number of CTRs required – the CCG is securing additional support and this will be kept under review

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HEALTH AND WELLBEING BOARD

22 November 2016

Title:	**Health and Wellbeing Outcomes Framework Performance Report – Quarter 2 2016/17 (July to September 2016)**

Report of the Director of Public Health

Open Report	**For Decision**
Wards Affected: ALL	**Key Decision:** No
Report Author: Dr Fiona Wright, Consultant in Public Health Medicine, lead author	**Contact Details:** Email: Fiona.wright@lbbd.gov.uk Tel: 07775 032105

Sponsor:

Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham

Summary:

In order to track progress across the wide remit of the Health & Wellbeing Board, the Board has agreed an outcomes framework which prioritises key issues for the improvement of the public's health and their health and social care services. This high-level dashboard is monitored quarterly by the Board, and this report forms the account of performance at the end of Quarter 2 (to end September 2016).

Additionally for this quarter, we now have the data available to be able to report on a comparison of the annual outturn performance against the Adult Social Care Outcomes Framework against our 'near neighbour' boroughs and London as a whole. This is included as an appendix, with highlights summarised in the body of the report.

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.

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 Introduction

1.1 The Health & Wellbeing Board has a wide remit, and it is therefore important to ensure that the Board has an overview across this breadth of activity. The indicators included within this report show performance of the whole health and social care system. Added to the Barking & Dagenham Health and Wellbeing Strategy Outcomes Framework are indicators from the Local A&E Delivery Group's Urgent Care Dashboard. A companion report provides an overview of quality indicators, including CQC inspections reported during quarter 2 on local primary, hospital and social care services.

2 Structure of the report, and the key performance indicators selected

2.1 The following report outlines the key performance indicators for the Health and Wellbeing performance framework. The indicators are broken down across the life course for:

- Children;
- Adolescence;
- Adults;
- Older people; and
- Across the life course.

2.2 All indicators are rated red, amber or green as a measure of success and risk to end-of-year delivery, and any indicator that is RAG rated as red or that has seen a significant change has additional commentary available in Appendix B, unless this analysis has been recently provided to the Board. Board members should note, therefore, that this means the covering report text is focused significantly on poor performance in order to highlight what needs improving, and is not to be taken as indicative of overall performance.

2.3 The dashboard is a summary of the important areas from the entire Health & Wellbeing Board Outcomes Framework, which is itself based on selections from the key national performance frameworks: the Public Health Outcomes Framework; Adult Social Care Outcomes Framework; the NHS Outcomes Framework; and Every Child Matters. Priority programmes such as the Better Care Fund have also been represented in the selected indicators.

2.4 The dashboard matches the Health and Wellbeing Strategy and is structured by stages in the life course and can be seen in Appendix A. Where performance is rated as red, or there has been a significant change in performance, further analysis has been provided within the report.

3 Performance Overview

Children

3.1 The dashboard draws attention to a number of indicators which are performing poorly relative to the targets set. These include 'red' ratings for:

- Percentage of Uptake of Diphtheria, Tetanus and Pertussis (DTaP);
- Percentage of Uptake of Measles, Mumps and Rubella (MMR2) Immunisation at 5 years old;
- Annual health check Looked After Children.

3.2 Appendix B contains further detail on DTaP and MMR immunisation uptake for Board Members' reference. The report on performance in quarter 1 (27 September 2016, minute 38 applies) provided further detail on performance on annual health checks for looked-after children, where assurance was provided that end-of-year outturns for previous years regularly met the 90% target.

3.3 In addition, the number of children subject to a Child Protection Plan is rated as 'amber' It is still not possible to provide a target to 'rate' progress against for the number of children and young people accessing Tier 3/4 CAMHS services. This is due to the lack of national benchmarking information. Performance is currently broadly consistent with previous years, and Board members will note the report on CAMHS Transformation elsewhere on the agenda.

3.4 In terms of NCMP measures of childhood obesity (reception year and at year 6), whilst provisional data for 2015/16 has been released, the finalised data is expected to be available in late November 2016 and a full report on these figures will be made in the quarter 3 performance report when analysis has been completed.

Adolescence

3.5 There remains a 'red' rating for the under-18 conception rate (per 1,000 population) and its percentage change against the 1998 baseline. There is not yet any new data since the previous report to the board (see minute 38) for quarter 1, which included a more detailed analysis.

3.6 There is an amber rating for care leavers not in education, employment or training (NEET).

Adults

3.7 There remains a concern about the performance against the number of four-week smoking quitters and Health check performance also remain a concern, and Appendix B contains a revised account of actions being taken to address these performance issues.

3.8 New data on both Cervical and Breast Screening performance (currently rated 'amber') is expected to be available in November 2016 and will be reported in the quarter 3 report.

Older Adults

3.9 Amber ratings remain in place against permanent admissions of older people (aged 65 and over) to residential and nursing care homes, and the level of service provision that follows short term services. These continue to be monitored closely for their impact on financial projections in adult social care, with a full analysis of residential care admissions having recently been completed.

3.10 There remains positive performance in injuries due to falls for people aged 65 and over, which a Better Care Fund measure.

3.11 Appendix C contains a summary of the borough's benchmarked performance against the Adult Social Care Outcomes Framework. In positive terms, Board Members' attention is particularly drawn to:

- Continued good performance, relative to other boroughs, in personalisations, with high rates of self-directed support and direct payment uptake, including both service users and carers;
- Continued positive performance around people with a learning disability living in their own home or in settled accommodation;
- A significant proportion of people completed our Crisis Intervention service successfully, and following this did not need long term services (78.5%), placing us in the top quartile for performance.

3.12 Areas that remain a concern, and will continue to influence our target setting around adult social care performance, include particularly:

- The proportion of people who had as much social contact as they wanted, which fell from an already poor result in the 2014/15 adult social care users' survey, from 43.0% to 39.3%, notwithstanding that we are broadly consistent with the comparator group average (40.9%);
- Performance on supporting people with a learning disability into paid employment, where our rate is around half the comparator group;
- Permanent admissions to residential and nursing care, where even though the borough is no longer the topmost outlier in the comparator group, it remains in the highest performers at 14th out of the 17 councils, and well above the mean for the comparator group.

Across the Life course

3.13 There are a number of key indicators that apply across the life course, which include positive, or low-risk performance (and therefore a 'green' or 'amber' rating) for:

- Delayed transfers of care from hospital, which remains a significant national concern but one that is well-managed in Barking & Dagenham;
- The number of leisure centre visits;
- The number of children and adult referrals to healthy lifestyle programmes;
- The percentage of people receiving care and support in the home via a direct payment.

3.14 The number of turned around troubled families is RAG rated 'red' as at quarter 2 and there is detail on performance of this programme included at Appendix C. This is based on progress to target set at 500 for 2016/17. As at the end of quarter 2 the number of turned around families was 219 (31 from target of 250 YTD). The DCLG is extremely positive about the TF2 programme in Barking and Dagenham and have recently confirmed that the number of turned around families (as measured by claims submitted to DCLG) is in the top quartile nationally and the highest borough in London.

3.15 In terms of performance of the urgent care system, figures reported to the A&E Delivery Board for October include an account of performance for the Trust overall for the **12th September to the 9th October 2016**, including the priority indicators below:

- Delayed Transfer of Care (DTOC) – As of October 2016 BHRUT have reported 99 delayed transfers of care (DToC). Numbers are down 30.3 percentage points from the September figure, as a new data reporting specification continues to 'bed in'.
- 4 hour waits - Overall performance for October was below the local trajectory target of 90.0%, with 88.1% of A&E attendances within 4 hours. This is 2.3 percentage points lower than performance in September, and 1.9 percentage points lower than the local trajectory.
- A&E Attendances – There were 19,260 A&E attendances in October, 9.2% higher than planned (17,639). This was also 7.6% higher than the number of attendances in September. The number of these patients who are subsequently admitted also rose, with 3,256 admitted (a 1.9% rise from the previous month).

3.16 There is no further update on rates of unplanned hospitalisation for chronic ambulatory care sensitive conditions, which has previously been flagged as a concern.

3.17 Following previous discussions on performance of BHRUT on referral-to-treatment waiting times, and agreement for regular update reports to be provided, **Appendix D** contains an update on the current position provided by the Trust.

4 Adult Social Care Statutory Returns 2015-16 Benchmarking Report

4.1 Attached at Appendix C is an analysis of London Borough of Barking and Dagenham's Adult Social Care statutory returns for 2015-16. Performance is compared with 16 other local authorities who share similar demographic and socio-economic characteristics, and who are used in the Adult Social Care Outcomes Framework (ASCOF) to benchmark performance.

4.2 Key areas of success, in terms of performance, include:

- We continue to perform well in measures of the delivery of personalised services to service users and carers. In the indicators for self-directed support, for both service users and carers, we remain in the top quartiles for performance. We also rank first in the indicator for direct payments.

- The proportion of people with a learning disability who live in their own home or in settled accommodation remains high, at 88.9%, and we rank first in the comparator group.
- A significant proportion of people completed our Crisis Intervention service successfully, and following this did not need long term services (78.5%). This places us in the top quartile for performance.

4.3 There are also a few areas for improvement:

- The proportion of people who had as much social contact as they wanted fell since 2014-15, from 43.0% to 39.3%, although it remains consistent with the comparator group average (40.9%).
- Permanent admissions to residential and nursing care are still a challenge for the council. At a rate of 900.5 older people per 100,000 we remain well above the ASCOF comparator group average of 600.0, although our relative position has improved and we now rank 14th out of the 17 councils in the comparator group.
- 3.5 % of people with a learning disability who are in receipt of long term services were employed during 2015-16, which is significantly below the ASCOF group average of 6.7, placing LBBD in the bottom quartile for performance.

5 Mandatory implications

Joint Strategic Needs Assessment

5.1 The Joint Strategic Needs Assessment provides an overview of the health and care needs of the local population, against which the Health and Wellbeing Board sets its priority actions for the coming years. By ensuring regular performance monitoring, the Health and Wellbeing Board can track progress against the health priorities of the JSNA

Joint Health and Wellbeing Strategy

5.2 The Outcomes Framework, of which this report presents a subset, sets out how the Health and Wellbeing Board intends to address the health and social care priorities for the local population. The indicators chosen are grouped by the 'life course' themes of the Strategy, and reflect core priorities.

Integration

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

Legal

5.4 Implications completed by: Dr Paul Feild

5.5 The Health and Wellbeing Board is established under Section 194 of the Health and Social Care Act 2012. The primary duty of the Health and Wellbeing Board is to encourage those who arrange for the provision of health or social care services to work in an integrated manner. This is further extended to include encouraging integrated working with those who arrange for the provision of health-related services (defined as services that may influence the health of individuals but are not health services or social care services).

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

Financial

5.7 Implications completed by: Katherine Heffernan, Group Manager, Finance

5.8 There are no financial implications from this report.

6 List of Appendices

- Appendix A: Performance dashboard
- Appendix B: Performance summary reports
- Appendix C: Adult Social Care Statutory Returns 2015-16 Benchmarking Report
- Appendix D: BHRUT Update on RTT Recovery

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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
SRG	Systems Resilience Group

Appendix A: Indicators for HWBB - 2016/17 Q2

Title	2014/15	2015/16				2015/16	2016/17				2016/17	DoT	RAG Rating	BENCHMARKING		HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4				England Average	London Average		
1 - Children																	
Percentage of Uptake of Diphtheria, Tetanus and Pertussis (DTaP) Immunisation at 5 years old	85.1%	84.4%	83.8%	84.0%	88.0%	..	83.6%	..	..	..	..	↘	R	85.9%	77.0%	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. Q1 2016/17 data has not yet published																	
Percentage of Uptake of Measles, Mumps and Rubella (MMR2) Immunisation at 5 years old	82.7%	81.0%	81.2%	80.3%	78.6%	..	80.5%	..	..	..	..	↘	R	87.5%	80.2%	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	27.5%					25.8%					..	↘	R	22.1%	21.9%	3	PHOF
Prevalence of children in year 6 that are obese or overweight	40.6%					43.5%					..	↗	R	34.2%	38.1%	4	PHOF
Number of children and young people accessing Tier 3/4 CAMHS services	1,217	585	490	526	539	1,114	530	..	..	..	..	→	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	91.8%	82.0%	72.0%	73.8%	94.2%	94.2%	80.1%	76.2%	..	..	..	↘	R	88.0%	90.0%	6	HWBB OF
The number of children subject to Child Protection Plans		320	323	292	253	253	265	271	..	..	..	↗	A			7	HWBB OF
2 - Adolescence																	
Under 18 conception rate (per 1000) and percentage change against 1998 baseline.	29.3	32.1	..	..	..	..	..	..	..	..	..	↗	R	21.6	19.9	8	PHOF
Number of positive Chlamydia screening results	541	118	130	125	120	493	..	..	..	..	..	↘	R			9	HWBB OF
Care leavers in education, employment or training (NEET)		52.0%	43.3%	45.2%	50.2%	48.4%	50.0%	50.8%	..	..	..	→	A	48.0%	53.0%	9	HWBB OF
3 - Adults																	
Number of four week smoking quitters	643	121	89	131	211	551	175	155	..	..	..	↘	R			10	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	70.1%					..					..	↘	A	73.5%	68.4%	11	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. 2015/16 data due to be published November 2016																	
Percentage of eligible population that received a health check in last five years	16.3%	2.5%	2.9%	3.2%	3.1%	11.7%	2.6%	2.5%	..	..	..	↘	R	9.6%	11.6%	12	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.																	

Key

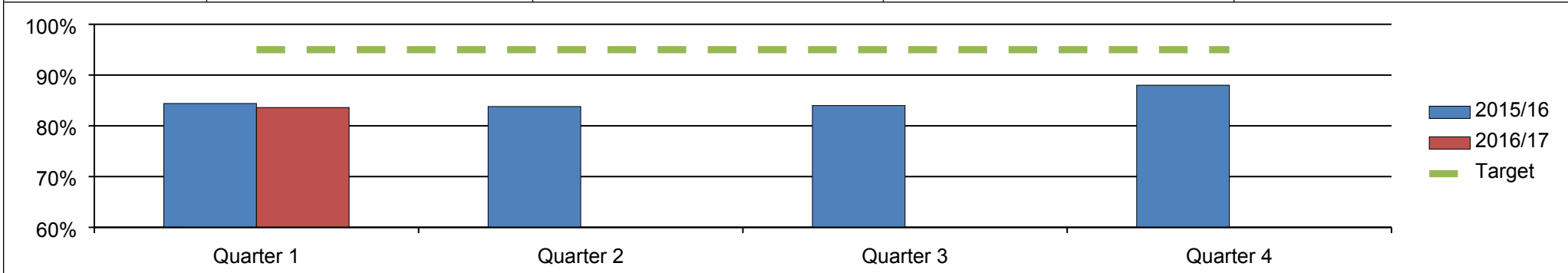
Appendix A: Indicators for HWBB - 2016/17 Q2

	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
SRG	Systems Resilience Group

Title	2014/15	2015/16				2015/16	2016/17				2016/17	DoT	RAG Rating	BENCHMARKING		HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4				England Average	London Average		
4 - Older Adults																	
Breast Screening - Coverage of women aged 53-70 years	64.3%					..					..	↘	A	75.4%	68.3%	13	HSCIC
Percentage of women whose last test was less than three years ago. 2015/16 data due to be released February 2017																	
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	936.58	188.24	401.91	625.35	910	910	223.7	437.24	..	..	..	→	A	628.2	516.5	14	BCF/ASCOF
Rates are cumulative throughout the year																	
The outcome of short term services: sequel to service	55.0%					77.5%	60.8%	59.8%	..	..	..	↘	A	75.8%	71.4%	19	ASCOF
Injuries due to falls for people aged 65 and over	1656.0					..					..	↘	G	2125.0	2253.0	16	BCF/PHOF
Directly age-sex standarised rate per 100,000 poulation over 65 years.																	
5 - Across the Lifecourse																	
The percentage of people receiving care and support in the home via a direct payment	75.7%	76.6%	75.1%	74.3%	73.2%	74.8%	71.4%	70.2%	..	..	..	↘	A	62.1%	67.4%	17	ASCOF
Delayed transfers of care from hospital	135.2	158.0	197.5	213.7	251.8	205.3	183.7	..	..	..	..	↘	G	401.66	N/A	18	ASCOF
Emergency readmissions within 30 days of discharge from hospital		..	..	..	..	8.99%	..	..	..	..	..	↘	G			19	NHSOF
Taken from BHRUT board papers - standard 14.5%																	
A&E attendances < 4 hours from arrival to admission, transfer or discharge (type all)	85.3%	93.4%	92.3%	86.5%	79.8%	88.0%	81.7%	,,	,,	,,	,,	↘	R	95.0%		20	SRG
Unplanned hospitalisation for chronic ambulatory care sensititve conditions	1,015.8					..					..	↘	R	807.4	723.3	21	NHSOF
2015/16 Q1 data due to be released September 2016.																	
The number of leisure centre visits	1,282,430	384,043	373,784	334,615	363,103	1,455,545	383,895	371,040	..	..	..	↗	G			22	Leisure
The number of children and adults referred to healthy lifestyle programmes		692	753	512	735	2,692	677	621	..	..	..	↘	G			23	Leisure
Number of turned around troubled families			23	25	127	175	100	119	..	..	..	↗	R			24	NHSOF
Rolling figure up to Q2 2016/17 is 219 against a target of 250. RAG rated red based on being more than 10% away from in year target Total number of claims submitted to DCLG since TF2 commenced Sept 2015 to Sept 2016 is 394.																	

Appendix C - Performance Summary Reports

Health and Wellbeing Board Performance Indicators Indicator 1: Percentage uptake of Diphtheria, Tetanus and Pertussis (DTaP)				Meeting date: November 2016, Data: June 2016 Source: NHS England									
Definition	Percentage uptake of Diphtheria, Tetanus and Pertussis (DTaP) Immunisation at 5 years old.			**How this indicator works**	The DTaP vaccination booster is given at 3 years and 4 months to 5 years. This is reported by COVER based on RIO/Child Health Record.								
What good looks like	Quarterly achievement rates to be above the set target of 95% immunisation coverage.			**Why this indicator is important**	DTaP is a vaccine that helps children younger than age 7 develop immunity to three deadly diseases caused by bacteria: diphtheria, tetanus, and whooping cough (pertussis).								
History with this indicator	2011/12: 82.0%, 2012/13: 85.5%, 2013/14: 83.4%, 2014/15: 85.1%, 2015/16: 80.3%			**Any issues to consider**	Quarter 2 data 2016/17 is expected to be available January 2017.								
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
2015/16		84.4%			83.8%			84.0%			88.0%		
2016/17		83.6%											



Performance Overview **RAG Rating**	• Poor performance is seen across the whole of London with this indicator. Barking and Dagenham are currently performing above the London average but below the national average for England. Low immunisation coverage is a risk to unimmunised children who are at risk of infection from the vaccine-preventable diseases against which they are not protected.	**Further Performance comments**	• Ensure Barking and Dagenham GP Practices have access to IT support for generating immunisation reports. • Children who persistently miss immunisation appointments followed up to ensure they are up to date with immunisations. • Identifying what works in the best performing practices and share. Practice visits are being carried out to allow work with poor performing practices in troubleshooting the barriers to increasing uptake. Encourage GP practices to remove ghost patients.
Benchmarking	In quarter 1 2016/17, Barking and Dagenham's DTaP rate (83.6%) was above the London rate (77.0%)		

Indicator 1: Percentage uptake of Diphtheria, Tetanus and Pertussis (DTaP) Immunisation at 5 years old

1. **Key information** (concise summary / main messages)

This indicator reports of eligible children who have received Diphtheria, Tetanus and Pertussis (DTaP) Immunisation from 3 years and 4 months to 5 years old.

The indicator is currently reported on a quarterly basis.

In Quarter 1 2016/17 83.6% of 5 year olds within Barking and Dagenham received a DTap vaccination. This is decrease (+4.4 percentage points) from the previous quarter and 8.6 percentage points higher than the London rate for quarter 1.

Quarter 2 data is due to be released in January 2017. There is a four-month lag on this indicator.

This indication is RAG rated as **Red**.

2. **What does this mean** (brief contextual analysis)

DTaP is a vaccine that helps children younger than age 7 develop immunity to three deadly diseases caused by bacteria: diphtheria, tetanus, and whooping cough (pertussis). A DTaP/IPV booster is given to children at the age of 5 years.

3. **What is the impact** (risks and opportunities / assessment of implications)

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

4. **What actions are required / being taken (**changes / decisions required)

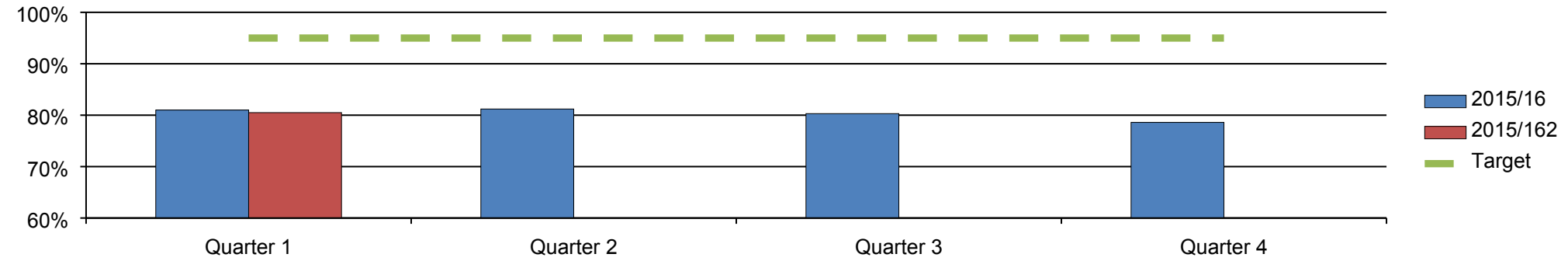
This indicator is led by NHS England.

Encourage GP practices to remove ghost patients.

Ensure Barking and Dagenham GP practices have access to IT support for generating immunisation reports.

Health and Wellbeing Board Performance Indicators Indicator 2: Percentage uptake of MMR (measles, mumps and rubella) vaccination (2 doses) at 5 years old				Meeting date: November 2016, Data: June 2016 Source: NHS England	
Definition	Percentage of children given two doses of MMR vaccination by their fifth birthday.		**How this indicator works**	MMR 2 vaccination is given at 3 years and 4 months to 5 years. This is reported by COVER based on RIO/Child Health Record.	
What good looks like	Quarterly achievement rates to be above the set target of 95% immunisation coverage.		**Why this indicator is important**	Measles, mumps and rubella are highly infectious, common conditions that can have serious, potentially fatal, complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby and can lead to miscarriage.	
History with this indicator	2011/12: 82.8%, 2012/13: 85.0%, 2013/14: 82.3%, 2014/15: 82.7%, 2015/16: 80.3%		**Any issues to consider**	Quarter 2 data 2016/17 is expected to be available January 2017.	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16		81.0%			81.2%			80.3%			78.6%	
2016/17		80.5%										



Performance Overview **RAG Rating**	• Poor performance is seen across the whole of London with this indicator, and the borough's performance is similar to the London average but below the national average for England. Low immunisation coverage is a risk to unimmunised children who are at risk of infection from the vaccine-preventable diseases against which they are not protected.	**Further Performance comments**	• Ensure Barking and Dagenham GP Practices have access to IT support for generating immunisation reports. • Children who persistently miss immunisation appointments followed up to ensure they are up to date with immunisations. • Identifying what works in the best performing practices and share. Practice visits are being carried out to allow work with poor performing practices in troubleshooting the barriers to increasing uptake. Encourage GP practices to remove ghost patients.
Benchmarking	In quarter 1 2016/17, Barking and Dagenham's MMR2 rate (80.5%) was similar to the London rate (80.2%)		

Indicator 2: Percentage uptake of MMR (measles, mumps and rubella) vaccination (2 doses) at 5 years old

5. **Key information** (concise summary / main messages)

This indicator reports of eligible children who have received two doses of MMR vaccine on or after their 1st birthday and at any time up to their 5th birthday.

The indicator is currently reported on a quarterly basis.

In Quarter 1 2016/17 80.5% of 5 year olds within Barking and Dagenham received a second dose of the MMR vaccination. This is a slight increase (+1.9 percentage points) from the previous quarter and 0.3 percentage points higher than the London rate for quarter 1.

Quarter 2 data is due to be released in January 2017. There is a four-month lag on this indicator.

This indication is RAG rated as **Red**.

6. **What does this mean** (brief contextual analysis)

MMR is the combined vaccine that protects against measles, mumps and rubella. Measles, mumps and rubella are highly infectious, common conditions that can have serious complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby and can lead to miscarriage.

7. **What is the impact** (risks and opportunities / assessment of implications)

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

8. **What actions are required / being taken** (changes / decisions required)

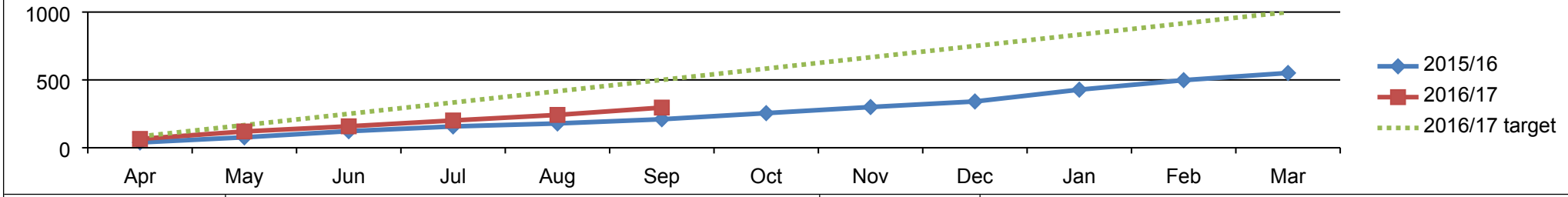
This indicator is led by NHS England.

Encourage GP practices to remove ghost patients.

Ensure Barking and Dagenham GP practices have access to IT support for generating immunisation reports.

Health and Wellbeing Board Performance Indicators Indicator 10: Number of smoking quitters aged 16 and over through cessation service				Meeting date: November 2016, Data: September 2016 Source: Quit Manager	
Definition	The number of smokers setting an agreed quit date and, when assessed at four weeks, self-reporting as not having smoked in the previous two weeks.		**How this indicator works**	A client is counted as a 'self-reported 4-week quitter' when assessed 4 weeks after the designated quit date, if they declare that they have not smoked, even a single puff of a cigarette, in the past two weeks.	
What good looks like	For the number of quitters to be as high as possible and to be above the target line. The annual target for number of quitters is 1,000.		**Why this indicator is important**	The data allows us to make performance comparisons with other areas and provides a broad overview of how well the borough is performing in terms of four week smoking quitters.	
History with this indicator	**2012/13:** 1,480 quitters **2014/15**: 635 quitters	**2013/14:** 1,174 quitters **2015/16**: 551 quitters	**Any issues to consider**	Due to the nature of the indicator, the quit must be confirmed at least 4 weeks after the quit date. This means that the data will likely increase upon refresh next month.	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	39	38	45	35	22	31	45	45	41	87	70	53
2016/17	65	55	38	43	41	28						



Performance Overview **RAG Rating**	• From April to September 2016/17 there have been 296 quitters. This is 59% against the year to date target of 498, slightly up from the previous month. • Although the indicator is RAG rated as Red, the above compares favourably to 210 quitters for the same time last year.	**Further Performance comments**	• The focus for improvement is in Primary Care. Public Health has reviewed the worst performing practices and, together with the Tier 3 (specialist) team, we will put in place supportive actions for the worst performing practices and pharmacies to help improve activity. This work will commence on 1 November. • The Tier 3 team will contribute support for the areas of highest prevalence. The Tier 3 team will continue to assign a proportion of their capacity to prevention work in schools and youth services.
Benchmarking			

Indicator 10: Number of smoking quitters aged 16 and over through cessation service

1. **Key information** (concise summary / main messages)

The service needs to deliver an average of 83 quits a month to stay on trajectory for meeting the target of 1,000 4 week quits; therefore, this would have delivered 498 quits by the end of September, compared to an actual delivery of 296 quits.

Tier 3 continues to lead the way in numbers of quits, with pharmacy second and GP practices third.

This indicator is RAG rated as **Red**.

2. **What does this mean** (brief contextual analysis)

We are behind target by 202 quitters (but as noted trends show a summer affect), though we are still in a better position than in 15/16; September's data is not yet complete.

3. **What is the impact** (risks and opportunities / assessment of implications)

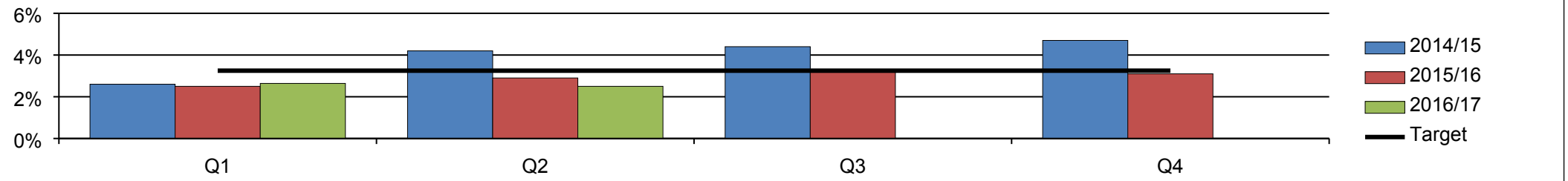
The risk is that activity will not increase compared to what is required to meet the target, though there is still time to put some remedial measures into action for the remainder of the 16/17 year, to improve the end of year result. The busiest quarter is also yet to come, so it is possible to increase activity with additional support.

4. **What actions are required / being taken** (changes / decisions required)

The focus for improvement is in Primary Care. Public Health has reviewed the worse performing practices and together with the Tier 3 team we will be able to put in place supportive actions for pharmacy and primary care to improve activity – the difference is already being seen through data cleansing work of Quit Manager which produced 12 more quitters this week than otherwise would have been. Other practical support will be given which may include hosting of clinics and mailing smokers. Public health will individually contact practices about their activity and suggest additional help be provided depending on each one's circumstance.

Health and Wellbeing Board Performance Indicators Indicator 12: Those aged 40-74 who receive Health Check			Meeting date: November 2016, Data: September 2016 Source: Department of Health
Definition	The NHS Health Check is a 5 year programme offered to people between the ages of 40 – 74yrs who have not previously been diagnosed with long term conditions, particularly - heart disease, stroke, diabetes, chronic kidney disease and certain types of dementia (eligibility criteria). Depending on the results of the risk score following the assessment, some patients may need to be referred to the relevant lifestyle programme or potentially included on a disease register. **Data reporting**: Performance as a percentage of the 5 year programme. **Time period**: April 2016 to March 2017.	**How this indicator works**	The programme is a 5-year rolling programme that intends to invite 100% of its eligible population by year 5 to receive a Health Check. Evidence suggests that for the programme to be truly cost effective nationally, 75% of those offered should receive a NHS Health Check. Number offered Health Check- maximum 20% of the population annually Number received/uptake Health Check* - 75% of those offered **PHE requests that this figure should at least be better than the previous year data.*
What good looks like	• Improvement on the previous year's performance. • Increased number of patients invited for a health check • Increased numbers of patients diagnosed with long term conditions. • Increased numbers of referrals made to existing lifestyle programmes. • Measured Targets: 20% invited each year; 75% uptake each year.	**Why this indicator is important**	The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, and kidney disease. It is a key approach for new patients to be identified and clinically managed with long term conditions to prevent premature deaths; also to influence lifestyle choices of patients to improve their overall health and wellbeing.
History with this indicator	2012/13*: 10.0%, 2013/14*: 11.4% received 2014/15*: 16.3%, 2015/16*: 11.7% received **Please note this is a fraction of the 5 year programme*	**Any issues to consider**	There is sometimes a delay between the intervention and data capture- this means that the data is likely to increase upon refresh next month.

	Q1	Q2	Q3	Q4
2015/16	2.5%	2.9%	3.2%	3.1%
2016/17	2.6%	2.5%		



Performance Overview **RAG Rating**	• The service needs to deliver 518 health checks a month in order to stay on trajectory for meeting the target. April to September has delivered an average of 405 health checks per month. This means that the monthly target has not been met.	**Further Performance comments**	1) All Practices will be advised about their individual targets and sent a league table of achievement on alternate months as a reminder and information on the gap to target. 2) New pharmacy provision to begin in October 2016. Non-providing practices will be encouraged to refer to named pharmacies within their local vicinity. 3) Practice visits continue and support is provided where needed. 4) Action plan is currently being developed to help improve performance.
Benchmarking	In 2015/16 LBBD completed eligible health checks on 11.8% of the eligible population. This is above the England and London rates of 9% and 10.7% respectively.		

Indicator 12: Those aged 40-74 who receive NHS Health Checks

1. **Key information** (concise summary / main messages)

Reporting is provided against a target of 20% invited and an uptake of 75% of eligible people receiving a Health Check of those invited over the 5 year period. On this basis, an average of 518 health checks per month is required to stay on trajectory (to meet a yearly target of 6,221 Health Checks). April to September data shows that 2,430 people have received a health check.

Please note that the September data is provisional and will likely increase upon refresh next month.

Following the evaluation of the programme an action plan has been drafted to address some key issues, the action plan will;

- address new ways to ensure future monitoring has a stronger focus on equity of provision.
- address new ways to promote the Healthy Lifestyle Services and ensure primary care are referring patients to this service, therefore behaviour change becomes a key part of the programme.

This indicator is currently RAG rated as **Red**.

2. **What does this mean** (brief contextual analysis)

The programme is part of a 5-year rolling programme of which we are in year 4. Some of the recommendations from the evaluation will enable the programme improve its outcomes and reach in the communities that need it the most. Also, there will be an even stronger agenda for more partnership working between primary care and the local authority.

However, it should be noted that currently in comparison to most London and England Boroughs, Barking and Dagenham has a better Health Check offer and uptake rate, which means we are doing much better than our peers.

Agreeing changes to the way performance of this programme is monitored will lead to a greater concentration on improving equity.

3. **What is the impact** (risks and opportunities / assessment of implications)

The impact of making the recommended changes will be a stronger focus on outcomes and an opportunity to deliver greater equity of delivery.

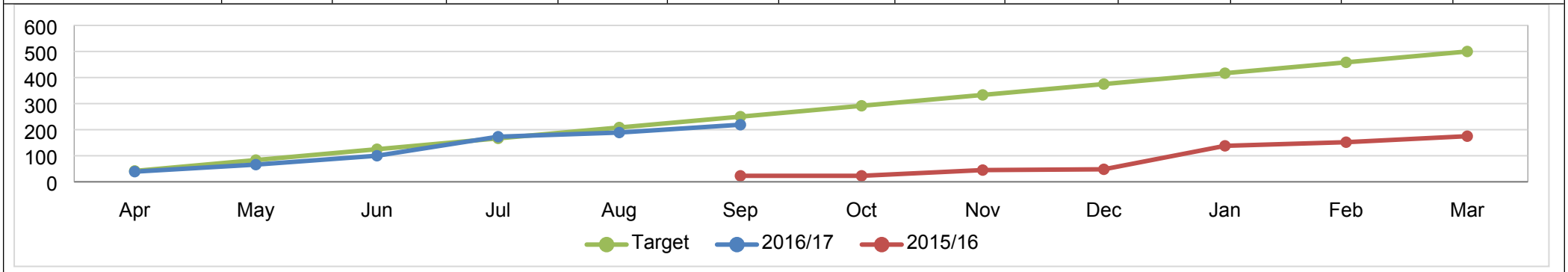
4. **What actions are required / being taken** (changes / decisions required)

Actions going forward will be dependent on the acceptance of the evaluation findings and recommendations; however, plans are already in place to effect considerable change across the programme.

10 pharmacies are due to commence delivering health checks from December 2016 which will help boost the accessibility of the health check programme to the local population.

Health and Wellbeing Board Performance Indicator Indicator 24: Number of 'turned around' troubled families				Meeting date: November 2016, Data: September 2016 Source: Children's Services
Definition	Number of families 'turned around' meeting all outcome targets and showing 'significant and sustained improvement'	**How this indicator works**	This indicates the number of families 'turned around' meeting all outcome targets, showing 'significant and sustained improvement' (rolling figure including TF2 claims approved internally and submitted to DCLG for payment.	
What good looks like	2,515 families to be 'turned round' by March 2020.	**Why this indicator is important**	TF2 is a payment by results programme. Successful family interventions mean significant reduction in costs to the Local Authority (LA) and its partners. The LA target for TF is to "turn around" 500 families in 16/17.	
History with this indicator			* Please note that the numbers below in brackets are year to date (red) and projected figures (black).	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	0(0)	0(0)	0(0)	0(0)	0(0)	23 (23)	0 (23)	22 (45)	3 (48)	90 (138)	14 (152)	23 (175)
2016/17*	39 (39)	27 (66)	34 (100)	73 (173)	16 (189)	30 (219)	44 (263)	44 (307)	44(351)	50(401)	50 (451)	50 (501)



Performance Overview **RAG Rating**	• Since the Troubled Families 2 (TF2) programme commenced (September 2015), 394 claims have been submitted to DCLG (175 between September 2015 to March 2016 and 219 as at the end of Q2 2016/17). Performance is RAG rated Red based on progress to target – 31 claims off target of 250 as at Q2. The DCLG is extremely positive about our TF progress. • We have an indicative target of 11 claims per week to meet the internally-set claim target of 500 claims per year.	**Further Performance comments**	Families that are successfully turned around are saving the LA substantially. Cost benefit analysis of TF carried out by DCLG shows that every £1 the LA spends on TF saves £2 on LA budgets. A DCLG spot check on claims/process undertaken in June 2016 produced very positive comments. The throughput of claims will inevitably be uneven as evidence such as school attendance, health and housing data is often only available at set times of the year.
Benchmarking	The DCLG is extremely positive about the TF2 programme in Barking and Dagenham and have recently confirmed that the number of turned around families (as measured by claims submitted to DCLG) is in the top quartile nationally and the highest borough in London.		

Indicator 24: Number of turned around troubled families

1. **Key information** (concise summary / main messages)

This indicator reports on the number of families turned around based on claims submitted and approved by the Local Authority (LA) data team and finance and auditing approval process. Once approved, claims are submitted to DCLG for payment.

TF2 is a Payment by Results programme set out by DCLG. Successful family interventions mean significant reduction in costs to the Local Authority (LA) and its partners. The LA target for TF2 is to "turn around" 500 families in 16/17. DCLG is encouraging front loading the programme to enable successful outcomes in 2020. LBBD is committed to turn around 2,515 families by March 2020.

Since the TF2 programme commenced (September 2015), we have submitted in total 394 claims to DCLG (175 between September 2015 to March 2016 and 219 as at the end of Q2 2016/17 – the next claim window closes on September 30th 2016. We now have an indicative target of 11 claims per week to meet the claim target of 500 claims this year.

A target of 500 turned around families has been set by end of year 2016/17 and to date performance is RAG rated red. Benchmark data is not available to date.

This indicator is RAG rated as **Red**.

2. **What does this mean** (brief contextual analysis)

LBBD are doing well compared to other London LAs but success can only be measured anecdotally as DCLG are not releasing data on other LA performance. TF2 is a significant potential funding stream if we are able to succeed in the outcomes for families.

3. **What is the impact** (risks and opportunities / assessment of implications)

The impact of TF is in its very early stages but families that are successfully turned around are potentially saving the LA in costs. Cost benefit analysis of TF is showing that for every £1 the LA spends on TF is saving £2 on LA budgets.

Risks: DCLG outcome targets are unachievable leading to a loss in funding.

Opportunities: Families are receiving early intervention services are not being assessed by CS and therefore saving money and officer time.

4. **What actions are required / being taken (**changes / decisions required)

TF project board meets monthly to monitor the programme. Currently developing work with schools to assist identification and direct work with families.

No current decisions needed. DCLG spot check on claims/process undertaken in June 2016 was very positive, and LBBD being asked to host good practice workshop as a result.

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Adult Social Care Statutory Returns 2015-16 Benchmarking Report

1. Introduction

1.1. The Adult Social Care statutory returns are used both locally and nationally to improve the quality of care and support, and the experiences of people who use social care services. They are also used to set priorities, measure progress, and strengthen transparency and accountability.

1.2. The comparable councils in the ASCOF were selected according to the Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbour Model, which identifies similarities between authorities based upon a range of socio-economic indicators. Havering has been added to the comparator group for local benchmarking and analysis, as it is a neighbouring authority. A full list of the authorities in our comparator group is available in Appendix 1.

1.3. This paper draws out the highlights of LBBD's performance in the following statutory returns, for the 2015-16 reporting year:

- Short- and Long-Term Support (SALT)
- Safeguarding Adults Collection (SAC)
- Adult Social Care Survey (ASCS)
- Deprivation of Liberty Safeguards (DoLS)

2. Supporting older and disabled adults and carers to have choice and control

Source	Measure	2014-15	2015-16	ASCOF group average	LBBD in quartile	DOT since 2014-15
SALT	ASCOF 1C (part 1a) Adults receiving self-directed support	90.5	**90.5**	85.1	Top	↔
SALT	ASCOF 1C (part 1b) Carers receiving self-directed support	73.8	**100.0**	89.8	Top	↑
SALT	ASCOF 1C (part 2a) Adults receiving direct payments	61.2	**62.6**	29.4	Top	↑
SALT	ASCOF 1C (part 2b) Carers receiving direct payments	61.5	**88.1**	76.4	Middle	↑

ASCS	ASCOF 1B Proportion of people who had control over daily life	72.3	**72.7**	70.4	Top	↑

ASCOF 1C (part 1a) - Adults receiving self-directed support

2.1. During 2015-16 90.5% of people who used services received a personal budget. We were above average in performance, placing us in the top quartile. The remaining 9.5% of our service users received long term support through directly commissioned services. We are currently working through the last elements of personalising extra care and supported living, which will address this gap, whilst providing people with further choice and providing a direct alternative to residential care.

ASCOF 1C (part 1b) - Carers receiving self-directed support

2.2. We also perform well in terms of delivering personalised services to carers. 100% of carers with services received a personal budget during 2015-16, an increase of 26 percentage points compared with the year before. The increase has moved us into the top quartile, although many comparator authorities performed well in this measure. All councils in the top quartile had a score of 100%.

ASCOF 1C (part 2a) - Adults receiving direct payments

2.3. Evidence used by NHS digital, as a rationale for the measure, has shown that direct payments increase satisfaction with services and enable the truest form of personalisation for people using services. LBBD is a high performing authority with regards to direct payments. We rank first in the comparator group, with 62.6% of people receiving their support in this form, more than double the group average.

ASCOF 1C (part 2b) - Carers receiving direct payments

2.4. Performance in this indicator increased by 26.6 percentage points compared with 2014-15, placing us in the middle quartile for the cohort. All councils in the top quartile had 100% of carers in receipt of a direct payment.

ASCOF 1B - Proportion of people who had control over daily life

2.5. The council's success in delivering the personalisation agenda may help to explain why 72.7% of people reported that they had control over their daily life in the Adult Social Care Survey. We performed well in this measure and were above average, ranking in second place.

3. Enhancing quality of life

Source	Measure	2014-15	2015-16	ASCOF group average	LBBD in quartile	DOT since 2014-15
ASCS	ASCOF 1A Social care related quality of life	18.3	**18.3**	18.5	Bottom	↔
SALT	ASCOF 1E Proportion of adults with a learning disability in paid employment	3.2	**3.5**	6.7	Bottom	↑
SALT	ASCOF 1G Proportion of adults with a learning disability who live in their own home or with their family	90.8	**88.9**	72.8	Top	↓

ASCOF 1A - Social care related quality of life

3.1. This measure is collected through a series of questions on the Adult Social Care Survey, that relate to different aspects of quality of life. Our service users had an average quality of life score of 18.3 out of a maximum of 24. Our position was not unique, and in total a third of the councils in the comparator group had the same score as us (18.3).

ASCOF 1E - Proportion of adults with a learning disability in paid employment

3.2. 3.5 % of people with a learning disability who are in receipt of long term services were employed during 2015-16. Our score was significantly below the ASCOF group average of 6.7, placing LBBD in the bottom quartile for performance.

ASCOF 1G - Proportion of adults with a learning disability who live in their own home or with their family

3.3. During 2015-16 88.9% of service users with a learning disability lived in settled accommodation, either in their own home or with family. Although this is a slight reduction compared with the previous year, we still rank first in the ASCOF group and therefore remain in the top quartile.

4. Supporting older people and disabled adults to live independently

Source	Measure	2014-15	2015-16	ASCOF group average	LBBD in quartile	DOT since 2014-15
SALT	ASCOF 2B part 1 – Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement services	67.2	80.5	86.7	Bottom	↑
SALT	ASCOF 2D – The outcome of short term services: sequel to service	55.2	78.5	70.5	Top	↑

ASCOF 2B (part 1) – Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement services

4.1. 80.5% of people supported by the Crisis Intervention Service following a hospital stay were back in the community within 3 months. This is an improvement of 13 percentage points compared with 2014-15. Despite the success compared with 2014-15, our performance is still below average for the comparator group (86.7%).

ASCOF 2D – The outcome of short term services: sequel to service

4.2. Short term interventions such as reablement, or locally Crisis Intervention, provide people with skilled help when they are unable to cope at home, or return home from hospital. This indicator measures the success of short term services, shown through the proportion of people do not need further services or who go on to receive low level support only, following the intervention. A significant number of our service users did not need long term support immediately after the service. Our score of 78.5% is an improvement of 23 percentage points compared with the previous year, and we have moved into the top quartile for performance.

5. Delaying and reducing the need for care and support

Source	Measure	2014-15	2015-16	ASCOF group average	LBBD in quartile	DOT since 2014-15
SALT	ASCOF 2A Part 1 Permanent admissions to residential and nursing care (18-64)	14.2	**13.9**	10.2	Bottom	↑
SALT	ASCOF 2A Part 2 Permanent admissions to residential and nursing care (65 and over)	900.5	**913.5**	600.0	Bottom	↓

ASCOF 2A Part 1 - Permanent admissions to residential and nursing care (18-64)

5.1. LBBD placed 17 people aged 18 to 64 into residential care during 2015-16 (13.9 per 100,000 population), the same number as the year before. The slight improvement in performance is due to growth in our younger adult population in the year, which affects the rate per 100,000.

ASCOF 2A Part 2 - Permanent admissions to residential and nursing care (65 and over)

5.2. During 2015-16 179 older people were admitted to residential and nursing care. Although this was 2 more than the year before, it comes in the face of unprecedented demand on the NHS and adult social care during the year. Our relative position is better than for 2014-15 when we had the worst performance in the comparator group. Although we remain in the bottom quartile we are now 14th out of the 17 councils.

6. Safeguarding vulnerable adults

Source	Measure	2014-15	2015-16	Comparator group average
SAC	Section 42 safeguarding enquiries per 100,000 population (18+)	199.9	**300.0**	192.0
SAC	Proportion of safeguarding concerns that ended in no further action	15%	**43%**	30%
DoLS	DoLS – Volume of applications (per 100,000 people aged 18 and over)	265	**343**	317

DoLS	DoLS - Proportion of applications granted	74%	**93%**	88%

Section 42 safeguarding enquiries per 100,000 population (18+)

6.1. LBBD had 425 Section 42 safeguarding enquiries during 2015-16, equivalent to a rate of 300 per 100,000 population aged 18 and over. This has increased since 2014-15, which had 199.9 enquiries per 100,000. The process for starting an enquiry may differ from authority to authority and this is reflected in the varying rates across the group.

Proportion of safeguarding concerns that ended in no further action

6.2. 43% of safeguarding concerns in Barking and Dagenham ended in no further action, a substantial increase from 15% in 2014-15. Although our score is higher than the ASCOF group average, the data indicates there is great disparity in practices between local authorities.

DoLS – Volume of applications (per 100,000)

6.3. During 2015-16 LBBD received 485 applications for DoLS, a 29% increase from 375 in 2014-15. The number of applications received in 2015-16 is equivalent to 343 per 100,000 adults and is higher than the comparator group average of 317 per 100,000. On average councils in the comparator group received 647 applications during 2015-16.

DoLS - Proportion of applications granted

6.4. In Barking and Dagenham 93% of DoLS applications were granted, an increase of 19 percentage points compared with 2014-15. The borough ranks 4th in the comparator group.

7. Ensuring people have a positive experience of care and support

Source	Measure	2014-15	2015-16	ASCOF group average	LBBD in quartile	DOT since 2014-15
ASCS	**ASCOF 3A Proportion of people who were satisfied with care and support services**	61.9	**59.7**	60.6	Middle	↓
ASCS	**ASCOF 3D Proportion of people who found information and advice easily**	68.9	**67.1**	71.1	Middle	↓
ASCS	**ASCOF 1I (part 1) Proportion of people who have as much social contact as they would like**	43.0	**39.3**	40.9	Bottom	↓

ASCOF 3A - Proportion of people who were satisfied with care and support services

7.1. 59.7% of people said that they were 'extremely' or 'very' satisfied with their care and support. Performance is marginally below both our score in 2014-15 and the group average.

ASCOF 3D - Proportion of people who found information and advice easily

7.2. One aspect of customer experience relates to the availability of information and advice about care and support services, which people can use to make informed choices about their lives. 67.1% of people who responded to the Adult Social Care Survey said they found it easy to find information about services, 4 percentage points less than the group average.

ASCOF 3D - Proportion of people who have as much social contact as they would like

7.3. 39.3% of people reported that they had as much social contact as they wanted. Our score fell from 43.0% in 2014-15 and is only slightly below the group average of 40.9%.

A list of councils in London Borough of Barking and Dagenham's ASCOF Comparator Group (with the addition of Havering)

- Brent
- Croydon
- Ealing
- Enfield
- Greenwich
- Hackney
- Haringey
- Havering
- Hounslow
- Lambeth
- Lewisham
- Newham
- Redbridge
- Southwark
- Tower Hamlets
- Waltham Forest

HEALTH AND WELLBEING BOARD MEETING 22 NOVEMBER UPDATE

Long Waiting Patient Trajectory

We have worked incredible hard to reduce the number of patients who have waited a long time (over 52 weeks) for their appointment or treatment.

We have developed a series of plans for treating current and all prospective patients who have waited over 52 weeks. This is in line with our trajectory to deliver the Referral To Treatment (RTT) standard by September 2017.

We had three patients who breached the standard we have set on having no patients waiting longer than 52 weeks for treatment by the end of September 2016. All of these patients have treatment plans and dates for next events in place.

At the end of September we also had forty-two patients who had been waiting longer than 52 weeks because they either chose to wait longer, did not attend or respond to our efforts to treat them sooner, or they have clinically complex needs which are extending their pathway of care. All of these patients have treatment plans and a date for their next appointment.

RTT Recovery Plan

Based upon the detailed demand and capacity modelling we have carried out, the expectation is to deliver the national 92% RTT standard by September 2017. Each key speciality has a demand and capacity model behind its trajectory that identifies sustainable waiting list sizes for patients waiting for new appointments (including two week wait appointments), follow-up appointments and admissions. This is in line with good RTT waiting list management and ensuring patients do not wait for their treatment.

In response to the legal directions placed on NHS Havering Clinical Commissioning Group by NHS England which came into force on 20 June 2016, we have supported our CCG colleagues with the development of a robust, credible and system-wide RTT recovery plan. This was successfully submitted on 30 September 2016 to NHS England.

Clinical Harm Reviews

A review of information on patients waiting more than 52 weeks to identify risk of harm and ensure they are appropriately and efficiently managed has been implemented;

Phase 1

- Focused on patients on admitted pathway
- More than 900 reviews carried out
- No moderate or severe harm identified.

Phase 2

- Focused on patients on non-admitted pathway
- More than 3,500 reviews carried out
- No moderate or severe harm identified

The next phase of the clinical harm reviews has started. We have begun by initially reviewing a 10% sample of those patients who have waited between 35 and 52 weeks across all specialties. We have 80 patients in this category of reviews, 77 patients had no harm found and 3 patients are having outpatient appointments in order to complete their reviews. This approach was agreed with NHS England through our External Clinical Harm Panel.

Return to Reporting

Following extensive validation and improvements in data quality we have taken steps to assure a return to reporting for RTT performance. We have planned to return to reporting the October incomplete RTT position. This data will be submitted on 17 November and reported nationally mid-December. We have a detailed plan to support this work and we are on track to complete this. Our Trust Board has signed off this work and they are happy for us to return to reporting. We have sought external assurance with this work.

Communications

An action plan is being developed to set out the communications which will take place to support our return to reporting.

We expect to publish our October performance in our papers for the 7 December Board meeting – prior to NHSE publishing our performance during the third week of December - and we will have a suite of materials in place to manage this, working towards a 5 December deadline.

This will include a dedicated section on the website, an issue brief to be circulated to all stakeholders, a briefing for the media, and information on the intranet for staff.

Lines will be agreed with our CCG and NHSE communications colleagues prior to publication.

In addition a system-wide communications and engagement strategy has been developed which sets out a joint approach between commissioners and service providers in relation to improving waiting times for elective care in Barking& Dagenham, Havering and Redbridge.

HEALTH AND WELLBEING BOARD

22 November 2016

Title:	**Health and Wellbeing Outcomes Framework Performance Report – Provider Quality for Quarter 2 2016/17 (July to September 2016)**

Report of the Strategic Director of Service Development & Integration

Open Report	**For Decision**
Wards Affected: ALL	**Key Decision:** No
Report Author: Mark Tyson Commissioning Director, Adult's Care & Support, LBBD	**Contact Details:** Email: Mark.Tyson@lbbd.gov.uk Tel: 020 8227 2875

Sponsor:

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

Summary:

In the companion report to this, the Health & Wellbeing Board has reviewed performance against its targets as reflected in the dashboard and accompanying narrative. The essential partner to performance is an analysis of quality in the system At a high level this can be captured in the activity of the quality regulator, the Care Quality Commission.

The Care Quality Commission periodically publishes reports of its inspections of services across adult social care, primary care and hospital services, and where there are concerns identified, these are documented in this report to the Board, together with actions being taken by commissioners and service providers to see those services improved.

Recommendation(s)

Members of the Board are recommended to:

- Note and discuss the outcomes of CQC inspections and the actions being taken as a result when improvements are identified as needed.

Reason(s)

The outcomes of inspections carried out by the Care Quality Commission provides important information about the quality of provision with Barking and Dagenham. It is therefore important that Board members use this opportunity to examine where provision

has been rated as requiring improvement or inadequate.

1 Introduction

1.1 The Health & Wellbeing Board has a wide remit, and it is therefore important to ensure that the Board has an overview across this breadth of activity. While the performance report focuses on indicators highlighting the performance of elements within the system and the system as a whole, this report highlights the quality of the provision of services within the borough, including the outcome CQC inspections.

1.2 Appendix A contains an overview of CQC inspection reports published during 2016/17 Q2, including those relating to GP surgeries, social care providers, and all other healthcare providers in the borough or who provide services to our residents.

2 Local hospital services: CQC reporting in quarter 2

BHRUT

2.1 Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) remains in special measures following the CQC revisiting the Trust in March 2015; finding that although there were improvements in responsiveness to patient needs, at times there were still significant delays in initial clinical assessment.

2.2 Both King George Hospital and Queen's Hospital 'Require Improvement', while the trust is marked as 'Inadequate' for responsiveness and 'Requires Improvement' for safety, effectiveness, caring, and being well-led.

NELFT

2.3 In April 2016 the Care Quality Commission (CQC) undertook a comprehensive inspection of 14 of NELFT's core services (5 Community Health services and 11 mental health services). Of these 14 core service reports, 9 were rated as good, 4 as requiring improvement and 1 as inadequate. The overall key lines of enquiry found that of the 5 inspection framework domains; 4 required improvement and 1 was rated as good. NELFT received an aggregated rating of Requires Improvement.

2.4 Below is a summary of the findings of the inspection, full details of the outcome of the inspection can be found via the following link
http://www.cqc.org.uk/sites/default/files/new_reports/AAAF3168.pdf

2.5 Community Health services (5 core services which did not include End of Life or Community Dentistry)

- In some of the community health services there were major staffing shortages and high caseloads which were impacting on the quality of care being provided and the well-being of community health staff.
- That community health services for adults had a lot of variation in the referral to treatment times for accessing specialist nursing services, which requires addressing to provide consistency.

- Within community health services for children, young people and families, there were long waiting times and waiting list breaches for referral to therapy and diagnostic services.

2.6 Mental Health Services (11 core services which did not include 'specialist' MH services such as MH perinatal)

- Child and Adolescent inpatient unit – environmental cleanliness, facilitates did not promote privacy and dignity, blanket restrictions, staffing issues, high number of restraints. Care plans and risk assessment were not person centred.
- In the acute inpatient core services risk assessment, risk formulations and care plans were not always being updated and reviewed.
- Care planning lacked personalisation and involvement.
- Environment safety – there were multiple ligature points in ward areas and patient bedrooms. Ligature risk assessments and action failed to provide the necessary detail and staff were not always aware of ligature points and the controls required.
- Access to psychological therapies

2.7 Corporate

- The board did not have assurance that all clinical risks including those linked to regulatory compliance had been addressed.
- The governance structures and quality assurance processes did not identify that core services were deteriorating and that there was inconsistency across core services regarding rates of staff mandatory training, appraisal and supervision.
- The trust did not meet the fit and proper persons requirement for directors and was noncompliant with the law.

2.8 In addition, the CQC identified several areas of good practice, including:

- In Havering, nursery nurses piloted nursery nurse led child health clinics, receiving positive evaluation by parents of 100%
- The community treatment team worked closely with local acute hospitals to reduce emergency admissions to hospitals for patients, who were treated in their own homes
- Partnership with London Ambulance Service (K466 Car) plus national patient safety award
- All memory services were accredited in the Memory Service National Accreditation Programme run by the Royal College of Psychiatrists
- The child and adolescent mental health community teams had joined CYP IAPT - national service transformation programme delivered by NHS England to improve mental health services for children and young people.
- Cited as one of the top ten global black and minority ethnic networks by The Economist in February 2016

- The trust has good overall systems and processes for managing safeguarding children and adults at risk. The trust was represented at all local authority safeguarding boards and contributes to sub groups

2.9 The CQC held a Quality Summit on 14 October 2016 and representatives from all partner organisations, Governors, patient groups and staff attended and a series of development workshops, to look at how the partnership can work together to support an improvement plan, took place.

2.10 The CQC report was discussed at the Joint Health and Overview Scrutiny Committee on 18th October, where there was discussion around the following issues:

- The closure, refurbishment and subsequent re-opening of Brookside Ward
- Changes to the recruitment process and further recruitment of nurses that had already taken place
- Development of a new model of care with more care delivered at home
- Transformation of the acute care pathway which had led to a reduction in suicide rates

2.11 The CQC report was also discussed at the recent Health and Adult Services Select Committee on 2 November, where the following issues were raised:

- The Trust's recruitment challenges and what the Trust is doing to reduce spend on temporary/ agency staff
- The Trust's explanation of why it did not meet the fit and proper person's requirements for directors and a lack of robust induction training for governors
- The finding that there was a lack of consistent recording of patient risk across the services to ensure these were captured and plans to minimise the risks – a GP in attendance made the point that the Trust needs to communicate very clearly with staff, including agency/ temporary staff, that risks must be recorded in line with the Trust's protocol and what the repercussions would be for non-compliance.

2.12 NELFT has developed a template Strategic Quality Improvement Plan which will address every area of improvement identified by the CQC inspection. This template was approved by the NELFT Board of Directors at its meeting on 26 October and is being populated with actions. The full, approved Strategic Quality Improvement Plan will be presented to the Health and Wellbeing Board at its meeting on 31 January.

3 Adult Social Care Services

3.1 The Care Quality Commission (CQC) published reports on 8 local social care providers in 2016/17 Q2 in Barking and Dagenham. These inspections have taken place under the new inspection criteria that came in to affect in October 2014.

3.2 Of the social care providers inspected, three were rated 'Good':

- Dagenham Road – Outlook Care
- Gascoigne Road Care Home (80 Gascoigne) - London Borough of Barking and Dagenham
- Park View - Barchester Healthcare Homes Limited

3.3 The remaining five were rated as 'Requires Improvement' and are listed below:

- Chestnut Court
- Lynwood
- Caronne Care Ltd
- Three Sisters Care Ltd
- Hanbury Court Care Centre - MNS Care Plc

Chestnut Court – Requires Improvement

3.4 Chestnut Court is a 62-bedded nursing home located in Dagenham. The home offers accommodation for persons who require nursing or personal care, dementia, end of life care and people with challenging behaviour.

3.5 The inspection found that all five areas (Safe, Effective, Caring, Responsive and Well-Led) required improvement.

3.6 The local authority, in conjunction with the CCG, has been working with Chestnut Court to improve provision following the inspection. An unannounced visit by the QA team and the CCG showed improvements in most areas and the local authority will continue to work through the improvement plan with the home and continue increased monitoring.

Lynwood – Requires Improvement

3.7 Lynwood is a supported living accommodation for people with learning disabilities, physical disabilities and sensory impairments for adults under the age of 65 years. Unannounced quality assurance monitoring was carried out by the local authority one week before the CQC inspection, and concerns were forwarded to the CQC. Lynwood was rated 'Requires Improvement' in four areas and inadequate on one area.

3.8 Quality Assurance and Commissioning are working closely with the provider to improve the quality of the service that is delivered. An improvement plan is in place, including increased monitoring and unannounced visits, with improvements being seen in several areas. The QA team will continue to work closely with the provider.

Caronne Care Limited – Requires Improvement

3.9 Caronne Care Limited is a home care provider on the Council's approved list of providers. Caronne Care were rated 'Good' in three areas: Effective, Caring and Responsive; however, the agency was rated as 'Requires Improvement' in two areas – Safe and Well-led.

3.10 The Quality Assurance team and the Commissioner responsible for homecare have put an improvement plan in place with the provider and will be carrying out visits and monitoring service user feedback. The provider has put new management into the service and social workers are providing feedback on the provider, which is also being incorporated into the improvement plan.

Three Sisters – Requires Improvement

3.11 Three Sisters is a home care provider on the Council's approved list of providers, based in Tower Hamlets. Three Sisters were rated 'Good' for Caring but rated 'Requires improvement' in all other areas.

3.12 The Quality Assurance team and the Commissioner responsible for homecare have met with the provider and an improvement plan is in place. Service users have been reviewed and all are happy with the quality of the service, while a visit from the QA team indicated improvements in many of the areas identified by the CQC. The QA team will continue to closely monitor the provider, and there has been communication with Tower Hamlets to ensure that the improvement plan is joined up.

Hanbury Court Care Home – Requires Improvement

3.13 Hanbury Court is a nursing care home for older people requiring nursing, dementia, end of life care. Care is also in place for people with physical disabilities. Hanbury Court was rated as 'Requires Improvement' overall, with four areas rated as requires improvement and one area (safe) rated as inadequate.

3.14 The Quality Assurance team and the Social Care Business Unit have been working closely with the provider to improve the quality of the service and an improvement plan is in place. Joint unannounced quality assurance monitoring visits have taken place, which identified some improvements, although further improvements are still required in medication audits, staff morale and culture, as well as robust systems to monitor the quality of care delivered. Increased monitoring is being undertaken by the Quality Assurance team.

4 Primary Care Services

4.1 The Care Quality Commission (CQC) published reports on 7 GP practices and 1 dental surgery in quarter 2 2016/17.

4.2 The CQC carried out an inspection at Rose Lane Dental Surgery in February 2016 which found breaches of legal requirements. The CQC then carried out a follow-up inspection on 20 July 2016 to check that they had followed their plan and they now met the legal requirements. The inspection found no further improvement actions were required.

4.3 Of the seven GP practices that had reports published in Q2, 4 were rated 'Good':

- Parkview Medical Centre - Dr DP Shah's Practice
- Thames View Health Centre - Dr Gurkirit Kalkat
- 7 Salisbury Avenue - Dr R Chibber's Practice
- Marks Gate Health Centre - Dr KP Kashyap's Practice

4.4 Both Urswick Medical Centre and Chadwell Heath Health Centre were rated as 'Requires Improvement', while Broad Street Resource Centre (run by Heathway Medical Centre) was rated 'Inadequate'.

4.5 Where a healthcare establishment is rated as 'Requires Improvement', or 'Inadequate', the practice is required to develop an improvement plan which is then monitored by the CQC. Where a practice is rated as 'Inadequate', the practice will be re-inspected by CQC within six months. The GP practices that are rated as such are listed below along with the main points of their action plans:

Heathway Medical Centre – Inadequate

4.6 The practice has been placed in special measures following the CQC inspection and a further inspection will take place within 6 months, where if there remains a rating of inadequate for any population group, key question or overall, action will be taken in line with CQC enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to the cancellation of their registration or to varying the terms of their registration if they do not improve.

4.7 The key findings across all the areas inspected included:

- Patients were at risk of harm because systems and processes were not in place to keep them safe
- The practice did not have systems or processes in place to record, analyse or share learning from significant events or complaints
- Patient outcomes were hard to identify
- Policies and procedure were generic, incomplete or did not contain relevant information
- The practice did not hold regular practice or governance meetings and issues were discussed with staff on an ad hoc basis
- Patients highlighted that the appointments system was not working and they experienced long waiting times to be seen
- Clinical staff assessed patient's needs and delivered care in line with current evidence based guidance

4.8 There are a number of areas where the provider must make improvements, which can be found in more detail in the full CQC report: http://www.cqc.org.uk/sites/default/files/new_reports/AAAF5830.pdf

Chadwell Heath Health Centre – Requires Improvement

4.9 The areas where the provider must make improvements are to:

- Review the mandatory training requirements for staff and ensure all staff receive the required training at appropriate intervals
- Ensure recruitment arrangements include all necessary employment checks for all staff and develop a role specific induction programme
- Implement a programme of continuous quality improvement including audits to show improvements in patient outcomes

- Ensure a risk assessment is completed or DBS checks are carried out for non-clinical staff who provide chaperone duties
- Act to improve patient satisfaction with access to the practice. • Review the practice appointment system

Urswick Medical Centre – Requires Improvement

4.10 The areas where the provider must make improvements are to:

- Ensure recruitment arrangements include all necessary employment checks for all staff
- Ensure there are systems in place to monitor and manage risk to patient and staff safety, including fire safety
- Ensure that there are systems in place to manage staff training for their roles so that staff have the skills and knowledge to deliver effective care

How the CCG is supporting practices to address issues

4.11 Practices are responsible for making the required improvements and ensuring they meet the CQC requirements. However, the CCG is working with practices to support them to deliver the high-quality care that patients expect.

4.12 Across Barking and Dagenham, and our partner CCGs, Havering and Redbridge, a review was undertaken (reported in the previous HWB performance report) that reviewed the common themes that have come out of recent CQC reports on GP practices.

4.13 To address the areas found by the review, the CCGs developed a plan to actively support practices to improve in key areas. This included providing practices with best practice guidance, and information on training available, along with information on other recommended services and support, such as how to access DBS checks and language services.

4.14 The CCG is also in the process of reviewing practice training requirements and will set up some specific training sessions for practice staff and GPs particularly around:

- Managing risk and learning from mistakes
- Health and safety
- CPR
- Equality and diversity
- Informed consent
- Informed decision making
- Whistle blowing
- Fire safety

5 Mandatory implications

Joint Strategic Needs Assessment

5.1 The Joint Strategic Needs Assessment provides an overview of the health and care needs of the local population, against which the Health and Wellbeing Board sets its priority actions for the coming years. By ensuring regular performance monitoring, the Health and Wellbeing Board can track progress against the health priorities of the JSNA

Joint Health and Wellbeing Strategy

5.2 The Outcomes Framework, of which this report presents a subset, sets out how the Health and Wellbeing Board intends to address the health and social care priorities for the local population. The indicators chosen are grouped by the 'life course' themes of the Strategy, and reflect core priorities.

Integration

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

Legal

5.4 Implications completed by: Dr Paul Feild

5.5 The Health and Wellbeing Board is established under Section 194 of the Health and Social Care Act 2012. The primary duty of the Health and Wellbeing Board is to encourage those who arrange for the provision of health or social care services to work in an integrated manner. This is further extended to include encouraging integrated working with those who arrange for the provision of health-related services (defined as services that may influence the health of individuals but are not health services or social care services).

Financial

5.6 Implications completed by: Katherine Heffernan, Group Manager, Finance

5.7 There are no financial implications from this report.

6 List of Appendices

- Appendix A: CQC inspection reports

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Appendix B – 206/17 Q2 CQC Inspections							
Provider Name	**Location**	**Weblinks**	**Org Type**	**Report Date**	**Inspection Date**	**Rating**	**Comments / Summary**
Chestnut Court	Chestnut Court	http://www.cqc.org.uk/sites/default/files/new_reports/INS2-2456809832.pdf	Social Care Org	18/07/2016	26/04/2016 - 27/04/2016	**Requires improvement**	Safe – Concerns were raised around medicine administration and management. Effective – CQC found that there were inadequate arrangements around training, appraisals and supervision of staff. Caring – Some concerns were raised by CQC around the way in which staff communicated with service users and that they were not always treated with respect and dignity. Responsive – Care plans were not regularly reviewed and there were a lack of activities in place. Well-Led – Effective systems were not in place to monitor quality assurance.
Lynwood	Lynwood	http://www.cqc.org.uk/location/1-114143405	Social Care Org	25/08/2016	14/07/2016 and 18/07/2016	**Requires Improvement**	Safe (inadequate) – The CQC report found that medications were not administered safely, service users were at risk of harm when moving around and no risk assessment was in place. Effective (requires improvement) – CQC found that staff did not always receive adequate training and supervision to support their role. Caring (requires improvement) – CQC found that there was a lack of knowledge regarding people who are gay, bisexual, transgender within the service). Responsive (requires improvement) - CQC found that there was a lack of appropriate weekend activities for residents. Well-led (requires improvement) – CQC detailed that there was no effective systems to audit the quality of service and staff had mixed views about the leadership of the service.
Caronne Care Ltd	Caronne Care Ltd	http://www.cqc.org.uk/location/1-2147273379	Social Care Org	25/08/2016	07/07/2016 - 08/07/2016	**Requires Improvement**	Caring: Good Effective: Good Responsive: Good Safe – Concerns were raised by CQC around the lateness of staff to people's homes. Well-Led – The CQC found that quality assurance systems were not always robust and that notifications were not being sent to the CQC as required by the regulations.
Three Sisters Care Ltd	Three Sisters Care	http://www.cqc.org.uk/location/1-503749931	Social Care Org	10/08/2016	22/06/2016	**Requires Improvement**	Safe – Concerns were raised around safer recruitment processes and medicines were not appropriately recorded and checked. Effective – The CQC reported issues around staff training, particularly around the Mental Capacity Act. Responsive – Although care plans contained detailed information about people's needs, preferences and wishes, the CQC felt that the plans did not always reflect the support that people received. Well-Led - Managers did not have sufficient audit systems in place to ensure high quality care was provided. Caring: Good
MNS Care Plc	Hanbury Court Care Centre	http://www.cqc.org.uk/location/1-119099319	Social Care Org	19/02/2016	21/01/2016	**Requires Improvement**	Safe (inadequate) – TheCQC found that medications were not always administered safely, and that people were at risk of harm during moving and handling. Inadequate staffing level to meet the needs of the people who use the service. Effective (requires improvement) – Staff did not receive adequate training, appraisals and supervision to enhance their role. Caring (requires improvement) - Staff did not treat residents with respect and dignity and there was a lack of knowledge around individuals identifying as gay, lesbian, bisexual and transgender. Responsive (requires improvement) – Care plans were not always detailed or regularly reviewed. Well-Led (requires improvement) – There were no effective systems in place to monitor the quality of the service provided. Staff had mixed views about the leadership and staff culture of the home.

Dagenham Road - Outlook Care	Dagenham Road - Outlook Care	http://www.cqc.org.uk/sites/default/files/new_reports/INS2-2460243462.pdf	Social Care Org	19/07/2016	10/05/2016	**Good**	Safe: Good Effective: Good Caring: Good Responsive: Good Well Led: Good
London Borough of Barking and Dagenham	Gascoigne Road Care Home (80 Gascoigne)	http://www.cqc.org.uk/sites/default/files/new_reports/INS2-2460817922.pdf	Social Care Org	08/08/2016	28/06/2016 - 29/06/2016	**Good**	Safe: Good Effective: Good Caring: Good Responsive: Good Well Led: Good
Barchester Healthcare Homes Limited	Park View	http://www.cqc.org.uk/location/1-125861732	Social Care Org	05/08/2016	09/06/2016 - 10/06/2016 and 16/06/2016	**Good**	Safe: Good Effective: Requires improvement Caring: Good Responsive: Good Well Led: Good
Rose Lane Dental Surgery	129 Rose Lane	http://www.cqc.org.uk/location/1-1413667912	Dentist	03/08/2016	20/07/2016	**N/A**	The practice was found to now be providing safe care in accordance with the relevant regulations. The practice was found to now be providing well-led care in accordance with the relevant regulations.
Dr DP Shah's Practice	Parkview Medical Centre	http://www.cqc.org.uk/location/1-559775380	Doctors/GPs	23/06/2016	18/04/2016	**Good**	Safe: Good Effective: Good Caring: Good Responsive: Good Well Led: Good
Dr Gurkirit Kalkat	Thames View Health Centre	http://www.cqc.org.uk/location/1-551125553	Doctors/GPs	19/07/2016	17/05/2016	**Good**	Safe: Good Effective: Good Caring: Good Responsive: Good Well Led: Good
Heathway Medical Centre	Broad Street Resource Centre	http://www.cqc.org.uk/location/1-2687718289	Doctors/GPs	01/09/2016	26/05/2016	**Inadequate**	Safe: Inadequate Effective: Inadequate Caring: Requires improvement Responsive: Requires improvement Well Led: Inadequate
Dr Hamilton-Smith And Partners	Chadwell Heath Health Centre, Ashton Gardens	http://www.cqc.org.uk/location/1-609934909	Doctors/GPs	05/09/2016	05/05/2016 and 26/06/2016	**Requires improvement**	Safe: Requires improvement Effective: Requires improvement Caring: Good Responsive: Requires improvement Well Led: Requires improvement
Dr KM Al-Kaisy Practice	Urswick Medical Centre	http://www.cqc.org.uk/location/1-529661202	Doctors/GPs	06/09/2016	17/05/2016	**Requires improvement**	Safe: Requires improvement Effective: Requires improvement Caring: Good Responsive: Good Well Led: Good
Dr R Chibber's Practice	7 Salisbury Avenue	http://www.cqc.org.uk/location/1-538798433	Doctors/GPs	23/09/2016	06/09/2016	**Good**	Are services safe?: Good
Dr KP Kashyap's Practice	Marks Gate Health Centre	http://www.cqc.org.uk/location/1-542613277	Doctors/GPs	29/09/2016	16/12/2015	**Good**	Safe: Good Effective: Good Caring: Good Responsive: Good Well Led: Good

HEALTH AND WELLBEING BOARD

22 November 2016

Title:	Safeguarding Adults Board and Safeguarding Children Board Annual Reports 2015 - 16

Report of the Independent Chair of the Safeguarding Adults Board and Safeguarding Childrens Board

Open Report	For Information
Wards Affected: ALL	**Key Decision:** No
Report Author: Sarah Baker, Independent Chair of the Safeguarding Adults Board and Safeguarding Childrens Board	**Contact Details:** Tel: E-mail: sarah.baker@lbbd.gov.uk

Sponsor:

Anne Bristow, Deputy Chief Executive and Strategic Director of Service Development and Integration

Summary:

Local Safeguarding Adults Boards (SAB) and Local Safeguarding Children Boards (LSCBs) have a statutory obligation to compile and publish an Annual Report and to provide this to the Chair of the local Health and Wellbeing Board. The reports are expected to provide an assessment of the effectiveness of local arrangements to safeguard and promote the welfare of vulnerable adults and children respectively.

Although the Safeguarding Adults Board (SAB) has been operating for a number of years the Care Act 2014 which was introduced in April 2015, placed the SAB on a statutory footing, (in the same way the LSCB is under the Children Act 1989 and 2004) together with a new set of duties and powers to act when abuse or neglect of vulnerable adults is suspected.

The Annual Reports highlight the work of the Safeguarding Adults Board (SAB) and Local Safeguarding Children Board (LSCB) between April 2015 and March 2016. They set out the key achievements, work of the partners and future priorities and seeks to demonstrate how the Safeguarding Boards have worked to improve the protection of vulnerable adults and children across Barking and Dagenham.

The Safeguarding Annual reports are published on behalf of the LSCB and SAB and their partners and is an opportunity to celebrate the achievements of 2015 - 16 and plan for the year ahead. The annual reports contain contributions from a range of organisations who are involved in safeguarding vulnerable adults and children in Barking and Dagenham.

Partners have worked successfully together over the past year. The statutory partners have provided financial resources to support the SAB and the LSCB to fulfil their functions and to support the undertaking of Safeguarding Adult Reviews (SARs) and Serious Case Reviews.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) receive the Safeguarding Adults Board and Safeguarding Children Board Annual Reports, and to provide comments on their contents for the LSCB and SAB to consider as they continue to develop their future plans.

(ii) In September 2014, the Health and Wellbeing Board (HWBB) and the LSCB agreed a protocol which covers how they will work together to safeguard children. In its broadest sense safeguarding refers to promoting the wellbeing of children, a shared responsibility of both Boards. The HWBB considers how the health needs of children are met and has an influence on this broader safeguarding agenda. The HWBB can also use this influence with health partners to ensure that the LSCB is getting the right support to ensure that agencies working with children are meeting the highest standards. In the light of the reports, activities and impact described, the Health and Wellbeing Board may wish to comment on and confirm how it perceives its role in relation to safeguarding and any joint work that should take place between the two Boards.

Reason(s)

For the Health and Wellbeing Board to have an opportunity to comment on the work of both the Safeguarding Adults Board and Safeguarding Children Board prior to the publishing of both of the annual reports.

1 Introduction and Legislative Background

1.1 The Care Act 2014 requires that local partners must co-operate around the protection of vulnerable adults at risk of abuse or neglect. Although the SAB has been operating for a number of years the Care Act puts it on a statutory footing. The statutory partners are the Local Authority, the Police and the Clinical Commissioning Group (CCG) and other Board members include the chairs of the committees, BHRUT and officer advisors The objectives of the SAB are to:

- ensure that local safeguarding arrangements are in place as defined by the Care Act 2014;
- embed good safeguarding practices, that puts people at the centre of its duties;
- work in partnership with other agencies to prevent abuse and neglect where possible;
- ensure that services and individuals respond quickly and responsibly when abuse or neglect has occurred;
- continually improve safeguarding practices and enhance the quality of life of adults in the local area.

1.2 Section 14 of the Children Act 2004 and Working Together to Safeguard Children 2015 sets out the statutory objectives and functions for an LSCB as follows:

- To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- To ensure the effectiveness of what is done by each such person or body for those purposes.

1.3 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

- developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:
  - the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
  - training of persons who work with children or in services affecting the safety and welfare of children;

- recruitment and supervision of persons who work with children;
- investigation of allegations concerning persons who work with children;
- safety and welfare of children who are privately fostered;
- cooperation with neighbouring children's services authorities and their Board partners.

- communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so.
- monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve.
- participating in the planning of services for children in the area of the authority; and
- undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

1.4 Regulation 5 (2) which relates to the LSCB Serious Case Reviews function and regulation 6 which relates to the LSCB Child Death functions are covered in chapter 4 of the Working Together to Safeguard Children guidance. Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

1.5 In order to fulfil its statutory function under regulation 5 an LSCB should use data and, as a minimum, should:

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned;
- monitor and evaluate the effectiveness of training, including multiagency training, to safeguard and promote the welfare of children.

1.6 In 2015/16 the government issued additional guidance to all LSCBs in respect of radicalisation and extremism which needs to be recognised as a safeguarding issue and should be included in the quality assurance work undertaken by the Board.

1.7 Additionally the government contacted all LSCB Chairs and Chief Executives of Councils in 2015 following publication of the Jay report reinforcing the importance of ensuring robust responses to Child Sexual Exploitation.

1.8 In accordance with Working Together to Safeguard Children Guidance 2015 the LSCB is required to publish an Annual Report detailing how it has achieved its

functions set out within Regulation 5 of the Local Safeguarding Children Boards Regulation 2006 under section 14 of the Children Act 2004.

2 Safeguarding Adults Board Annual Report

2.1 This is the second Annual Report that has been produced by the Safeguarding Adults Board under its statutory status. Taking into account the feedback received and discussions with regards to the 2014-15 annual report, the chapters are themed around the six safeguarding principles which are accountability, empowerment, protection, prevention, proportionality and partnership. There is information about the activity of the Board and of partner agencies. These follow a foreword by the Independent Chair of the Board, information about the Board structure and its committees and safeguarding data. There is also an account of the outcomes and recommendations from the Safeguarding Adult Review that was undertaken by the Board, information around the learning and development undertaken by the Board and partner organisations in relation to safeguarding, a statement from Healthwatch and a chapter around the Board's priorities for the coming year.

3 Key Achievements for the Safeguarding Adults Board 2015 - 2016

Public Awareness Raising

3.1 Work to raise the awareness of safeguarding issues included the relaunch of the 'iCare' Campaign to raise the profile of vulnerable adults at risk of abuse to support concerns to be raised by local communities and professionals. Leaflets and posters were produced and have been distributed to partner organisation and it has a presence on the safeguarding website.

Safeguarding Performance

3.2 The annual report summarises performance during 2015/16 in the 'safeguarding at a glance' chapter.

3.3 In summary, for the year, the Council received and processed 1,362 alerts. 492 of these concerns were progressed to an enquiry and 87 resulted in safeguarding investigations. The number of alerts is comparable to the previous year cases, however a higher number of cases were progressed to enquiry stage.

3.4 The Performance and Assurance committee is developing a performance framework to assist the Board in understanding safeguarding issues across partner organisations and in the community and to highlight areas of risk and concern.

Safeguarding Adults Reviews

3.5 The Safeguarding Adults Board has a duty to carry out Safeguarding Adult Reviews (SARs) where an adult in the local authority area:

- Has died as a result of abuse or risk (either known or suspected) and there are concerns that partner organisations could have worked together more effectively to protect that adult; or
- Has not died but the Safeguarding Adults Board knows or suspects that an adult has experienced serious abuse or neglect.

3.6 Each member of the Safeguarding Adults Board must co-operate and contribute to the review. The recommendations of a Safeguarding Adults Review must be reported in the Safeguarding Adults Board's Annual Report. A robust SAR process is now in place for the consideration of cases.

3.7 In 2015/16 one Safeguarding Adult Review was undertaken. This concluded and reported to the SAB in December 2015. This is reported in the annual report under the title of a Safeguarding Adults Review. A learning event was undertaken to share outcomes with practitioners from across all partner agencies. The review made a number of recommendations and the action plan has been monitored by the Safeguarding Adult Review committee. The actions are almost all complete.

3.8 The Corporate Assurance Group are kept abreast of developments around SARs and the SAB and SAR committee lead on embedding the learning from SARs across all partner agencies.

3.9 So far in 2016/17 a number of cases have been considered via the SAR process. Two SARs have been commissioned along with a Single Agency Management Review.

Strategic Plan

3.10 A three year strategic plan has been developed which includes actions for the Board overall and the committees. The actions are set out under the safeguarding principles and the strategic objectives. The actions form part of the committee's work plans and updates against the actions are reported to the SAB every 6 months. The plan will be refreshed on an annual basis.

Multi Agency Safeguarding Adults Policies & Procedures

3.11 The SAB signed up to the Multi Agency Safeguarding Policies and Procedures in March 2016. The Board has since developed an action for implementation of these.

4 SAB Priorities for 2016 - 17

4.1 The SAB has set a number of priorities for 2016/17. These were discussed and endorsed at the SAB development session in April 2016. The key areas the SAB will be focussing on in 2016/17 are:

- Making Safeguarding Personal (MSP) – It is recognised that some development is required to be confident that Barking and Dagenham and its partners have fully embedded the principles of MSP. The ADASS roadmap has been adopted to guide further work.

- Mental Capacity Act (MCA) Compliance – although a considerable amount of MCA training has taken place with staff across all agencies, there is still some way to go in raising the confidence of staff to undertake MCA assessments.

- Learning from SARs – The SAB will continue to lead on embedding the learning from SARs and other reviews across all agencies.

- Joint safeguarding training – The SAB will lead on providing joint training opportunities across partner agencies.

- Performance Framework – the development of a performance management framework is a key focus to assist the Board in understanding safeguarding issues across partner organisations and in the community and to highlight areas of risk and concern.

5 Local Safeguarding Childrens Board Annual Report

5.1 The LSCB Annual report provides an account of the work of partners in safeguarding children across Barking and Dagenham. The report sets out the demographics and associated safeguarding issues facing children – poverty, domestic abuse and child sexual exploitation (CSE). A safeguarding snap shot provides the context for the partnership response to safeguarding work across Barking and Dagenham. The report focuses on the Effectiveness of Safeguarding Arrangements in Barking & Dagenham, Early Intervention and Domestic Violence. We describe the partnership response to CSE, Children Missing Home, Care and Education and Prevent.

6 Key Achievements for the Safeguarding Childrens Board 2015 - 2016

Engagement of Children and Young people

6.1 The Young People's Safety Group enables children from senior schools across the borough to meet each term to discuss safeguarding issues identified by them. These have included mental health issues, sexual health and CSE and Prevent. The board engage in Young People's Takeover Day and last year saw young people manage the LSCB board meeting giving them with the opportunity to challenge partners about safeguarding in Barking and Dagenham. Young People are leading Takeover Day for the LSCB again this year.

Children Missing from Home, Care and Education

6.2 Going missing is a dangerous activity. There are particular concerns about the links between children running away and the risks of sexual exploitation, gangs and radicalisation. The LSCB has strengthened its oversight of the work of partners to identify and protect children missing. The figures show that most children who go missing do so repeatedly continuing to put themselves at risk.

Early Help

6.3 The report highlights the increasing number of contacts to children's social care but a drop in the number of referrals by 21% due to effective screening at the MASH and the provision of early help services.

6.4 The significant volume of Merlins (contacts from the Police) has led to positive collaborative working between Children's Social Care, Police and Early Help services. In particular where there are concerns around low level domestic abuse, arrangements are now in place to visit and offer support at a Tier 2 level before considering a referral.

Child Death Overview Panel (CDOP) and Serious Case Reviews (SCRs)

6.5 There is a summary of the work of the Child Death Overview Panel which considers circumstances relating to the deaths of children and a section which describes Serious Case Reviews (SCRs). These are initiated where abuse or neglect of a child is suspected and the child has died or has been seriously harmed. One SCR commenced in the borough during the year and actions were taken in response to another one which was completed earlier. Key learning from the SCRs were:

- information sharing between professionals
- compliance with procedures – national and local
- the 'invisible' father
- professional optimism
- disguised compliance.

6.6 The report concludes that the LSCB has a good overview of practice which protects and safeguards children and young people, has worked well to anticipate and respond to significant issues affecting their lives and has challenged LSCB members to promote the best outcomes for children and young people.

6.7 The report highlights areas where further development is required. These areas are reflected in the 2016/17 Safeguarding Business Plan which informs the current activities of the LSCB. Current priorities will respond to the need to continue to improve local practice in relation to national issues such as female genital mutilation, child sexual exploitation, children who go missing and radicalisation of young people.

Learning from Serious Case Reviews and Audit

6.8 In Line with Working Together 2015 the LSCB ensures that learning from reviews and audit is shared and discussed across the partnership. Workshops for the serious case reviews enabled over 300 practitioners and managers to come together to reflect on the recommendations identified in the reviews and consider the implications for their practice.

7 LSCB Priorities for 2016 - 17

7.1 Based upon a review of progress to date as reflected in the report, the LSCB has identified its priorities for the current year which are listed at the end of the report and reflected in the 2016/17 Safeguarding Business Plan. The intention is to continue to address and make progress with these priorities whilst responding to emerging issues. These are developed through the strategic plan and work plans of the sub committees of the LSCB. The chairs of the sub committees meet with the LSCB chair six times a year to review progress and identify areas for development and joint working.

- Board members are assured that arrangements are in place to identify and safeguard groups of children who are particularly vulnerable.

- Board partners will own and share accurate information which informs understanding of safeguarding practice and improvement as a result.

- The Board will see children and young people as valued partners and consult with them so their views are heard and included in the work of the LSCB.

- Arrangements for Early Help will be embedded across agencies in Barking and Dagenham who work with children, young people and their families.

- Board partners will challenge practice through focused inquiries or reviews based on performance indicators, practitioner experience and views from children and young people. Collectively we will learn and improve from these reviews.

8 Proposal and issues

8.1 The Health and wellbeing Board is asked to discuss the reports and provide comments on their contents for the Safeguarding Adults Board and Safeguarding Childrens Board to consider as they continue to develop future plans.

8.2 In the light of the report and the activities and impact described, the Health and Wellbeing Board may wish to comment on and confirm how it perceives its role in relation to safeguarding and any joint work that should take place between the two Boards.

8.3 Members of the Board identify priorities which may benefit from further consideration by the Health and Wellbeing Board or more collaboration between the two Boards.

Consultation

8.4 All partners were consulted as part of the development of the report process and the Annual Reports have been agreed and signed off by the SAB on 21st September and the LSCB on 22nd September. All member agencies of the SAB and LSCB have contributed to the report which is now a public document.

9 Mandatory Implications

Joint Strategic Needs Assessment

9.1 The JSNA has a section dedicated to the analysis of safeguarding children and vulnerable adults. This report is used to update this section of the JSNA and its recommendations annually

Health and Wellbeing Strategy

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

Integration

9.3 Both the Boards have statutory partners as members. The committees are chaired and have membership from across all partner agencies.

Financial Implications

9.1 All statutory partners have contributed to the budget for the LSCB and SAB. In addition, resources have been received from the wider partnership of the LSCB which are reported on in the LSCB annual report.

Implications completed by: Katherine Heffernan, Group Finance Manager

Legal Implications

9.5 The Health and Wellbeing Board is asked to review and take note of the LSCB and SAB's annual reports which aims to provide a rigorous and transparent assessment of the performance and effectiveness of local services throughout the past year.

9.6 The legislative framework for the contents of the report for the SAB is set out in the Care Act 2014 which has been mentioned above. The annual report must contain details of the reviews that have been undertaken, what it has done to meet its strategy, objectives and any findings of reviews of past years. The report submitted to this Board fulfils those criteria.

9.7 The legislative framework for the contents of the report for the LSCB is set out in the Children Act 2004 and 'Working Together to Safeguard Children' (2015) . The report should identify areas of weakness, the causes of those weaknesses and the action being taken to address them; lessons from reviews undertaken within the reporting period; how the LSCBs partners' respond to child sexual exploitation; how to promote service improvement for vulnerable children and families; data on children missing from care, and how the LSCB is addressing the issue. The report should also list the contributions made to the LSCB by partner agencies and details of what the LSCB has spent, including on Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training. The Annual Report should be published on the local LSCBs website and is drawn to the attention of the Health and Wellbeing Board, the Police and Crime Commissioner, the local authority Chief Executive and the Leader of the Council. The reports provided to this Board fulfils those requirements.

Implications completed by: Eirini Exarchou, Senior Solicitor

Risk Management

9.8 An LSCB and SAB must be established for every local authority area. The LSCB and SAB have a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements.

The Local Safeguarding Children Board is a significant source of external assurance to the Council concerning the effectiveness of its Child Protection arrangements. Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals that should be represented on LSCBs.

The Chair of the LSCB and SAB must publish an annual report on the effectiveness of safeguarding and promoting the welfare of children and vulnerable adults in the local area (this is a statutory requirement under section 14A of the Children Act 2004 and the Care Act 2014). The annual reports should be published in relation to

the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the Health and Wellbeing Board.

Patient / Service User Impact

9.9 Involving families in the work of the safeguarding boards though the Safeguarding Adult Reviews and Serious Case Reviews provides an opportunity to understand the impact of how partners have worked together and what lessons can be learnt for the future.

10 Non-mandatory Implications

Crime and Disorder

10.1 The Safeguarding Boards have links to the Community Safety Partnership Board and there is representation on the Boards from the Borough Commander. Other representatives from the Police sit on the committees. For each Safeguarding Adult Review and Serious Case Review that is undertaken a Police Officer from the specialist central safeguarding adult review and children review unit is allocated to the case.

Safeguarding

10.2 The Care Act 2014 which was introduced in April 2015, placed the Safeguarding Adult Board on a statutory footing, together with a new set of duties and powers to act when abuse or neglect of vulnerable adults is suspected. The Children Act 1989 and 2004 provides the statutory guidance through which partners must operate to safeguard children and young people. Working Together 2015 sets out the requirement of partners to work together to safeguard children and young people.

Property / Assets

10.3 N/a

Customer Impact

10.4 The work of the statutory partners and wider agencies have an impact on how we commission and provide services to protect vulnerable children, young people and adults. The engagement of the local community in the work of the safeguarding boards is critical to partners understanding the safeguarding issues they face.

Contractual Issues

10.5 N/a

Staffing issues

10.6 N/a

Public Background Papers Used in the Preparation of the Report:

- Joint Strategic Needs Assessment
- Working Together 2015
- The Care Act 2014

List of Appendices:

Appendix A Safeguarding Adults Board Annual Report 2015 – 16

Appendix B Safeguarding Children Board Annual Report 2015 – 16

APPENDIX A

Barking and Dagenham Safeguarding Adults Board

Annual report

2015 – 16

Contents

Foreword 1

Foreword by Sarah Baker, Chair of the Barking and Dagenham Safeguarding Adults Board

During this year the Barking and Dagenham Safeguarding Adults Board (SAB) has worked to implement the requirements of the Care Act 2014.

The executive board whose membership comprises of the statutory partners – the Local Authority, the Clinical Commissioning Group and the Police have all shown commitment through attendance at both board and committee meetings and training and development sessions. Statutory partners have also provided financial resources to support the SAB fulfil its functions and to support the undertaking of SARs.

The SAB has been supported by the Chief Executive of the London Borough of Barking and Dagenham and the Cabinet Member for Social Care & Health Integration with whom I meet on a regular basis.

The Multi Agency Safeguarding Policy and Procedures were launched in March 2016 and all board members signed up to implementing these across their organisations. This included ensuring practitioners and mangers engaged in Care Act training. During the year I have had the opportunity to work alongside front line practitioners.

An example has been working with the officers visiting care homes to gain greater insight into how the council works in partnership to support care homes to provide high quality care and monitor those, where the Care Quality Commission have inspected and identified areas for development.

The Performance and Assurance committee have been developing a performance framework to help the Board understand the quality of service delivery across the partnership. It is recognised that there is still much to do to provide assurance to the board and in turn the local community around safeguarding issues.

The SAB has three committees to support its work and these are the Safeguarding Adults Review (SAR) committee, the Learning and Development (L&D) Committee and the Performance and Assurance (P&A) committee. All have challenging work plans which support the SAB to deliver its agenda through the strategic plan.

This year the SAR committee has overseen the commissioning of a Safeguarding Adult Review – the first under the auspices of the Care Act. This has provided the SAB with the opportunity to review its procedures for undertaking SARs and to strengthen and enhance assurance regarding open and transparent work and engagement with clients and families.

The Learning and Development committee has developed a revised communication strategy to facilitate the Board reaching out to the community and to ensure that all organisations working with vulnerable adults are engaged in SAB activities.

The SAB launched its second iCare campaign to raise awareness of vulnerable adults in the local community.

As independent chair of both the Safeguarding Adults Board and the Local Safeguarding Children's Board we have continued to strengthen joint working between the two boards recognising the vulnerabilities of families and issues relating to safeguarding.

In addition membership of the Health and Wellbeing Board allows for my involvement in debate and discussion regarding future service commissioning and provision and allows me to ensure safeguarding is an integral part of all service development.

As partners work to deliver high quality services within challenging financial situations the SAB partners have worked together to ensure safeguarding vulnerable adults and families is not compromised.

I would like to take this opportunity to thanks all partners of the SAB for their continued commitment to the work of the board and I look forward to working in partnership over the coming year.

Introduction 2

The Care Act 2014 came into force on 1st April 2015. The Act introduced new requirements for safeguarding adults and the arrangements that each locality must have in place to ensure that vulnerable people are protected from the risk or abuse or neglect. Some of these new requirements are directly relevant to the Barking and Dagenham Safeguarding Adults Board (SAB).

As a result of the Care Act, the SAB was reviewed and has now been working as a statutory body throughout 2015/16. The local authority, Clinical Commissioning Groups and the Police are all required by law to be members of the SAB and other partners are encouraged to engage with the SAB work.

The SAB must publish an Annual Report each year as well as a Strategic Plan.

In addition the SAB has a statutory duty to carry out Safeguarding Adult Reviews (SAR) where an adult in the local authority area:

- Has died as a result of abuse or risk (either known or suspected) and there are concerns that partner organisations could have worked together more effectively to protect that adult.
- Has not died but the SAB knows or suspects that adult has experienced serious abuse or neglect

The implementation of recommendations and action plans from a SAR must be reported in the Annual Report, including any decision not to implement any recommendation. One SAR was commissioned during 2015/6 and an overview is given on page 25.

This Annual Report of the Barking and Dagenham SAB looks back on the work undertaken by the SAB throughout 2015/16. and provides an account of the work of the SAB including successes, challenges and priorities for the coming year.

Over the past year partnership working, co-operation and involvement in adult safeguarding has been strengthened. Some of the successes include the re-launch of the iCare campaign, signing up to the Multi Agency Safeguarding Policies and Procedures, strengthening of the committees and their work programmes, undertaking of the first Safeguarding Adult Review under the Care Act an integrated approach to nursing and residential home inspection and the various joint learning events that have taken place across the partnership.

The Care Act identifies 6 key principles that should underpin all safeguarding work, These are accountability, empowerment, protection, prevention, proportionality and partnership. We will discuss the SAB's achievements, successes and challenges for the coming year in more detail in this annual report.

The Board and Committees 3

The Barking and Dagenham Safeguarding Adults Board is made up of the following statutory partners:

The Local Authority (representing senior adult social care management, Housing and Children's Services)
The Borough Police
The Clinical Commissioning Group (CCG)
And the Chairs of Sub Committees

In addition, the SAB Board may invite other organisations or individuals to attend and speak at their meetings where they have contributions to make.

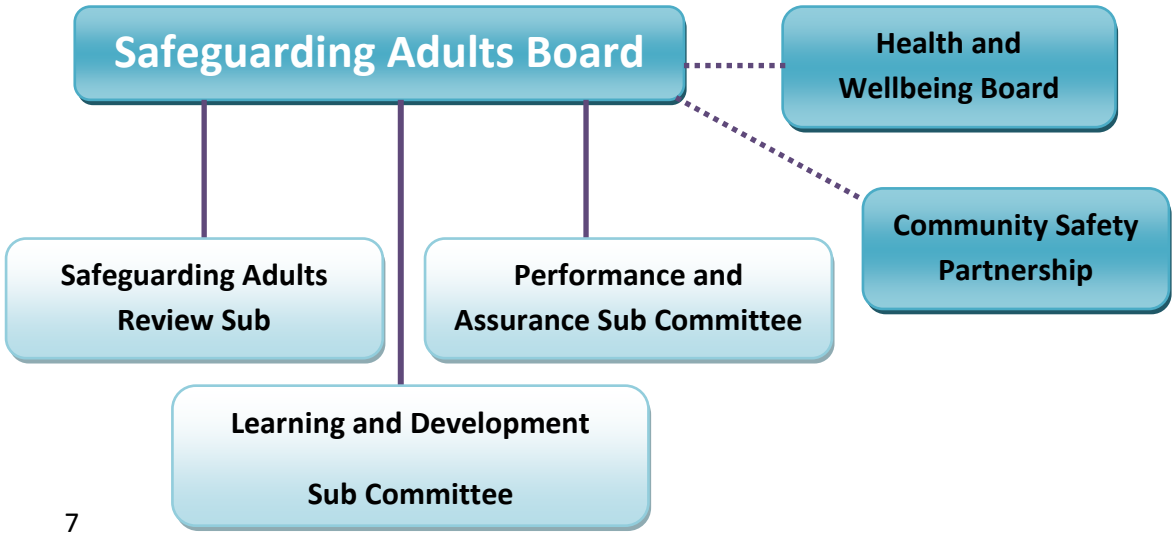
The SAB Executive has three standing groups, which are chaired by different organisations:

Safeguarding Adults Review Committee (chaired by Adult Social Care)
Learning and Development Committee (chaired by North East London Foundation Trust)
Performance and Assurance Committee (chaired by the Clinical Commissioning Group)

The Chair of each committee is responsible for:

- Developing a work programme which will be incorporated into and monitored through the SAB strategic plan
- Reporting on the progress of the group's work to the SAB
- Resourcing the meetings of the group
- Ensuring that the membership of the group draws in the required experience from relevant organisations and community groups or professionals.

Time limited Task and Finish Groups can also be established by the SAB to undertake specific pieces of work and report back to the Sub Committees or directly to the Board.



Safeguarding At A Glance 4

Accountability | Empowerment | Protection | Prevention | Proportionality | Partnership

Successes

- iCare Campaign
- Development of 5 year strategic plan
- Development of a SAB Communications Strategy
- Multi agency training events

1362 safeguarding concerns reported to LA

492 concerns progressed to an enquiry

87 safeguarding investigations

1 Safeguarding Adult Review

Learning

- Managing risks across agencies
- Joint working
- Prioritising high risk cases

Priorities for the coming year

- Implementation of 'Making Safeguarding Personal'
- Mental Capacity Act compliance
- Learning from SARs
- Joint safeguarding training opportunities

Accountability 5

Accountability and transparency in delivering safeguarding.

"I understand the role of everyone involved in my life and so do they."

Achievements and Successes

The Safeguarding Adults Board are ensuring that safeguarding is given due prominence in the Council's Ambition 2020 programme and are committed to making it everyone's responsibility across all organisations. Partners will continue to robustly apply safer recruitment policies, ensuring that safeguarding vulnerable adults is a requirement identified in contracts and commissioning. The CCG have provided appropriate challenge and regulation of commissioned services through Clinical Quality Review Meetings (CQRM), quality and surveillance visits. The Independent Chair of the Board reports to the Chief Executive of the Council and has regular meetings. The Cabinet Member for Social Care & Health Integration is a member of the SAB and the Independent Chair of the SAB regularly attend the Health and Wellbeing Board to ensure that safeguarding issues are considered.

BHRUT is committed to ensuring that all staff receive the correct level of training, in line with their roles and responsibilities, to ensure adults at risk receive the right care. At the end of March 92% of non-clinical staff had received training at Level 1 which is a 17% increase in the numbers trained in the previous year, whilst 83% had received level 2 training. To comply with the Prevent Duty, effective as of 1st July 2015, healthcare staff are expected to be able to recognise and refer people at risk of radicalisation. To date, 877 staff have received WRAP training and 586 Basic Prevent Awareness Training. An e-learning package for all non-clinical staff has been developed by the lead Prevent officer.

The Community Safety Partnership (CSP) continues it's work through the Protecting Vulnerable People (PVP) sub group. The Borough Commander is deputy chair to the CSP and is a member of the SAB and the Health and Wellbeing Board. The Metropolitan Police Service (MPS) have a Strategic Case Review Group (SCRG), whose responsibility it is to support safeguarding reviews and investigations. Outcomes are fed into organisational learning and training and allows the MPS to hold itself and partner agencies to account.

NELFT continues to revise policies and procedures in line with changes in legislation and local and national guidance to ensure all staff are aware of their roles and responsibilities in relation to safeguarding. The Safeguarding Adults Policy has been reviewed in line with the Care Act (2014) and Prevent, Domestic Abuse and DoLS procedures have been implemented. NELFT participates in annual self-assessments in relation to safeguarding to identify areas where improvement is required and to develop priorities. Over the last year there has been more effective partnership working between the Serious Incident, Safeguarding and Complaints team and HR to ensure that any concerns relating to delivery of care are appropriately investigated and that learning is shared to prevent similar incidents occurring in the future. A 'Lessons Learned' strategy has been developed to look at the variety of ways learning can take place.

Challenges

The Council will continue to focus on up-skilling staff in the Multi Agency Safeguarding Policies and Procedures. The SAB partnership will work to develop a joint training offer around safeguarding to maximise learning opportunities for partners and share experiences, and to ensure that this learning translates into practice and positive changes within service provision. Challenges for the CCG include ensuring that concerns from providers are communicated appropriately and in a timely way. The Police focus will be to ensure that Barking & Dagenham is prepared to meet the new Mayor of London's priorities for policing as well as local needs and priorities. We plan to work with partners and the Home Office to meet the requirements of the Prevent Duty. The Board faces challenges and financial constraints around funding to undertake Safeguarding Adult Reviews.

Priorities for the coming year

- Joint training opportunities.
- Learning from SARs.
- Embed learning to ensure positive changes within service provision.
- Focus on the Prevent agenda.

Empowerment 6

People being supported and encouraged to make their own decisions and informed consent.

"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

Achievements and Successes

All organisations have worked to foster a learning and listening environment so that service user views are used to inform strategy and operational development. The Safeguarding Adults Review (SAR) committee, ensures that service users' views are central to investigation processes. A SAR process has been developed and piloted to guide the process of commissioning a SAR.

The CCG have worked to ensure that safeguarding adults is embedded, with the development and addition of safeguarding standards within contracts. A proactive approach has been taken to safeguarding by conducting quality and assurance monitoring visits to commissioned services along with the collection of feedback, from people at risk of abuse. Work has been undertaken to develop a Nursing Home Strategy as well as the gathering of information to measure levels of risk and monitoring within an early warning system.

All organisations are committed to ensuring staff are aware of their legal responsibilities around consent, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs). The focus has been to strengthen the training opportunities available to staff which now includes empowerment, the person-centred approach and the national initiative of Making Safeguarding Personal. BHRUT have implemented an MCA & DoLS e-learning package to run alongside and bespoke MCA & DoLS practice seminars. The CQC provided positive feedback in the Inspection Report, June 2015 *"Consent, Mental Capacity Act 2005 and Deprivation of*

Liberty Safeguards were well understood by the majority of staff and part of a patients plan of care". BHRUT have developed a series of easy read information sheets to ensure people with learning disabilities who are accessing hospital services are prepared for their appointment, their possible stay in hospital and treatment. The Trust was a finalist at the National Patient Experience Awards in the Access to Information category for the development of the easy read information sheets.

The Metropolitan Police Service have now instigated the "Victim Right to Review" procedures. This means that all victims of adult safeguarding crimes along with their families and interested parties will be informed of a Police decision not to prosecute an individual, against whom an allegation has been made. This will allow victims the right to request a review into their investigation. The Victim's Code of Practice and Victim's Charter are both monitored and officers are held to account for compliance. The MPS remains committed to working in partnership to achieve the desired outcomes for individuals involved in safeguarding processes.

NELFT we are committed to involving patients and service users in all decisions regarding their care and treatment through the gaining of consent. Engagement with patients/service users about the outcomes they want is key. The Safeguarding Adults Team has introduced an audit which is in line with the principles of 'Making Safeguarding Personal'. The most recent findings show that in 100% of cases, consent is sought to raise a safeguarding alert. Raising awareness around domestic abuse, historical abuse and harmful practices amongst frontline staff also supports people to feel empowered to make decisions around safeguarding.

The National Probation Service (NPS) issues an Offender Survey twice yearly to gain offender's feedback on their views of the organisation. This feedback informs operational delivery plans and local commissioning arrangements. A policy has been developed to ensure exit interviews are taking place so that feedback and evaluation can be used to improve the services and support provided to offenders, victims and their families. Improvements are being made to the NPS case management system to more accurately record adult safeguarding concerns, so that services can be targeted and focussed based upon need and priority. National training has been developed and an e-learning module is available for all staff.

Challenges

All partners of the board have agreed Making Safeguarding Personal as a priority over the next year and will be focusing on developing robust intelligence around this to inform strategy development. Work has also been undertaken to ensure individuals who are purchasing their own care and employing personal assistants understand their own vulnerabilities and are able to safeguard themselves. The council provides an accreditation scheme for inclusion on its PA's list which can be accessed by people looking for PA's. BHRUT will be implementing an 'audit of consent' at the point of making a safeguarding referral, to capture the views of the individuals who have been involved in the safeguarding process. Challenging areas for the NPS include enabling and encouraging staff to improve the recording of safeguarding concerns so that this can be used to influence local resource decisions and training and development.

Priorities for the coming year

- Implementing the Making Safeguarding Personal agenda.
- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) training opportunities and support to apply this to practice.

Protection 7

Support and representation for those in greatest need.

"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."

Achievements and Successes

1,363 safeguarding concerns have been raised to the Safeguarding team at the Council with 492 moved to a safeguarding enquiry. The recommendations and agreement outlined in Winterbourne Concordat is now captured within the Transforming Care Programme. The Council and the CCG have taken joint responsibility in ensuring the principles and outcomes are delivered. These are to discharge patients out of hospital when they are fit to leave, develop solutions to prevent admissions into hospital and ensure that patients receive good quality treatment.

A common theme across all partners over the last year is quality assurance. The Council have recently invited providers to tender for the opportunity to deliver Home Care and Crisis Intervention services in the borough. The tender process was undertaken to develop an approved list of providers, from which packages of care could be allocated. In terms of quality assurance, prospective providers were scored on questions that mirrored the Care Quality Commission's homecare standards and covered areas such as treating people with respect, involving people in decisions about their care, treatment that meets people's needs, caring for people safely, protecting people from harm, staffing and quality and sustainability of management.

Throughout 2015/16 a small team of four Social Workers in the Council's Adult Social Care Business Service Unit have worked to complete all social care reviews for residents of care homes and nursing homes, as well as following up all safeguarding referrals and undertaking safeguarding enquiries for residents of care and nursing homes. The social workers in this team have been allocated to specific local care homes and have built up excellent working relationships with providers enabling reviews to be undertaken more easily. This has increased participation in safeguarding enquiries, improved the quality of care being provided and reducing the risk of harm to people living in local care homes.

The Council's Quality Assurance Policy sets out the overarching principles and key processes that enable the Council to ensure that services offered to residents are of the highest quality. Central to the provision of high quality services in social care is the requirement of all services to have in place clear and robust safeguarding procedures as set out by the London Multi Agency Adult Safeguarding Policies and Procedures[1], which the SAB has adopted. Protecting adults at risk is the business of everybody in Barking and Dagenham, including all organisations that work with adults at risk of abuse or neglect. Quality Assurance information is likely to be used in any Safeguarding investigations and information from these investigations will feed into future monitoring. The Councils Quality Assurance Team works closely with frontline social work teams, commissioning, health and other partner agencies to achieve the above.

The CCG has appointed a Designated Nurse – Adult Safeguarding to strengthen their commitment to adult safeguarding including MCA/DoLS and the Prevent Strategy. Effective review of provider policies and procedures relating to adult safeguarding and MCA/DoLS, has also been undertaken to provide assurance of effective, legal and robust responses to concerns. The CCG were recently assessed as having areas of good and outstanding practice following a safeguarding CQC "Deep Dive" inspection and areas of work were identified by the CQC as good practice. These will be shared with other commissioning services.

Within BHRUT a total number of 381 referrals were raised by Trust staff during 2015/16 which is consistent with the numbers referred in the previous year. Safeguarding referrals for self neglect have been received which demonstrates awareness amongst staff of the changes set out in the Care Act 2014. A further 52 referrals were received from external agencies raising concerns with regard to neglect whilst in our care. Where concerns are raised, an action plan is developed for the ward area involved. Further

[1] http://londonadass.org.uk/safeguarding/review-of-the-pan-london-policy-and-procedures

work to prevent and protect service users with learning disabilities from being admitted to hospital is the development of an “at risk” register to support people who require care and treatment in the community.

Within the Police a local ‘achieving best evidence suite’ is now fully operational allowing victims a safe and comfortable environment in which to speak confidentially and/or provide evidence to the Police. Police partnership working with local residential and nursing homes has recently led to successful investigations into incidents. Staff have been supported to make statements and attend court appearances. In addition front line Police Officers are now able to access Mental Health Triage staff and ‘Language Line’ facilities at the point of first contact with adults at risk. This enable’s effective evidence gathering at an earlier stage of the safeguarding process.

NELFT ensures that staff working within the organisation have access to the appropriate advice and guidance to enable them to raise safeguarding concerns and to keep the people at the centre of all decision making, including carers and relatives. Work has been undertaken to ensure that through training and awareness raising there is increased referrals to advocacy services including Independent Mental Capacity Advocates (IMCAS) and Independent Domestic Violence Advocates (IDVAS). Safeguarding enquiries increased in the last quarter of 2015 to 67 enquiries for Barking and Dagenham. Overall a total of approximately 600 safeguarding alerts were made by NELFT in 2015/16. Significant work has taken place around guidance for staff on identifying domestic abuse. Multi agency Risk Assessment Conference (MARAC) conferences across NELFT reported an increase of between 10-15% reporting of high risk cases of domestic violence. Ongoing analysis suggests that the increase is partly due to increased awareness.

Safeguarding Adults is included in the existing National Probation Service London Business Plan. A Safeguarding Adults ‘quick guide’ has been issued to all staff which reminds them of their responsibilities regarding safeguarding adults.

Challenges

The Council will work to develop consistent safeguarding practice across all partner agencies and ensure that MCAs/DoLs is embedded into contracts and the new advocacy pathway is rolled out. The CCG faces challenges around ensuring that users of domiciliary care and personal assistants have access to the information and knowledge to keep themselves safe, as well as the collation of information and intelligence regarding providers. BHRUT have developed an Adult Safeguarding Trigger Checklist to

enhance the safeguarding procedures within the Emergency Department, and this will be reviewed to ensure it meet requirements. The National Probation Service are currently reviewing job descriptions and staff induction processes to ensure that they specifically include a responsibility towards adult safeguarding.

Priorities for the coming year

- Quality Assurance processes embedded.
- MCAs/DoLs embedded into contracts.
- New advocacy pathway implemented.
- Information for people employing PAs and carers.

Prevention 8

It is better to take action before harm occurs.

"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

Achievements and Successes

The Council and partners, along with support from the Learning and Development committee, has undertaken an iCare publicity campaign which includes leaflets, posters and a online presence. It is hoped that this will raise the profile of safeguarding, helping people to recognise potential safeguarding issues in the community and increase understanding of how to report these.

An action plan has been developed and agreed in response to the publishing of the London Multi Agency Adults Safeguarding Policies and Procedures. Safeguarding Adults Review committee leads on undertaking Safeguarding Adult Reviews and implementing learning and changes as a result of the findings. The Care Act 2014 states that a local authority must provide or arrange for services, facilities or resources to prevent, delay or reduce individuals' needs for care and support, or the needs for support of carers. As a result a local prevention framework has been developed and this promotes a strengths-based approach to assessing

needs and supporting people. The three guiding principles of the prevention framework are that it is only effective when individuals, communities and public services work together.

The CCG have been leading on the Transforming Care Programme (TCP), reviewing community resources to support effective transition from out-patient to community. Regular reports are provided to the Governing Body on high risk safeguarding and quality concerns within the local health economy.

BHRUT has been working alongside Victim Support to progress the Domestic Violence agenda. The provision of an Independent Domestic Violence Advisor has been secured through Victim Support and their role is to support both staff and victims dealing with domestic violence. An e-learning training module has also been developed.

Improved Police Officer awareness around safeguarding has led to a 28% increase in 'adults coming to notice' reports compared to the previous year. These can be raised when there are concerns that a person may have care and support needs and may be at risk of abuse or neglect. Front line reporting and investigating Police Officers have undertaken MAST (Mental Health Awareness and Safeguarding Training). This focused on the effect of Mental Health and ill health of young adults and in particular 'gang' behaviour.

NELFT staff have continued to undertake training to strengthen their understanding of their roles responsibilities in relation to safeguarding. Safeguarding training has been extended to cover domestic abuse and harmful practices. Following the Counter Terrorism and Security Bill (2015) Prevent training also became mandatory for all NELFT staff in July 2015. Following a merger of the safeguarding adults and children's team at NELFT there is a daily duty desk where frontline staff can directly access advice and guidance in relation to safeguarding concerns. This has further embedded the 'think family' approach and this early access to advice and interventions can prevent safeguarding concerns escalating. Staff are supported and encouraged to recognise where potential abuse may be taking place and service users are invited to voice any concerns or fears they may have, particularly in relation to the care they are receiving.

The National Probation Service work directly with offenders and the organisational focus is upon protection of the public and reducing the risk of further offending. In the past year there has been evidence of increased number of safeguarding referrals. This is linked to the delivery of mandatory safeguarding training for all staff, as well as identified local Safeguarding Adult 'champions'

who attend relevant multi agency meetings and support front line colleagues to identify safeguarding concerns. 'Making Safeguarding Personal' has been incorporated into training events, as well as work around modern slavery. The National Probation Service engage with Multi Agency Public Protection Arrangements (MAPPA), Multi Agency Risk Assessment Conference (MARAC) and offender management to support the prevention of abuse and neglect.

Challenges

The CCG will continue to ensure that lessons learnt through Serious Incident reporting processes are shared, in order to reduce and manage safeguarding risks. NELFT have identified the further embedding of the Mental Capacity Act and Deprivation of Liberty Safeguards as a priority for the coming year. The challenge remains around transferring knowledge around the Mental Capacity Act (2005) into practice. The Council aims to raise community awareness around safeguarding. The iCare campaign will be evaluated and reviewed. A communications protocol has been developed and will be reviewed in the coming year. In addition the council is completing inspections of residential and nursing homes in conjunction with its CCG partners. The NPS are planning to undertake a review of local information sharing practice to ensure that decisions regarding the management of an offender fully incorporate a multi agency approach. This will assist in prioritising preventative measures that can be considered and implemented to ensure the ongoing safeguarding of the public and offenders.

Priorities for the coming year

- Further embedding of MCAs/DoLs into practice.
- Increasing community awareness and confidence and how to report safeguarding concerns.

Proportionality 9

Proportionate and least intrusive response appropriate to the risk presented.

"I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."

Achievements and Successes

The partnership is committed to ensuring that commissioners and service providers have safeguarding processes and practices in place that are proportionate to the circumstances and situation of each individual. Work has been undertaken by the Council to ensure that providers progress safeguarding and serious incidents, through contract monitoring and quality assurance processes. The Board has led on learning from Safeguarding Adult Reviews and this along with training is shared with providers where relevant.

The CCG have undertaken appropriate challenge of providers through reporting and analysis of safeguarding concerns and have supported them to improve in terms of quality and outcomes for users of services. The CCG have also developed processes for the early identification of emerging risks through an effective partnership approach to safeguarding concerns. A focus this year has been the work undertaken to improve the understanding of Deprivation of Liberty Safeguards (DoLS) and this has been shown through the rise in the number of DoLS authorisations raised in 2015/16.

The Police have implemented training to ensure that officers seek the views of vulnerable adults' involved in safeguarding process. This helps to manage risks around safeguarding and supports people to recognise when safeguarding issues arise.

NELFT staff work alongside patients, service users and their families to ensure that any interventions are proportionate to the level of risk. This is undertaken effectively through a multidisciplinary approach and through seeking specialist advice where appropriate. An identified success is the increase in appropriate application of the Deprivation of Liberty Safeguards (DoLS). There has been a significant increase in the number of authorised applications in community inpatient settings which indicates the impact of training, visibility of specialist safeguarding and the role of the dedicated DoLS administrator.

The National Probation Service has statutory responsibility to work with offenders. Delivery of interventions and protective measures are considered on a case by case basis to ensure proportionality. Learning from Domestic Homicide Reviews, serious case reviews, safeguarding adult reviews and other management reviews are shared. Multi agency forums such as MAPPA, MARAC and MASH are central for NPS to ensure proportionality and appropriate utilisation of resources across the cluster.

Challenges

Over the coming year the Board will focus on embedding Making Safeguarding Personal into all safeguarding processes with the aim of ensuring that the individual's wishes and best interests are central to the safeguarding process. There are challenges around ensuring consistency across providers in response to safeguarding concerns. There will also be a focus on effective collection and analysis of data that can used by the Board to ensure areas for improvement are acted upon and areas of good practice are identified. BHRUT will focus on the development and use of advocacy services to support patients. The Police are required to ensure proportionality with regard to their involvement against taking an action which is in the greater public interest. There is a need to gain trust of victims throughout the criminal justice process particularly when cases need to be taken to court. Challenges for the National Probation Service include enabling and encouraging staff to improve recording of safeguarding concerns. This will support the collection of more reliable performance information that can be used in influence decisions about local resources, service provisions and training.

Priorities for the coming year

- Development of effective performance information for the Board.
- Embedding of Making Safeguarding Personal.

Partnership 10

Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."

Achievements and Successes

The Safeguarding Adult Board is Care Act compliant and board processes are in place. All partners continue to work effectively on the safeguarding adults agenda and make linkages with the Local Safeguarding Children's Board, the Community Safety Partnership Board and the Health and Wellbeing Board.

The CCG continues to support the development of a Transforming Care Pathway Board and has been successful in listening to user feedback and implementing a system-wide approach to effective transition. The CCG also have in place effective integrated work-streams between internal child-protection and adult safeguarding functions.

The BHRUT Named Nurse for Safeguarding Adults works collaboratively with the borough Safeguarding Teams and the Trust's Joint Assessment Team to ensure that safeguarding concerns have been addressed and responded to appropriately. Members of external agencies from both the public and voluntary sector have been invited to attend the Safeguarding Adult and Learning Disability Champions Workshops. This has provided an opportunity to raise awareness amongst staff of the services available in the local community.

Barking & Dagenham Police have a unique working relationship with partnerships agencies through the dedicated Safeguarding Adults at Risk Investigator. Information is shared to assist in safeguarding processes and other joined up working includes conducting visits with mental health workers and social workers in order to support good communication and evidence gathering.

NELFT continues to embrace and engage in partnership working in order to ensure the effective safeguarding of not only patient and service users but the wider community. NELFT hosted a self neglect conference, which looked at the learning from a Safeguarding Adult Review and focussed on strengthening effective partnership working. The Prevent Lead and the Prevent Engagement Officers have worked together to implement training for the Safeguarding Team.

The Police continue to share the findings from Serious Further Offences, MAPPA Serious Case Reviews and other internal audits, where appropriate, with partners to strengthen learning.

Challenges

There is a need to ensure that the SAB is funded by partners to carry out its statutory duties. Cost analysis of future safeguarding adult reviews will be undertaken to ensure that the funding agreements that are in place meet future requirements for the SAB. Challenges for the CCG includes continued support to the Performance and Assurance committee and the Transforming Care Pathway Board. The Police will be implementing a new IT system in 2018 and the challenge will be to ensure any updated requirements are identified early and incorporated into future models as safeguarding develops. The Probation Service are aiming to improve the tracking of safeguarding referrals in order to monitor outcomes of offenders and provide protection to victims.

Priorities for the coming year

- Ensuring funding for the SAB's statutory duties.
- Continued partnership working to achieve the SAB's priorities.

Safeguarding Adult Reviews 11

Safeguarding Adult Review - RC

During 2015/16 the Safeguarding Adults Board undertook one Safeguarding Adult Review. An independent reviewer prepared a report based on information provided from Barking, Havering and Redbridge University Trust (BHRUT), Clinical Commissioning Group (CCG) (particularly the GP service), London Borough of Barking and Dagenham (LBBD) Commissioning Services, the Adult Social Care team, the service provider and the Speech and Language Therapy Service (SALT).

RC was a 61 year old man who was born in Dagenham. RC was supported by staff every day with his personal care, medication, meals and drinks. He had a number of health related difficulties which required consistent health and social care support, the most significant to his daily living and safety was the risk of choking when eating food, this is known as dysphagia. On 30 May 2015 RC choked on some food, an ambulance was called and he was taken to hospital. Despite extensive efforts to save him the decision was taken on 4 June 2015 to end the life sustaining medical interventions and RC died.

The scope of the SAR, set by the Safeguarding Adult Review Sub Group, was to consider:

- The extent to which the assessment of RC's health and social care needs was comprehensive and of sufficient depth
- The extent to which any specialist assessments were of sufficient depth, and contributed to the overall assessment
- Whether the assessments had been reviewed and updated in a timely fashion
- Whether assessments and reviews had considered issues of capacity, in any areas of RC's life, and whether the steps taken as a result of any judgements were sufficient
- The extent to which the care plan in place at the time of RC's death reflected the outcomes of assessments about RC's health and social care needs
- The extent to which the services commissioned by the local authority, provided by the Service Provider 1, were sufficient to meet RC's assessed needs

- Whether the transfer of provider in 2015 had ensured continuity of care for RC
- The extent to which any services delivered by the CLDT, whether by local authority staff, or NELFT staff, were sufficient to comprehensively assess RC's needs, and arrange and oversee appropriate care and treatment
- The extent to which particularly Primary Care and the Acute Trust, was able to meet RC's needs for care and treatment in the context of his disability.

As a result of the review a number of learning and development points were presented to the Safeguarding Adults Reviews sub group and the Safeguarding Adults Board in December 2015 and an action plan to address the above learning points was agreed by both Safeguarding Adults Review sub group and the SAB itself.

The full Safeguarding Adult review Report and the Executive Summary can be found at this link
http://careandsupport.lbbd.gov.uk/kb5/barkingdagenham/asch/advice.page?id=cGthvG2UuNE

Learning and Development 12

The Safeguarding Adults Board itself and colleagues from partner organisations have led and taken part in a number of learning and development opportunities over the last year.

Following a management review a hoarding learning event took place in March 2016. Around 50 people attended the event including colleagues from health, the Fire Service, Environmental Health officers, Housing officers, the Police and the Council. There were presentations from the independent reviewer on the case and also a representative from Hoarding UK. Attendees took part in workshops and used hoarding risk and audit tools to increase their knowledge and understanding of the issues facing hoarders. Positive feedback was received and actions were developed as a result of discussions.

A programme of multi agency training has been undertaken covering aspects of the Care Act and the Multi Agency Safeguarding Policies and Procedure in advance of their official launch on 1st April 2016. PREVENT training has also taken place and been offered across the SAB partnership.

A joint adults and children's safeguarding practitioners forum took place at which the fire service led some training around fire safety, managing fire risks and safeguarding.

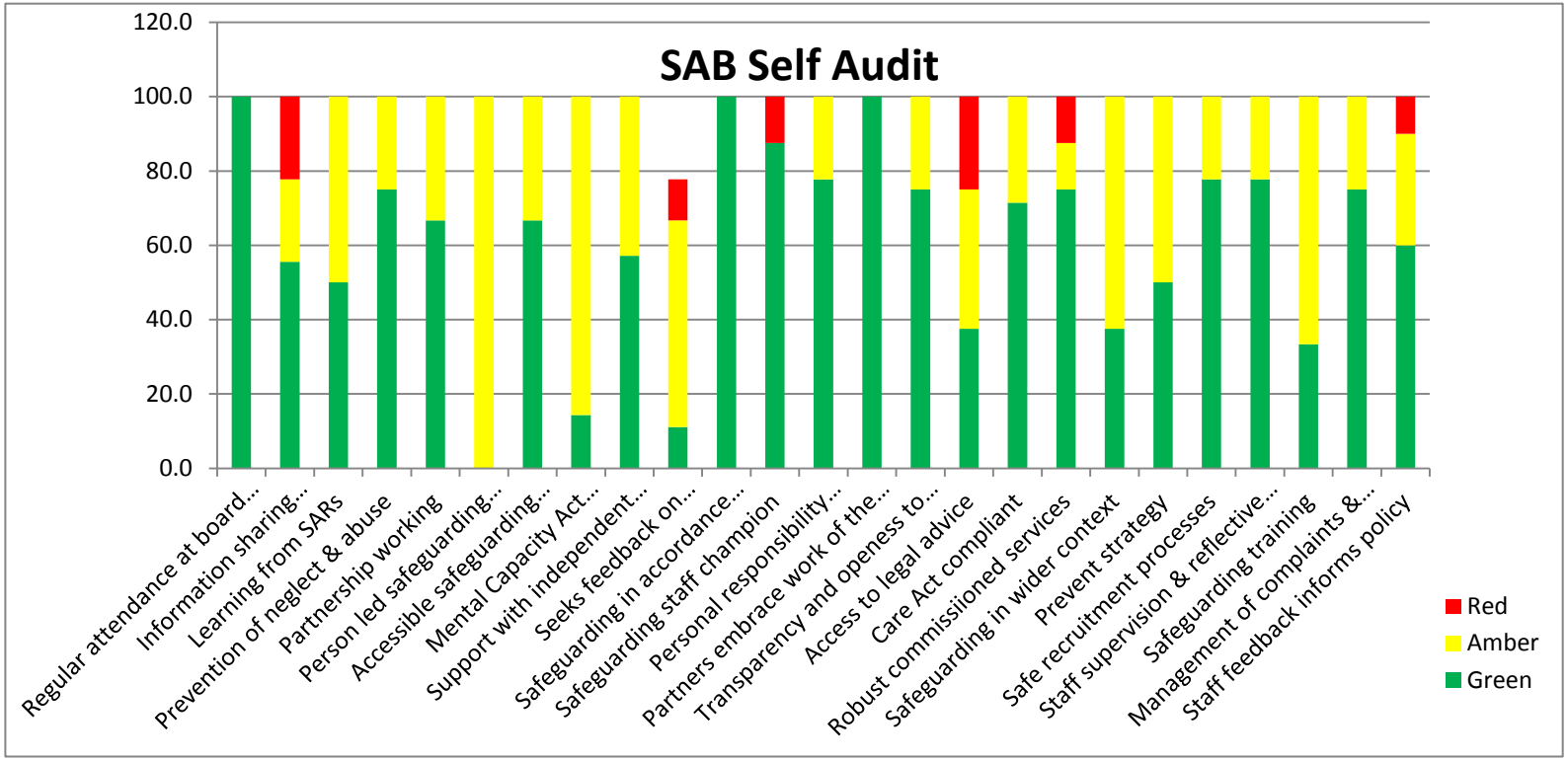
Working with Healthwatch 13

Healthwatch, Barking and Dagenham have worked in partnership with the Adult Safeguarding Board throughout the year and are a member of the Performance and Assurance Committee. The particular role of Healthwatch is to be the voice of patients and service users of Health and Social Care. Healthwatch fully support the Board's priorities around Making Safeguarding Personal and believe that people who are making the difficult journey through the safeguarding process should be empowered to make decisions and achieve outcomes that are important to them. Healthwatch is committed to ensuring that service users' views are central to improvements made to the safeguarding process, and are committed to working in partnership with the Board ensure this continues to happen.

Priorities for 2016/17 14

Safeguarding Adult Board Self Audit

As part of the Safeguarding Adults Board away day the Board participated in a self audit. The self audit looked at a number of areas as set out below and partners were required to 'score' themselves as red, amber or green. The results are set out below and these have been used by the board to develop priorities for 2016/17.



Safeguarding Adult Board Priorities for 2016/17

The Safeguarding Adult Board priorities for 2016/17 are set out below. These will be incorporated into the SAB's 3 year strategic plan and sub group work plans.

- **Joint training opportunities.**
- **Learning from SARs.**
- **Embed learning to ensure positive changes within service provision.**
- **Focus on the Prevent agenda.**
- **Implement the making Safeguarding Personal agenda.**
- **Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) training opportunities and support to apply this to practice.**
- **Quality Assurance processes embedded.**
- **MCAs/DoLs embedded into contracts.**
- **New advocacy pathway implemented.**
- **Information for people employing PAs and carers.**
- **Further embedding of MCAs/DoLs into practice.**
- **Increasing community awareness and confidence and how to report safeguarding concerns.**
- **Development of effective performance information for the Board.**
- **Embedding of Making Safeguarding Personal.**
- **Ensuring funding for the SAB's statutory duties.**
- **Continued partnership working to achieve the SAB's priorities.**

Further Information About Safeguarding 15

For further information about safeguarding and information about the Safeguarding Adults Board please use the following link

https://www.lbbd.gov.uk/residents/health-and-social-care/adults-care-and-support/safeguarding-adults/safeguarding-adults-overview/

To report a safeguarding concern:

Adult Social Care Intake and Access Team
020 8227 2915
intaketeam@lbbd.gov.uk

Out of Hours Emergency Social Work Duty Team
020 8594 8356
intaketeam@lbbd.gov.uk

In an emergency:

Call 999 and ask for the Police

Call 101 if you are worried but it is not an emergency.

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APPENDIX B

Barking & Dagenham Safeguarding Children Board

BDSCB Annual Report 2015/16

Contents

Message from the Independent Chair

I am pleased to present to you the Barking & Dagenham Safeguarding Children Board Annual Report for 2015-16. The report is a retrospective look at the work of the BDSCB.

The BDSCB is responsible for coordinating local agencies in safeguarding children and has a responsibility for closely scrutinising the safeguarding work undertaken with children in Barking & Dagenham in order to identify areas for improvement. The report outlines the progress that has been made in relation to the objectives that we set for ourselves in 2015-16; highlights key achievements and challenges that the Board has faced and it also sets the scene for the work that we will do during 2016-17.

There have been changes in personnel, locally within Health, Police and the Council and significant changes in the delivery of Probation services nationally and locally. Continued budget pressures for all agencies have challenged partners' priorities and it is the Board's task to ensure that safeguarding remains a priority locally. The aim to 'deliver more for less' and make best use of contributions from partner agencies continues to be a challenge. As a Board we recognise that keeping children safe requires a culture, across all agencies, where staff are open to challenge and new ideas.

I am a member of the London Group of Local Children's Safeguarding Board Chairs. As a group of chairs we are disappointed that the Metropolitan Police continues to choose to fund partnership safeguarding in London 45% less than all the other large urban Metropolitan Police Forces in England. Safeguarding is a complicated and demanding partnership arrangement that needs appropriate resourcing if it is to be effective. If LSCB's are to be able to carry out their statutory duties they need proper support.

The guidelines we adhere to (Working Together 2015) makes it clear that funding arrangements for safeguarding should not fall disproportionately and unfairly on one or more partners. In London this burden does fall unfairly upon Local Authorities because the Metropolitan Police does not provide rational or reasonable levels of funding to LSCB's.

The safeguarding structures are due to change soon and when they do there will still be a need to resource whatever arrangements are put in place. The Police are a key partner in the future arrangements for safeguarding and we ask that the Metropolitan Police and the Mayor's Office for Police & Crime increase their funding to a level which is fair to the other partners and which will assist in keeping London's children safe.

We re-looked at how the agenda for the Board was structured and introduced a 'themed 'session at each Board, where we were able to focus on specific areas of safeguarding work. The areas that we have considered during the themed sessions have been: Finance & Business Planning; Child Death Overview Panel; Faith and Culture; Young People's Takeover Day; and the Voice of the Child.

In December 2015, the Government asked Alan Wood to undertake a review of LSCBs, SCRs and CDOPs. The review was submitted in March 2016 and the Government responded in May 2016 accepting the recommendations of the review. I will be working with partners to embed the changes once they are agreed through Parliament in 2017.

I am privileged to work with partners who share my commitment in ensuring that children and young people are safer as a result of our collective actions and are open and willing to analyse their performance to ensure it improves outcomes for children and young people.

To conclude, I would like to thank members of the Board, and all the frontline practitioners and managers for their commitment, hard work and effort in keeping children and young people safe in Barking & Dagenham.


Sarah Baker, LSCB Independent Chair

WHAT IS THE BDSCB?

The BDSCB is the key statutory body overseeing multi-agency child safeguarding arrangements across the London Borough of Barking & Dagenham

Governed by the statutory guidance in Working Together to Safeguard Children 2015 and the Local Safeguarding Children Board (LSCB) Regulations 2006, the BDSCB comprises senior leaders from a range of different organisations.

The Board has two basic objectives set out in the Children Act 2004:

- to co-ordinate the safeguarding work of agencies and
- to ensure that this work is effective.

The Independent Chair

The Independent Chair of the BDSCB is Sarah Baker who is supported by a Board Manager. The Chair is tasked with ensuring the Board fulfils its statutory objectives and functions. Key to this is a culture of transparency, challenge and improvement across all partners with regards to their safeguarding arrangements.

The Chair is accountable to the Chief Executive of the London Borough of Barking & Dagenham and the Director of Children's Services.

Whilst unable to direct organisations, the BDSCB does have the power to influence and hold agencies to account for their role in safeguarding the welfare of children and young people.

PARTNER AGENCIES

All partner agencies across Barking & Dagenham are committed to ensuring the effective operation of BDSCB. This is supported by a signed Compact by each

partner agency that set out their agreement to the fundamental principles of the BDSCB. Members of the Board hold a strategic role within their organisations and are able to speak with authority, commit to matters of policy and hold their organisation to account.

RELATIONSHIP WITH OTHER BOARDS

There is a clear expectation that LSCBs are influential in the strategic arrangements that impact upon and improve performance in the care and protection of children. There is also a clear expectation that this is achieved

through robust arrangements with key strategic bodies across the partnership. During 2015/16, engagement continued with the Children's Trust Board, Safeguarding Adults Board (SAB), the Health and Wellbeing Board and Community Safety Partnership.

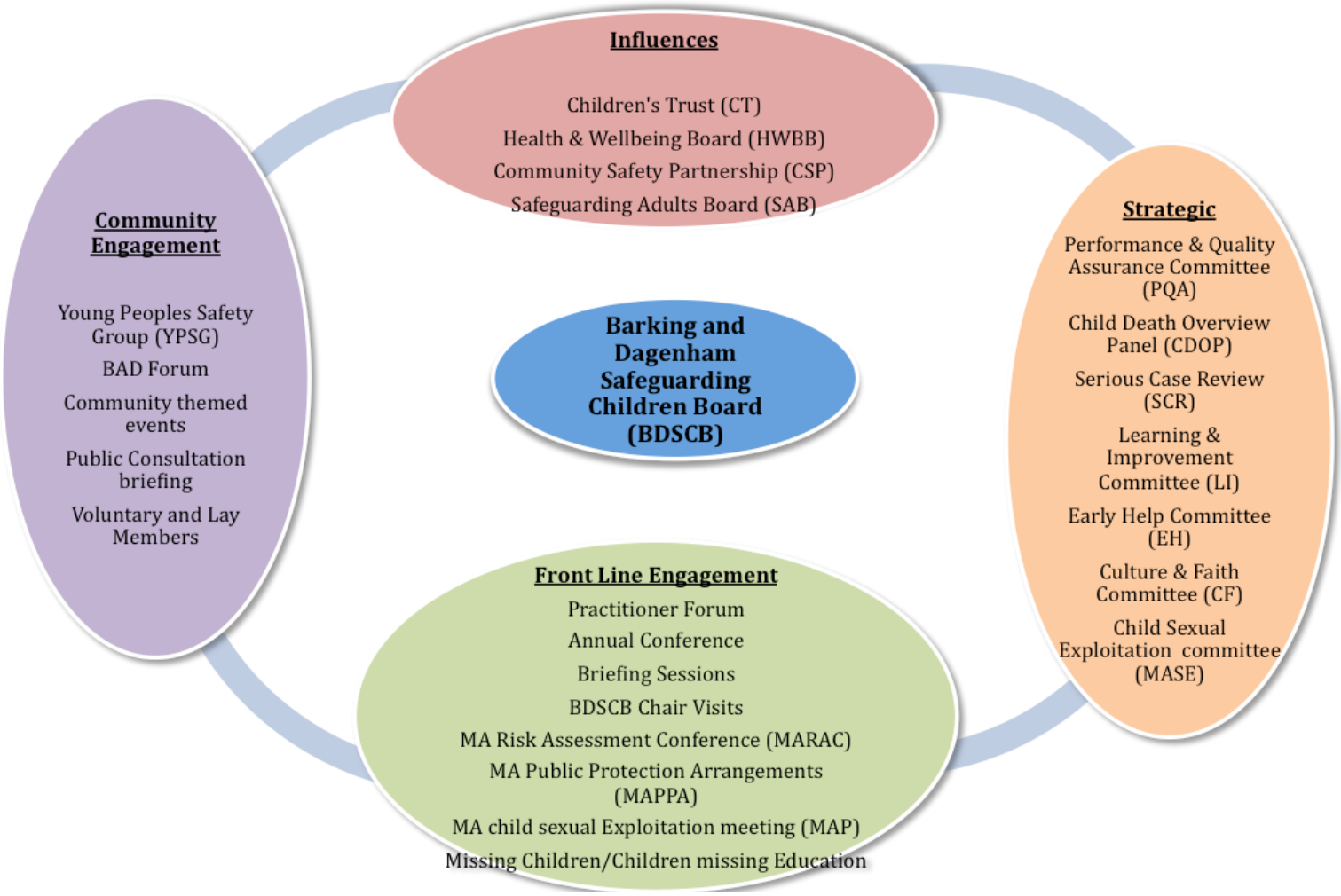
BOARD MEMBERSHIP & ATTENDANCE

The Board met six times, during the 2015/16 and had a membership made up of representatives from all statutory partners and others concerned with safeguarding children. The attendance rates by agency for 2015/16 to the full Board meetings are set out below:

Membership

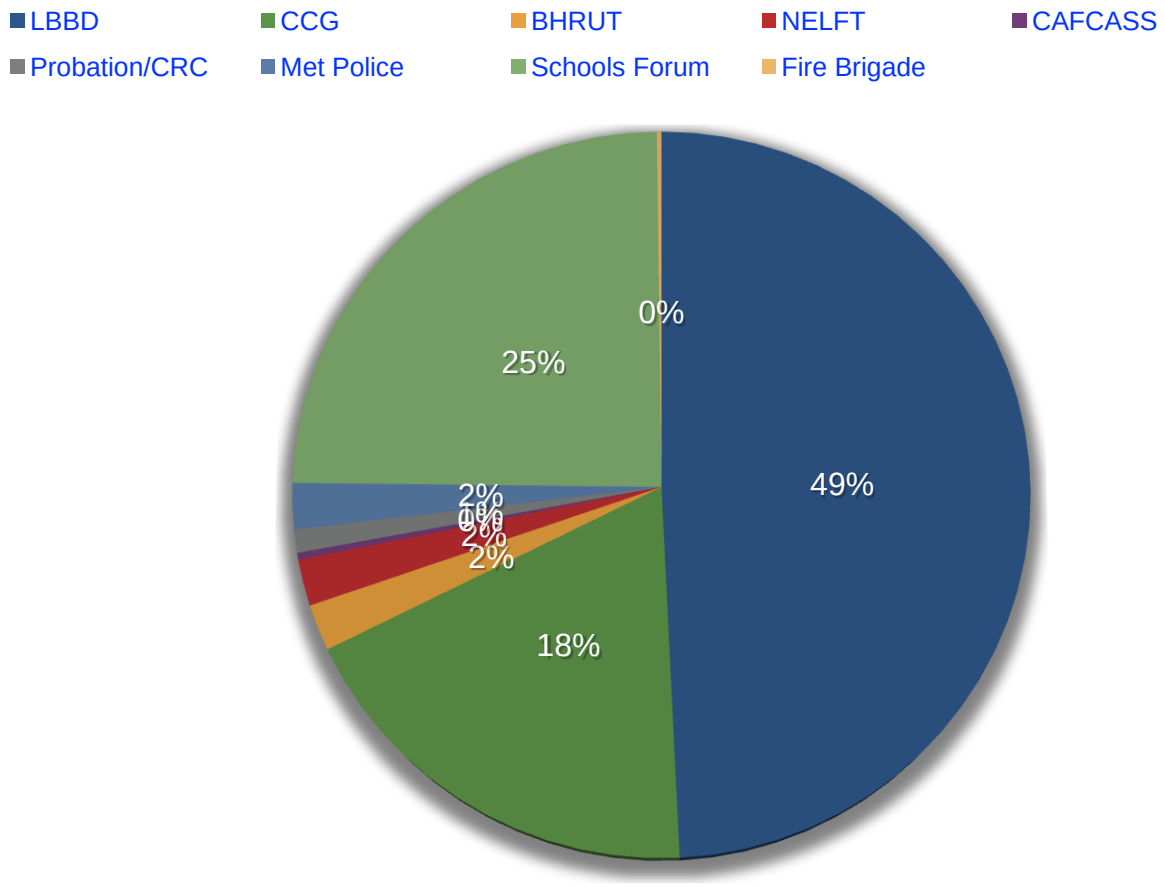
Name	No of seats	% of attendance
Independent Chair	1	100
LBBD Chief Executive	1	17
Lead Member	1	83
Children's Services	6	100
Adult Services	1	100
Housing	1	33
Legal	1	50
Public Health	1	83
NHS England	1	0
CCG	4	83
BHRUT	1	100
NELFT	1	83
Primary schools	2	50
Secondary schools	2	50
Further Education	1	67
Police	2	100
Probation - CRC	1	100
Probation NPS	1	33
Voluntary Sector	1	50
Faith Sector	1	50
CAFCASS	1	33
Fire Service	1	33
LAS	1	100

Structure

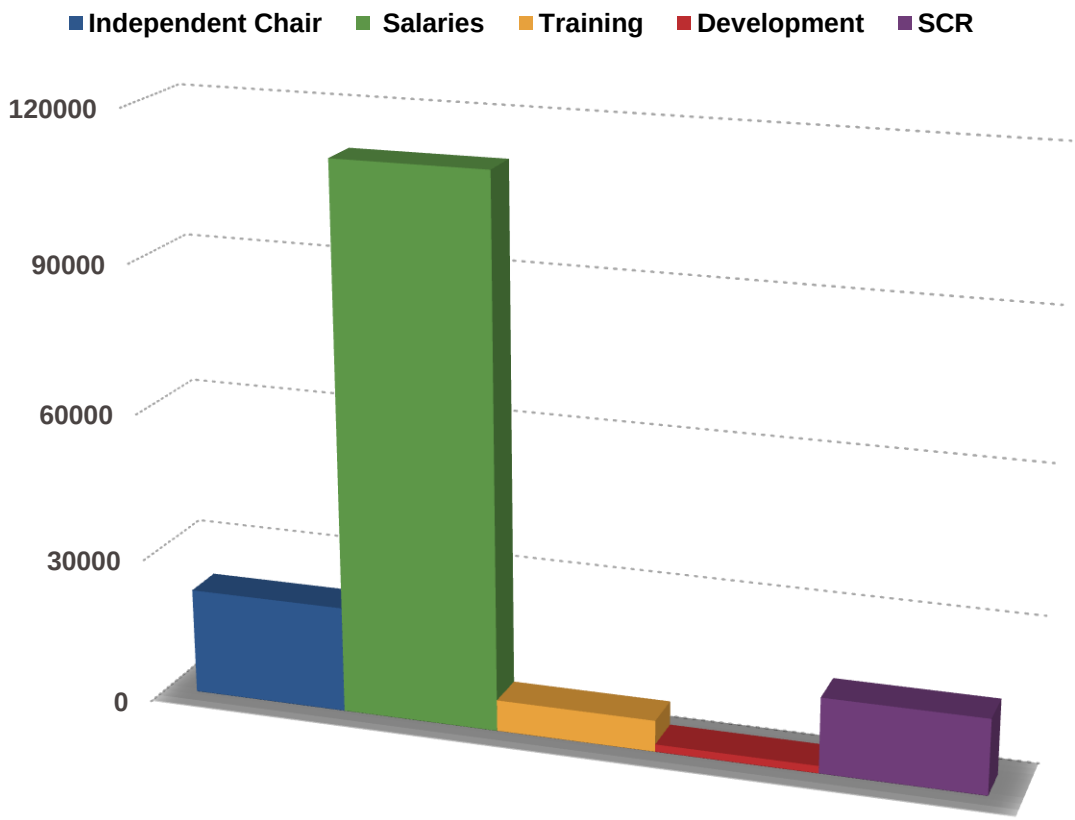

Influences
Children's Trust (CT)
Health & Wellbeing Board (HWBB)
Community Safety Partnership (CSP)
Safeguarding Adults Board (SAB)
Community Engagement
Young Peoples Safety Group (YPSG)
BAD Forum
Community themed events
Public Consultation briefing
Voluntary and Lay Members
Barking and Dagenham Safeguarding Children Board (BDSCB)
Strategic
Performance & Quality Assurance Committee (PQA)
Child Death Overview Panel (CDOP)
Serious Case Review (SCR)
Learning & Improvement Committee (LI)
Early Help Committee (EH)
Culture & Faith Committee (CF)
Child Sexual Exploitation committee (MASE)
Front Line Engagement
Practitioner Forum
Annual Conference
Briefing Sessions
BDSCB Chair Visits
MA Risk Assessment Conference (MARAC)
MA Public Protection Arrangements (MAPPA)
MA child sexual Exploitation meeting (MAP)
Missing Children/Children missing Education

Financial Arrangements

Partner agencies continued to contribute to the BDSCB's budget for 2015/16. Contributions totaled £206,737, with Barking & Dagenham Council contributing 49% of the total agency funding in addition to staff time and venues for meetings. Charges for non attendance at training events provided an additional income of £5,500.



There was increased expenditure of £15,460 arising from Serious Case Review costs. An under spend of £44,770 was carried forward from the previous financial year making the total income available to the Board of £251,507. This income ensured that the overall cost of running the BDSCB was met.



What our Lay Member says

“

As the Lay Member role within the Board continues to embed and develop, I have enjoyed my role and felt a deeper understanding of its expectations. I have continued to work with vulnerable groups within the Borough, promoting the work of the Board. I have delivered a powerpoint presentation plus a CSE video resource to 30 parent carers on CSE, and the Prevent agenda and on the work of the LSCB.

I have also presented to the parent carer group information on FGM and facilitated a discussion about this difficult topic. It was good to be part of such an open debate and promotion of safeguarding children and young people from harmful practices.

I had the pleasure of attending the Borough’s 50th Anniversary Event and took the opportunity to network on behalf of the BDSCB, handing out information to local people. Many of the local people I met had not realised an LSCB existed and knew little of its work. Providing information was a great way to promote the BDSCB’s work into the community.

I have set up a link for Young Carers with the new Youth Zone and some of those young carers have been involved in the branding process and have taken pivotal roles in steering this fantastic resource for young people. In addition I worked with colleagues to set up training for Young Carer’s staff, CSE and Prevent training was delivered by the Metropolitan Police. As a result of this training the ‘Young Carers of B&D’ added the link to CEOP to their website providing access to safe and secure information.

Young Carers also benefitted from ‘Sexting & Cyber Bullying’ training and information on ‘Project Violet’. I have also raised awareness on the important subject of Private Fostering with staff working with vulnerable families and the process for reporting.

It was good to see some of our young people being in charge of an LSCB meeting and contributing to the formation of the agenda and taking on lead roles in the meeting itself. Everyone was reminded about ensuring we capture the views of young people about keeping safe.

I have been able to ask questions and add my thoughts to a Serious Case Review and take forward some of the learning.

I look forward to the coming year with the increasing challenges and my continuation as BDSCB Lay Member.

Local Context - what life is like for a child in Barking & Dagenham

Barking & Dagenham is located in the East of London and has a population of 207,292, of which 61,793 are under 18. The child population in Barking & Dagenham is increasing by around 2-3% each year. The borough has a predominantly white British population, with 49% of the residents from a non white ethnic group. Black Africans are the largest minority ethnic group at 17% of the overall population.

White British school aged children make up 26% of the population and 13% are White Other, predominantly Eastern European groups. The remaining 61% are from other minority ethnic groups with Black African making up the biggest group at over 23%.

Barking & Dagenham has 44 primary schools, 10 secondary schools, 2 special schools and 1 pupil referral unit. 5.7% of Barking & Dagenham's16 to 18 year old cohort were not in Education, Employment or Training (NEET), compared to London (3.4%) and England (4.7%) averages.

Barking & Dagenham is a borough with high areas of deprivation and poverty and these factors alongside domestic violence impact significantly on social care. Barking & Dagenham has the 6th highest level of child poverty in England and across London is ranked 4th 'worst' for children aged under 16 and 6th 'worst' for children aged under 18. Domestic violence and abuse continues to be a significant issue in Barking & Dagenham. During 2015/16 there were 2,568 offences which represent an increase of 5.4%. Barking & Dagenham recorded the highest rate of domestic abuse offences across London in 2015/16 - 27.2 recorded incidents per 1,000 population.

The average property in Barking & Dagenham costs around £310,000 which is over 12 times the average household income of £25,499. This makes home ownership unaffordable for many residents. The majority of households presenting as homeless will live in private rented accommodation.

Market rents have been rising much faster than household incomes, particularly for those families on benefits. Private rents have increased by 25% over the last two years, outstripping both inflation and Local Housing Allowance rates. This has led to difficulties for low income households accessing or sustaining affordable tenancies in the private rented sector and consequently significantly increased the number of households presenting as homeless.

There is only a 3% turnover in council housing every year, which severely limits the amount of council housing available to re-house homeless households.

The largest single factor for households becoming homeless is loss of private rented sector tenancy. The second largest factor is parental/household 'ejection'. Overcrowding and non-violent relationship breakdown were the most significant causes followed by violent breakdown which is usually associated with domestic violence, anti social behaviour or gun crime.

Safeguarding 'Snapshot' 2015/16

- 61,793 Total Number of children (0-18) in the Borough
- 30% of total population
- 2,064 children & young people open to children's social care
- 1,189 Child in Need cases
- 130 children identified as being at risk of CSE
- 41 incidents of children & young people missing from care
- 18% of children in receipt of free school meals
- 90 incidents of missing from home
- 11,393 contacts into MASH - a 34% increase
- 3,255 referrals (29%) - a decrease of 20%
- 16.6% re-referrals within 12 months of a previous referral
- 2,530 statutory social work assessments completed - reduction of 14%
- 1,184 child protection investigations
- 325 Initial Child Protection Conferences

- 253 Child Protection Plans decreased from 353 in 14/15
- Increase in CP medicals from 113 (2014/15) to 196 (2015/16)
- 457 Looked After Children
- 176 Care Leavers aged over 18
- 5393 Domestic Abuse Notifications in the year
- 185 Allegations against staff working with children & young people
- 45 Private Fostering Notifications

Effectiveness of Safeguarding Arrangements in Barking & Dagenham

In 2015/16, alongside population growth and in the context of a high population of children and young people aged between 0-17 years, there has been a decline in safeguarding and looked after children numbers.

The activity and performance information for the financial year 2015/16 demonstrates a reduction in numbers, although the number of contacts made from partner agencies increased. There has been a fall in the number of social care referrals, the total number of statutory cases, the number of assessments completed, the number of child protection plans and looked after children.

The MASH

The Multi Agency Safeguarding Hub (MASH) acts as a single point of contact for referrals to both Early Help Services and Children's Social Care (CSC). The MASH screens activities and ensures all contacts are progressed as a referral if the threshold for a statutory social work assessment is met.

In 2015/16 the number of contacts increased to 11422 which was a real time increase of 34%. The increase was in part due to a rise in the number of Police Merlins. However, there was a 21% decrease in referrals at year end, 3222 compared to 4084 in 2014/15. The monthly average was 269 during the year as compared to 340 average during 2014/15. Following contact the MASH aims are that only those children meeting thresholds for statutory assessments are progressed as referrals to Children's Social Care. The assessment will determine what services to provide and what action to take.

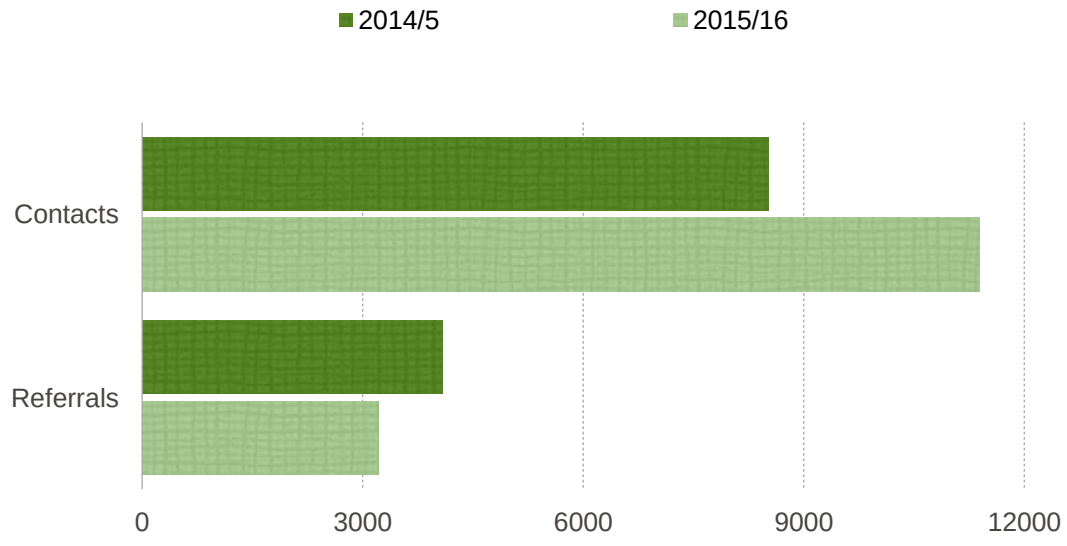
Barking & Dagenham's referral rate per 10,000 children aged 0-17 has fallen from 691 to 544. This is in line with the national average of 548, below our statistical neighbours (715) but above the London rate of 478. The percentage of contacts

progressing to a referral has decreased from 48% in 2014/15 to 28% in 2015/16. Whilst the number of repeat referrals has remained similar at year end 2015/16 to the previous year at 16.6% the number of cases decreased from 688 to 534.

The significant increase in the rate of contacts and the conversion to referrals, reinforces the importance of the 'strong front door'. The gate keeping role of MASH ensures an appropriate response but this may not always be from Children's Social Care.

The high number of contacts not progressing to referral has continued to merit attention and work regarding the quality of information provided by partner agencies and this remains an important practice issue going into 2016/17.

The significant volume of Merlins (contacts from the Police) has led to positive collaborative working between Children's Social Care, Police and Early Help services. In particular where there are concerns around low level domestic abuse, arrangements are now in place to visit and offer support at a Tier 2 level before considering a referral.



Children in Need

The number of Children in Need cases has reduced by 12% (291) at year end when compared to year end 2014/15. The numbers of Children in Need on social worker

caseloads has been high and some cases have received less oversight than would be expected as social workers have prioritised Child Protection and court work. Identification of this led to the successful Children in Need project team, consisting of a team manager and social workers working with Children in Need cases to move on including step down to Tier 2 services. In some cases there has been targeted involvement from Troubled Families workers.

Children on a Child Protection Plan

The number of children made subject to a child protection plan has reduced compared to year end 2014/15 from 353 to 253, a reduction of 28%.

The rate of child protection enquiries (section 47) in 2015/16 was 206 per 10,000. An audit has concluded that the threshold for section 47 is appropriate and whilst higher than statistical neighbours, London and national rates, children are safe and risk is identified and managed. This area of practice will be subject to further scrutiny and constructive discussion. Analysis shows that in 29% (355 children) of the cases where a S47 enquiry was begun, the children were assessed as not being at risk. Possible questions that the BDSCB will test out in audits in the coming year could be:

- Is the application of threshold being appropriately applied?
- are referrals and risk being framed by referring agencies appropriately
- are there alternative solutions to avoid escalation to S47 such as the input of universal or early help services?

100% of Initial Child Protection Conferences take place within 15 days of the strategy meeting where the decision was taken to convene an enquiry. This means that children receive a timely service when safeguarding concerns are apparent.

The total number of cases considered at initial child protection conferences in the 2015/16 period was 328 which is a rate per 10,000 of 55. There has been a positive reduction from 76 per 10,000 during 2014/15.

There were 10 children (2.4%) who remained on plans for longer than 2 years, lower than the national and statistical averages and 24 children (7.8%) that became subject of a plan for the second time.

The number of multi agency Core Groups meeting within timescale is 84% and is a positive increase when compared to 2013/14 when performance was below 40%.

The profile of children subject to a Child Protection Plan shows a high proportion of younger children aged 9 and under. This emphasises the need for early intervention and prevention work in pregnancy and early years settings.

There has been an increase in the number of males subject to a child protection plan in 2014/15 51% were male, in line with the local population. During 2015/16 this has risen to 60%. 49% of children subject to a child protection plan are white British. This is an increase on 46% reported in 2014/15 and in context of a declining whit British local population, which is currently 33% for under 18's.

Analysis of the types of abuse resulting in child protection plans highlights emotional abuse and neglect as the two largest categories used in the borough. 50% of plans are due to emotional abuse, linked to the rate of domestic violence. The percentage of children on plans due to neglect increased to 35% during the year.

Looked After Children

The number of Looked after Children at year end is 418, compared to 457 in 2014/15, a decrease of 9% making the rate per 10,000 71 (from 77). This above the national (60) and London (52) rates but in line with similar areas (69).

The number of children taken into care as a result of police protection has been very high in previous years and was identified as an area for improvement following the Ofsted inspection in 2014. Positive and focused partnership work between the Police and Children's Social care has led to a reduction in numbers during the year to 54, representing 25% of all admissions into care. This compares to 69 in 2014/15 and 134 in 2013/14

Children at Risk of Child Sexual Exploitation (CSE)

Multi agency work to identify children and young people who may be at risk of child sexual exploitation continues to be a priority for the BDSCB and partner agencies.

- 130 children were flagged as at risk of or subject to CSE - an increase of 37%
- 5th highest number of incidents in London according to police data
- 88% of the children and young people were female, a slight increase
- 81% were teenagers, a slight decrease
- 56% were white British, a 5% decrease
- 25% of victims had been reported missing with a high incident of repeated missing reports, a 5% increase
- 33% open to Children's Social Care

There is no national or regional dataset for CSE so at present there is no mechanism for comparing Barking & Dagenham's performance against other areas. The locally produced Problem Profile will be updated and collate information across a range of agencies. At year end the CSE data collected showed:

Children Missing from Home, Education & Care

Children missing from home, care and education are a priority for the BDSCB. The partnership response is steered by a multi agency missing children group and the development of a revised strategy.

The Local Authority maintains a database that records all instances of missing children. Data is recorded via Police MERLINS of children reported missing for 24 hours or more. The financial year end 2015/2016 figures for missing children are as follows:

- LBBD all under 18s: 213 children with 490 instances of being reported missing for 24 hours or more
- LBBD LAC/CP: 78 children with 200 incidents (includes our LAC placed out of borough)

Of these:

- LBBD all under 18s at risk of CSE: 28 children with 82 missing incidents
- LBBD LAC at risk of CSE: 18 children with 44 missing incidents
- Return interviews completed: 45

Whilst data for 2014-15 shows that there were only 239 missing instances relating to 125 children, it is only since April 2015 that data for LAC who are placed in our borough from other LAs has been counted. The borough's systems and partnerships to safeguard missing children have been strengthened through the MASE and CSE committee. This has resulted in a rise in the number of LAC being identified as being at risk of CSE. This should however be viewed as positive.

Elective Home Education

Data for the numbers of resident children and young people of statutory school age who are home educated in Barking and Dagenham for the 2015-16 is as follows:

April 2015	**110**	**October 2015**	**166**
May 2015	**127**	**November 2015**	**170**
June 2015	**136**	**December 2015**	**186**
July 2015	**141**	**January 2016**	**188**
August 2015	**146**	**February 2016**	**190**
September 2015	**146**	**March 2016**	**151**

Whilst the data is subject to substantial monthly variation, it does demonstrate an upward trend in the numbers of children and young people who are home educated. The numbers of EHE children has effectively doubled since 2010. It should be noted that whilst parents have a right to refuse to engage with the Local Authority (the only statutory requirement being that they submit an annual educational philosophy statement), less than 10 families fall within this category in the borough. The LA therefore has a constructive relationship with the vast majority of parents who choose to home educate. The majority of parents continue to home educate not for philosophical reasons but because their child was not offered a place at the school of their choice, or they have been withdrawn from school following a particular incident e.g. bullying or behaviour.

The EHE database 'RAG rates' each child in relation to safeguarding and any other concerns, with appropriate action taken in each case.

Private Fostering

A child under the age of 16 (under 18, if disabled) who is cared for and provided with accommodation by someone other than a parent, person with parental responsibility or a close relative for 28 days or more is privately fostered. A full analysis of activity in Barking & Dagenham over 2015/16 is available in the Private Fostering Annual Report.

During the year 2015/16 the Fostering team held a total of 29 children who were privately fostered. Of those 29, 14 were closed during the year and at year end there were 15 children open. This is an increase on last year 2014/15 when there were 10 children open.

Number of Notifications	Number of cases processing to PF arrangements	Closed within 28 days of referral	Total cases at year end
45	12	1	15

During the year the Fostering team received 45 notifications compared to 26 during the previous year. Of the 45 notifications 12 (27%) met the criteria for for Private Fostering. Of those 12 - 4 cases were referred to the Assessment service as there were safeguarding concerns, 1 was closed after the 28 day assessment as the young person returned home, 2 children were made subject to Child Arrangement Orders that removed them from Private Fostering regulations, 5 cases remain open.

Ethnicity of notifications	Black African	White British	Lithuanian	Russian	Portuguese	Dual Heritage	Asian	Black Caribbean
45	20	9	2	1	2	2	2	7

The age range of the 15 children were:

- aged 0-6 = 1
- aged 6-9 = 2
- aged 10-16 = 12

There were no children with disabilities living in Private Fostering arrangements during 2015/16.

All notifications were responded to by way of a visit to the child and carer's home within 7 days of notification which is 100% compliance with statutory timescales. All new arrangements were assessed and completed with the 42 days which meets the regulated timescales.

Private Fostering campaigns continue with the multi agency workforce and the community, including raising awareness of children who may have been trafficked. Schools, Children's Centres and libraries display leaflets and posters for children & young people and carers.

During Private Fostering week an awareness campaign was aimed at professionals to remind them of the duty to refer.

Next Steps

- increase and maintain the level of publicity and awareness raising activities
- continue to promote links with partner agencies
- contribute updates to key newsletter & bulletins

MAPPA

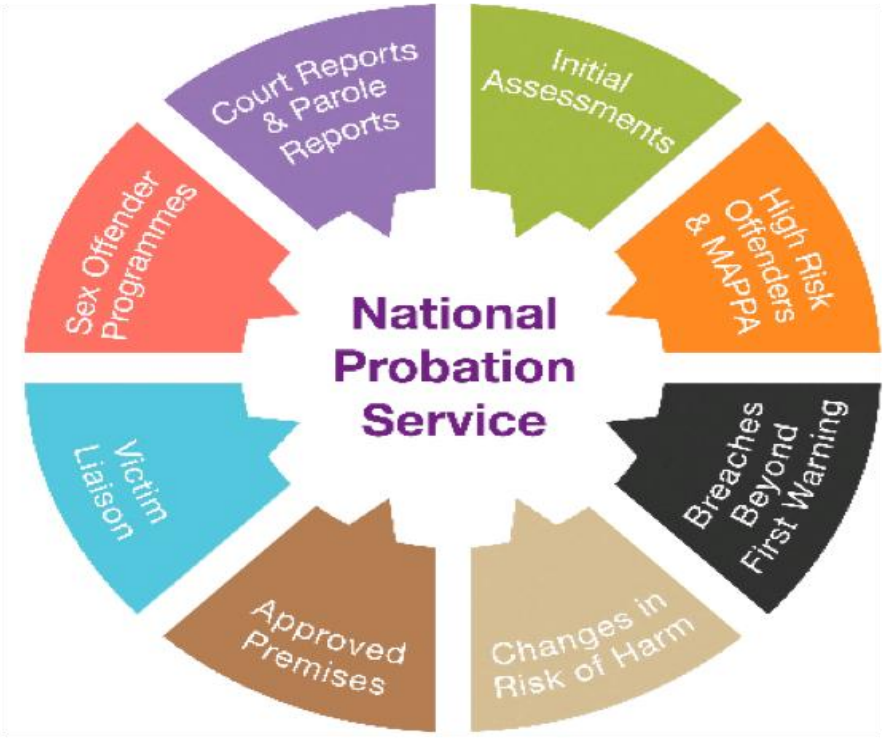
Multi Agency Public Protection Arrangements (MAPPA) operate in all 32 London boroughs. The arrangements are statutory which means that there is a duty on all agencies involved to share information about sexual offenders and violent offenders and to fulfil their obligations in helping to manage them safely in the community.

MAPPA across London is overseen by the London MAPPA Strategic Management Board that is made up of representatives from probation, police and prisons. The Strategic Management Board ensures that MAPPA operates consistently and in line with the national MAPPA guidance issues by the Ministry of Justice.

There are 3 categories of MAPPA eligible offender: Category 1 - registered sexual offenders; Category 2 (in the main) violent offenders sentenced to imprisonment for 12 months or more and Category 3 - offenders who do not qualify under categories 1 or 2 but who currently pose a risk of serious harm.

MAPPA reports in the main on a London wide basis and there is little local data and analysis reported to the BDSCB. Up to end of year 2015 there were 169 registered sexual offenders in Barking & Dagenham, this is from a London total of 6604.

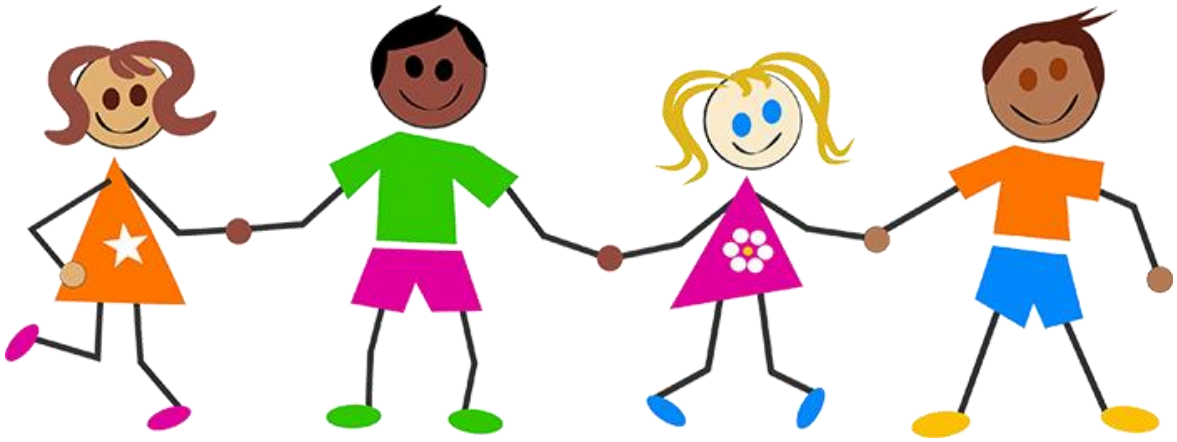
The London National Probation Service (NPS) in partnership with the other members of the MAPPA Responsible Authority in London prioritises public protection and working with victims. They assess and manage the risk posed by offenders on a continual basis and information sharing between agencies is vital and fully supported by the MAPPA process



Early Intervention

This is about taking action as soon as possible to tackle problems for children and families before they become too difficult to reverse.

Early help describes any service that involves a targeted intervention into the lives of children & families. These range from brief periods of support identified through universal provision to longer term plans for families who, without them would be supported by statutory services.



JSNA Key Messages

1. Barking and Dagenham is the 22nd most deprived authority in England and many families in the borough are either on low incomes, where full-time salaries are lower than any other authority in London, or they are dependent on benefits. More than a fifth of working age residents in the borough claim at least one type of benefit, compared to the national average of one in seven. Housing benefit claimant levels are high and have increased by 12% since 2008.

2. Barking and Dagenham has among the highest teenage pregnancy levels in England although rates have fallen considerably in recent years. The Chlamydia rate among the under 25s is the twelfth highest rate nationally, although the screening coverage is much more comprehensive (almost a third of young people are screened locally compared to a quarter nationally).

3. The population of children and young people has increased over the last ten years and is set to rise by another 16% over the next ten years. The projected 0-19 population growth in the borough will be driven primarily by the recent surge in the 0-4 population. Extra demand is already impacting on nursery and reception classes and the number of school places among 3-4 year olds has increased by nearly 20% between 2006 and 2010.

4. The gap in school attainment between Barking and Dagenham and the national average is small despite large numbers of economically disadvantaged children and young people. Results for FSM pupils are higher than national average each year and for all age groups.

5. GCSE performance levels are now higher than the national average among pupils not passing English and maths. There is a lower number achieving passes in English and maths than the national average and less achieving A or A* at GCSE level in any subject.

6. A-level results are lower than national averages as are the number of young people entering university.

7. The level of children known to Social Care is much higher than it is nationally for Children in Care, Children subject to a Protection Plan and Children in Need.

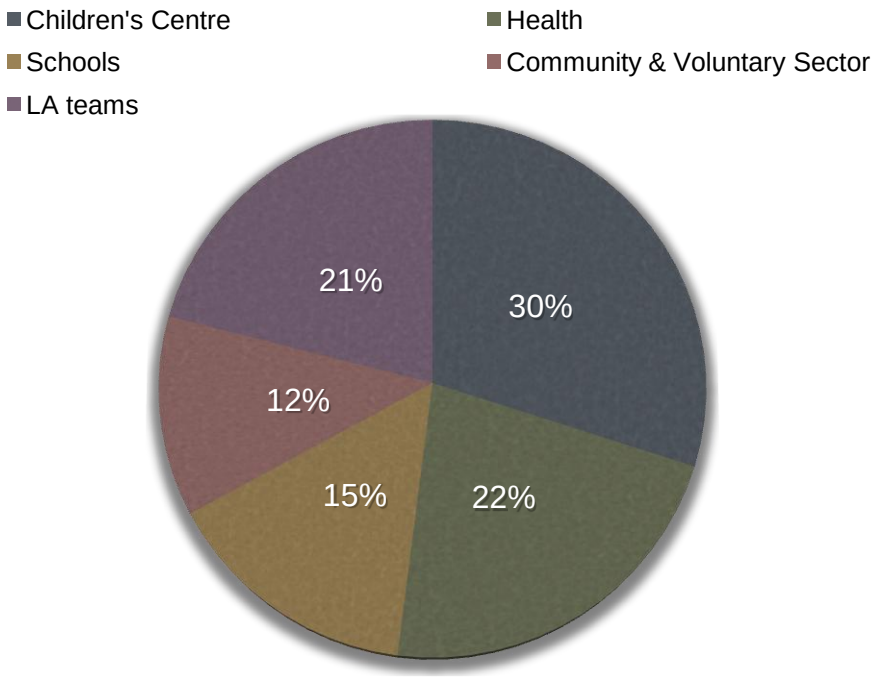
Early help services are delivered in partnership with all statutory, private and third sector agencies within the borough. An Early Help strategy (2014-2018) provides a framework by which partners can co-ordinate services for children & families and is led by the Early Help sub group which jointly reports to the Children's Trust Board and the LSCB. The strategy focuses on ensuring the right help is provided at the right time and includes a range of existing enhanced universal and targeted services supporting early help that include:

- Community Health Services
- Children's Centres
- Family Nurse Partnership
- Integrated Youth Services

- Locality Based Multi Agency Support Panels
- Troubled Families

CAF & Family CAF (FCAF) are the primary assessment tools used in Barking & Dagenham's Early Help. They support inter agency working along with established integrated pathways across the partnership and ensure effective coordination and information sharing across the Team around the Family (TAF) approach. The eCAF system is being promoted as the borough's primary choice of early help assessment, rather than the paper based system.

Practitioners in Barking & Dagenham continue to build on the successful implementation of the CAF process through early identification and intervention. Assessments are undertaken by trained staff members who have identified families with additional needs and who require multi agency involvement in order to bring them back to universal services without needing ongoing support from a targeted service. The CAF is the primary tool used for evidencing work with families involved with Troubled Families 2.



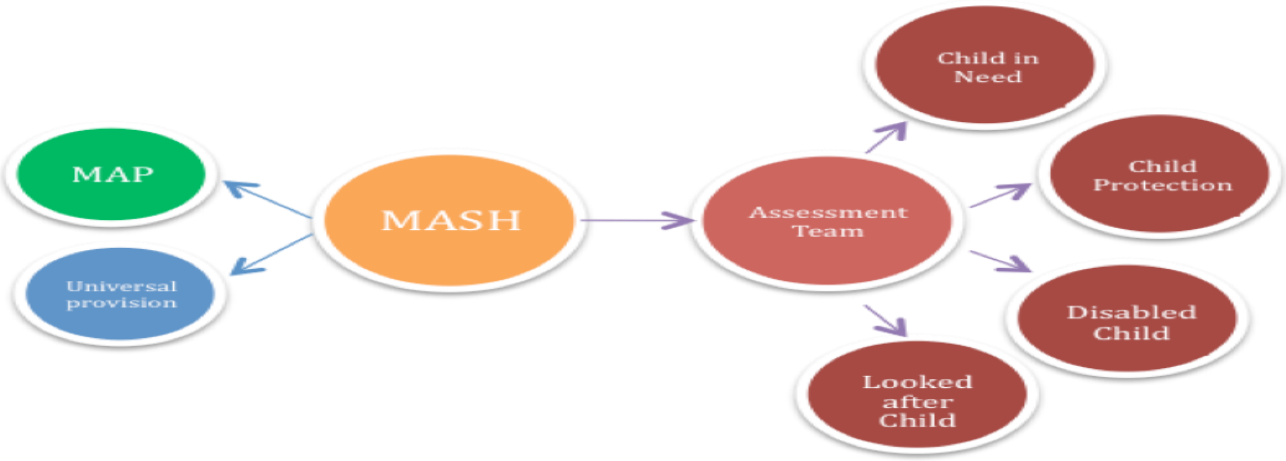
2099 CAF's were undertaken for children aged 5 and under. A third (30%) were undertaken by Children's Centre staff which includes Targeted and Universal Early Intervention Workers. Health services are the second highest initiator with 22% of all CAF's undertaken for this age group. This is an increase of 3% on last year's data.

TAF is an embedded concept in Barking & Dagenham and used where a family require multi agency support. Regular TAF reviews are held to ensure plans are on track and to collectively review progress.

Workers from Early Help have been co-located into the MASH and are able to provide a seamless response for children and practitioners. Located in the MASH allows Early Help workers to draw upon the information and intelligence held by partner agencies within a secure information sharing environment.

Work to revise the Thresholds document was initiated in 2015/16 and subsequently re-launched to BDSCB partners. The publication of this document is a statutory requirement for LSCBs as set out in Working Together 2015. The document details the process for the early help assessment and the type and level of early help services to be provided. Awareness raising on this aspect will continue through 2016/17.

Three Multi Agency Panels (MAP) encourage wider partnership involvement and to ensure that families who require universal or targeted support receive it as soon as possible. The last financial year saw a significant increase in the referrals coming to MAP. This was in part due to scrutiny on Child in Need cases and a 'step down' process aimed at reducing the impact on Children's Social Care demand. Over the year 2015/16, a total of 3578 referrals were received to the MAP's



The Early Help Committee has been a sub group to the BDSCB since 2014. It has excellent multi agency attendance from partners. For full details of Early Help see reports on: http://www.bardag-lscb.co.uk/Pages/EarlyHelp.aspx

Domestic Violence

Some of the biggest victims of domestic violence are the smallest.

Tackling Domestic and Sexual Violence (DSV) is crucial for creating a community within which everyone is safe: as strategic assessments continuously demonstrate, Barking and Dagenham has one of the highest Domestic Violence rates in London.

Prevalence

Domestic and sexual violence are significant issues for Barking and Dagenham and the borough has the highest number of reported incidents of domestic violence and abuse (DVA) per 1000 population in London. Using year to date totals:

- in 2015/16, there were 5393 incidents reported to Police.
- Of these, 2,568 were offences.
- This represents an increase of 5.4% compared with 2,436 offences in 2014/15.
- The majority of domestic violence incidents were recorded as violence with injury (VWI) and accounted for 46.2% of all recorded incidents on the borough in 2015/16.

This data does not include those victims who do not report to the police and therefore, is only an indicator of the true scale of the problem.

Domestic Abuse is a factor that features in the majority of open cases to Children's Social Care - 62% Numbers have increased by 86% in 3 years from 1195 in 2012/13 to 2228 in 2015/16. However the number of those contacts that progressed to referral decreased by 14% from 501 to 432.

Contacts & Referrals to social care where domestic abuse is a factor

No of Contacts	**11,393**
of which domestic abuse a stated issue	2228
% of contacts in which domestic abuse a stated issue	19.6
Number of Referrals	3215
of which domestic abuse a stated issue	432
% of referrals in which domestic abuse is a stated issue	13.4

The borough has a high number of standard/medium risk DVA cases. Taking into account potential under reporting and repeats there were in the region of 5,016 cases in 2015/2016. These numbers demonstrate the level of need for services to improve access to safety and prevent escalation of risk.

Sanction detection, arrests, charge and caution rates are above the regional average in Barking and Dagenham. The sanction detection rate for Barking and Dagenham stood at 48 % (October 2015) which represented an improved performance against 43% for the same period in 2013/14 and is significantly above the MPS average of 32.5%. With Barking and Dagenham ranked at joint first with LB Richmond for detections (Mayors Office for Police and Crime. Domestic Abuse in London 2015/16).

During 2015/16, pan London there were 26 recorded domestic violence homicides in London. This represented a 44% decrease compared to 2014/15. However, Barking and Dagenham saw an increase with one homicide on the borough compared with nil in 2014/15.

Recent MPS analysis highlights a significant correlation between alcohol use and DVA incidents in Barking and Dagenham. The data indicates a steep increase in the number of DVA cases where alcohol had been consumed by the victim and/or

perpetrator. This accounts for 70% of all incidents in the borough compared with 25% across the MPS as a whole and 40% across East London (MPS. Dec 2015).

There are many factors that may influence this including deprivation. However, there is no national evidence to show that alcohol use drives DVA

The Multi Agency Risk Assessment Conference (MARAC) discussed 337 high risk cases. This represented a 28% increase compared to 286 cases the previous year. Of these 26 % (86) were repeat cases. This is on par with the Safe lives national recommendation of 28% repeats to MARAC. A significant number of children (381) attached to these cases, which represents a 19% increase compared to 322 in 2014/15.

In terms of equalities, the MARAC data for the borough highlights a reduction in the number of victims with protected characteristics (41% of all MARAC cases compared to 60% during 2014/15. With the exception of LGBT victims, all the other protected characteristics saw a decreased level of referrals when compared with the previous year.

Equalities Profile of MARAC cases

	2014/15	2015/16	Variance
Total number of MARAC cases	286	377	+51
Total number of Equalities cases	171	156	-15
BME	130	124	-6
Disability	14	11	-3
Young Victims	14	10	-4
Gender (Male)	12	8	-4
LGBT	1	3	-3

Sexual Violence

There has been an increase in reporting of sexual violence in Barking and Dagenham of 2% with 441 crimes reported in the rolling year from April 2015 to March 2016 compared with 404 for the same period the previous year.

Harmful Practices

The identification and reporting of harmful practices (HP) is limited with 'Honour' based violence (HBV) and forced marriages which although distinct forms of violence, fall under the definition of domestic violence and abuse, rarely showing in Police reports. The findings of the recent inspection by Her Majesty Inspectorate of Constabulary (HMIC) into the response by the Police to honour based violence, forced marriage and female genital mutilation cases highlighted areas for improvement. (The depths of dishonour: Hidden Voices and Shameful Crimes. An Inspection of Police Responses to honour based violence, forced marriage and female genital mutilation, HMIC, 2015). The review concluded that there were pockets of good practice but found inconsistencies across the constabulary into how cases were dealt with. It has not been possible to assess local Police data about the prevalence of harmful practices locally, however, over the entire MPS area, 44 cases were investigated in the period between October 2014 to October 2015 YTD. The Forced Marriage Unit state that 50% of all the reports they receive are from London. Whilst the local Independent Domestic and Sexual Violence Advocacy (IDSVA) service worked with 9 victims where HBV was a concern during 2014/15.

It is estimated that 27.6 per 1000 women in population in Barking and Dagenham have experienced Female Genital Mutilation compared with 12.4 in Redbridge and 4.2 in Havering. Southwark is estimated to have the highest level of FGM in the country at 47. (Prevalence of Female Genital Mutilation in England and Wales: National and Local Estimates, Alison MacFarlene et al, City of London University, 2015).

Specialist Services

The specialist Domestic and Sexual Abuse services worked with 1,463 victims in 2015/16. The Independent Domestic and Sexual Violence Advocates (IDSVA) worked with 400 high risk cases. Of these, the majority were referred via the Police. This trend reflects the referral data profile for the MARAC with high level of Police referrals and low levels of referrals from all other key statutory and voluntary agencies. Consequently, in Barking and Dagenham most victims are generally identified if their

case has come to the attention of the criminal justice system and not at an earlier stage of victimisation.

The refuge service worked with 70 women and 52 children during 2015/16 and of these, 68% reported psychological abuse, 50% reported physical abuse, 13% reported sexual abuse, whilst some 13% were affected by “honour based violence”.

Data from the ASCENT Consortium shows that 330 women and girls from Barking and Dagenham used the service. Ascent is a pan – London consortium of 22 women’s services funded by London Councils to deliver advice, advocacy and counselling services

Partnership response to Child Sexual Exploitation

Child Sexual Exploitation (CSE) has become an issue of growing significance and is a fast moving area with new reports, requirements and guidance being published on a regular basis.

In response to the growing awareness of the prevalence of CSE, significant work has been undertaken to provide a co-ordinated response among agencies.

The BDSCB oversees a partnership approach to CSE which has led to development of a framework of strategic and operational work:

- The creation of the MASH has enhanced the information gathering and sharing for children where there are risk factors.
- 2 dedicated CSE officers located in MASH who act as a 'single point of contact'. They scan missing person reports and other police notices and records to identify possible CSE and progress them
- The Pan London CSE Operating Protocol has been adopted locally
- MASE meetings have been initiated, chaired by the Police.
- the CSE risk assessment tool has been redesigned, its purpose, to assist practitioners identify risk factors that may indicate young people are at risk of sexual exploitation
- CSE 'surgeries' to Tier 2 workers and social workers to discuss practice issues, disseminate information on referral pathways and CSE risk assessments
- CSE Referral Pathways have been revised and published on the BDSCB website
- A Children's Social Care 'virtual team' discusses practice issues and recommendations for improving practice.

- Links between missing children and CSE are recognised and the Missing from Care, Home & Education group has been formally joined to the BDSCB and now report into the strategic CSE group.

- The chair of the 'Gangs' group is a member of the MASE and is able to make links across the groups.

- Victim Support have appointed a young person's IDVA to work with young people aged 13-18 who are at risk of CSE/sexual violence and are also victims of domestic abuse.

- a CSE 'Champion' has been identified from most agencies including schools. The Champions meet for a whole day training & networking session on a quarterly basis.

- CSE training is available via BDSCB training programme

- subscription to the National Working Group (NWG)

The children who are most at risk of being targeted by CSE perpetrators are children who:

- are frequently missing from school, home or residential care

- are vulnerable due to living in 'neglectful' households

- have been separated or trafficked

- are unaccompanied or seeking asylum

- are living in residential care

The BDSCB work to a CSE strategy which sets out four key priorities:

1. **Prevention** - focusing upon early identification of children at risk of exploitation and early interventions to build resilience and to reduce the risks

2. **Protection** - to work collaboratively with the young person, their family and other agencies to develop tailored safety plans

3. **Prosecution** - building on the work of the Police, the Crown Prosecution Service and Probation to identify and disrupt perpetrators

4. **Publicising** - raising awareness of CSE among staff, parents and the community

Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where the young person receives 'something' (e.g., food, accommodation, drugs, alcohol, cigarettes, gifts, affection, money) as a result of them performing, and/or another or others performing on them, sexual activities.

Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain. Violence, coercion and intimidation are common. Involvement in exploitative relationships is characterised by the child or young person's limited availability of choice resulting from their social, economic or emotional vulnerability. A common feature of CSE is that the child or young person does not recognise the coercive nature of the relationship and does not see himself or herself as a victim of exploitation. Perpetrators of CSE can be from within or from outside a child or young person's family.

The Borough Police have responsibility for identifying and reporting Child Sexual Exploitation (CSE). Dedicated Detectives in this department scrutinise a number of indices (including MERLINS, custody records, crime reports etc) to try and identify factors which may make the child vulnerable to CSE and initiate early interventions. These cases are classed as follows:

Category 1: Cases where children believed to be at risk of CSE.

Category 2 and 3: Cases are those where there is evidence that the child is actually being exploited. SC&O17 Sexual Exploitation Team (SET) investigate these matters.

Additionally SET and the Paedophile Unit have proactive capabilities, developing intelligence and utilising undercover techniques both online and in the community to target perpetrators of child abuse.

The MASE process has been under review during this reporting period in an effort to ensure a strategic focus is maintained rather than a case by case analysis. An effective system has been adopted locally of conducting a pre-MASE meeting weekly

within the MASH to monitor and manage cases with CSE concerns and ensure referral thresholds are consistent.

The MASE process was subject to a peer review by SET between January and May 2016 to ensure a standardised approach is being delivered across London. A detailed report and recommendations have been implemented by the CSE team in Barking and Dagenham, leading to a revised agenda and focus.

The local CSE unit has increased resourcing during the reporting period from two Detective Constables to two Detective Constables and a Detective Sergeant. Staff are carefully selected to ensure they have the necessary background in children's safeguarding. The personnel in this unit has remained consistent, providing continuity of service and strong links to other agencies through the development of close working relationships.

The CSE Unit takes the lead in training for CSE to both police personnel and also deliver training to other agencies via a series of workshops. Training has now been rolled out to all officers and is now on a rolling basis to ensure new officers and staff are trained and existing officers are refreshed.

Barking & Dagenham CSE Profile

A Problem Profile was compiled in 2015 and is being updated for 2016. The analysis used individual data from Children's Social Care, Police, education, youth offending, substance misuse, children centres, Tier 2 services, SEN and domestic violence services, and cross referenced to build up a local profile.

Partner agencies in the borough continue to share intelligence that may influence the knowledge of the CSE profile. The Police ensure that they have an appropriate and skilled response to CSE crime and produce statistics that show, suspicion, crime detections, and interruptions/disruptions for London boroughs. Looking at the number of committed crimes, Barking & Dagenham holds the 5th highest place.

The 'suspicion' column denotes the number of category 1 cases (Children may be at risk of CSE), at 72 this is 8 less than at year end 2014/15. This is a clear demonstration that the goal of raising awareness with all front line staff is working and that we are identifying a number of children that may be at risk.

An intervention can be anything from a referral to to Children's Social Care to obtaining an injunction or obtaining a court order against a perpetrator.

Suspicion	Crime	Interventions	Detections	Disruptions
72	24	48	4	33

In response to the growing awareness of CSE there has been significant work undertaken to provide a co-ordinated response across key agencies. The BDSCB oversees a partnership approach to CSE which has led to the development of a framework of strategic and operational work. The creation of the MASH has enhanced the information gathering and sharing for children where there are risk factors. MASE meetings have been initiated and are chaired by the Police. This panel provides oversight of all cases of child sexual exploitation and ensures appropriate safeguarding plans are in place and tracks progress. MASE meetings are also used to identify and disrupt offenders and alleged perpetrators as part of actions to protect young people whilst considering a borough wide picture, emerging trends and challenges.

The CSE risk assessment tool has been redesigned. Its purpose is to assist practitioners identify risk factors that may indicate young people are at risk of sexual exploitation. Young people at risk of CSE may not initially meet the thresholds for section 47 inquiries and often will not engage with social workers or police officers. Young people who have been groomed may not even recognise themselves as a victim and may reject initial offers of help and support. To assist these young people the CSE co-ordinator has worked hard to identify a named 'CSE Champion' from each statutory agency and school in Barking & Dagenham. A quarterly whole day training session assists with information sharing and networking and ensures that CSE remains a 'live' issue. These training days include the police and the involvement of agencies such as the National Working Group (NWG), an organisation that Barking & Dagenham council subscribes to.3838

BDSCB includes training on CSE in its annual training programme which is available to staff from across the partnership.

The MPS flag crimes that have an element of CSE within them and also record and flag incidents that may not amount to a crime, but where indicators of CSE are present, i.e. repeatedly going missing. This allows work with other agencies to prevent the exploitation from escalating or ever happening, at the earliest possible stage. The flagging of cases where there is a 'suspicion of CSE' often occurs as a result of the department's commitment to ensuring all instances of reports involving

children are holistically assessed to consider if indicators of CSE may be present. If the team feels they may be at risk, a report is created and flagged and the process of further investigation commences.

This approach sees Barking and Dagenham displaying one of highest numbers of 'Suspicion of CSE' in the MPS. Rather than being cause for concern this data should be interpreted positively as they are being proactively identified locally as children vulnerable to potential CSE and early intervention strategies can be put in place. This is a clear demonstration that the MPS goal of raising awareness to recognise the risk factors early on that was given to all front line staff is working. The fact that we are identifying so many children and young people that ***may*** be at risk of CSE provides all agencies within the partnership the opportunity to take action to prevent CSE taking place. This approach demonstrates the unit's commitment to early identification and prevention.

The actual recorded crimes (as oppose to suspicion that CSE may be a factor) shows 24 cases within the reporting period. This is down from 31 last year but is above average for the MPS which may suggest that CSE is more prevalent in Barking and Dagenham than other London Boroughs.

The fourth & sixth columns show the number of interventions and disruptions that have taken place. An intervention can be claimed if effective positive measures have been put in place which addresses the particular safeguarding needs identified within the report. Interventions have increased from 20 in the previous year to 48 in this reporting period, highlighting the closer effective working relationship with other agencies to ensure appropriate referrals are made to third sector organisations and the investigation remains focused on ensuring interventions put in place which alleviates the risks faced by the young person.

The disruptions measure activity taken against suspected perpetrators including Abduction Notices served and Civil Orders. These total 33 up from 20 in the previous reporting period and scores the highest in the MPS. This shows the increased drive in this year of looking at different ways to target suspected offenders even when the victim will not provide the necessary evidence to obtain a judicial outcome.

Station	Suspicion	Crime	Interventions	Detections	Disruptions
Hackney	62	18	83	1	26
Tower Hamlets	72	18	30	4	10
Waltham Forest	73	16	40	1	14
Redbridge	52	10	95	40	18
Havering	80	27	58	4	36
Newham	53	25	29	0	18
Barking&Dagenham	72	24	48	4	33
Camden	50	13	16	3	3
Islington	29	12	32	0	18
Harrow	30	7	18	0	8
Brent	36	22	16	8	10
Barnet	33	13	17	0	42
Enfield	41	22	22	2	10
Haringey	59	26	28	3	34
Lambeth	36	26	33	1	3
Southwark	50	16	19	1	7
Lewisham	47	14	33	6	9
Bromley	37	11	37	2	5
Greenwich	37	12	23	0	9
Bexley	25	8	11	5	10
Croydon	81	18	45	0	4
Sutton	34	4	24	2	1
Keningston & Chelsea	12	5	3	0	3
Westminster	25	29	13	14	7
Hammersmith & Fulham	35	11	7	2	3
Heathrow	0	1	0	0	0
Richmond	34	7	56	1	0
Hounslow	35	27	8	4	10
Kingston	48	5	28	3	0
Merton	41	14	25	5	1
Wandsworth	71	18	28	9	4
Ealing	59	20	57	4	16
Hillingdon	27	12	1	2	3

Barking & Dagenham council was successful in a bid for funding from Barnardos and the Big Lottery for a CSE worker for 3 years to work with the voluntary sector on hard to reach and vulnerable children and young people. The aims of the project are:

- to work with children and young people at low levels of risk of CSE around keeping safe, specifically targeting young carers and young people with disabilities who are in mainstream education

- to deliver workshops to community groups, but for voluntary organisations to be a priority, so they can continue to provide 'keep safe' workshops and increase capacity within their own agencies

There are robust arrangements in place for 'return interviews' with young people who go missing and these occur within 72 hours of a young persons return. Work will continue to analyse findings of these interviews to identify any commonalities or themes.

Operation Makesafe

Operation Makesafe seeks to educate people working as taxi drivers, hoteliers and those working in licensed premises who encounter young people, of CSE warning signs. The Metropolitan Police Service (MPS) provides this group of staff with bespoke CSE awareness training by specially trained officers, showing scenarios and action to take should they suspect a child is at risk.

Operation Makesafe is now embedded with the MPS, having been in place for over a year. It has been extended to local businesses and the police will continue to raise awareness.

Local Risk Factors

- High number of school exclusions or excluded within last **2 years**
- Low numbers of SEN : Attainment low at all **Key Stages**
- A fifth of the children flagged **at risk of CSE** had previously been reported missing
- Two thirds had previously accessed **support** through **Children's Centres** and **Targeted Support**
- **a** third had been subject to a CAF
- 37% were known to **Victim Support IDVA** service
- No teen parents were known
- 10% of children were known to **drug services**
- 12% were known to **Youth Offending** service

CSE Peer Review

In October 2014 the London Safeguarding Children Board, and the Association of London Directors of Children's Services requested that all London authorities complete a peer review of practice in relation to CSE. The boroughs of Hackney, Newham and Barking & Dagenham developed an audit tool and completed self audits ahead of a cross borough peer challenge meeting. A review of this work was undertaken in early 2016.

Themes

✱ work with the police, particularly at borough level CSE SPOC and the East London CSE team is strong and focused. Police attend MASE and strategic meetings and are proactive in seeking information to pursue prosecution and disruption tactics

✱MASE meetings are running in line with the London CSE Protocol

- strengthened cross borough information sharing will assist local authorities to safeguard looked after children placed out of borough

- Commissioning & support of foster carers and the development of specialist CSE foster carers

Next Steps

- Review & update of Problem Profile
- Review & update of the operational plan
- Review and analysis of 'return interviews'

Oversight of Children Missing from Home, Care & Education

A child missing from home, care and education remains a priority for BDSCB. In 2015 the London Safeguarding Children Board updated the London Child Protection Procedures and agreed a protocol for missing children.

Going missing is a dangerous activity. There are particular concerns about the links between children running away and the risks of sexual exploitation, gangs and radicalisation. A child/young person who goes missing just once faces the same immediate risks as faced by a child/young person who regularly goes missing. However, children who go missing when they are young (and/or with greater frequency) are more likely to face longer-term problems.

The most effective assessment and support comes through good information sharing, joint assessments of need, joint planning, and professional trust within the

interagency network and joint action in partnership with families. Interventions will include a consideration of risks for each individual child/young person and a focus on reducing repeat missing episodes. All interventions will be informed by effective return interviews and for children in care must be informed by and reflected in the placement information record and in the care plan.

Children and young people go missing for a variety of reasons; they may be "pushed away" by factors at home or "pulled away" by outside factors. When they are missing they face immediate risks for which they may be ill-prepared. Children may run away from home due to:

- Arguments and conflicts
- Conflict within a placement
- Poor family relationships
- Physical and emotional abuse
- Boundaries and control
- Step parent issues

Children are at risk from:

- Being groomed for sexual exploitation
- Involvement in criminal activities
- Victim of crime
- Alcohol/substance misuse
- Deterioration of physical and mental health
- No means of support or legitimate income – leading to high risk activities
- Missing out on schooling and education

Longer-term risks include:

- Long-term drug dependency / alcohol dependency
- Crime
- Homelessness
- Disengagement from education
- Sexual exploitation, prostitution
- Poor physical and/or mental health

The Metropolitan Police have implemented the new ACPO missing person definition. This differentiates between people who are missing and those who are classed as absent.

- **Missing** – "Anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be the subject of crime or at risk of harm to themselves or another."
- **Absent** – "A person not at a place where they are expected or required to be and there is no apparent risk".
- The reporting process remains the same as it has always been: it will be a police decision whether a person is classified as missing or absent. The classification is determined on the perceived level of risk to the individual. Only a person who is assessed as **no risk** will be classified as absent. No person under the age of 18 will be assessed as being **no risk**, and as such no person under 18 will be classified as absent.

The BDSCB has a **Missing Children Strategic Group** (MCSG). It is a multi-agency meeting comprising of representatives from the police, Social Care, Education and Health and meets every six weeks to review missing children procedures and data. The CSE Coordinator is a member of the MCSG so that links between children missing and CSE can be explored.

Each quarter, data is provided to the Performance and Quality Assurance Committee on children reported missing within this borough.

The Information Sharing Group is a multi-agency meeting comprising of representatives from the police, Social Care and Health. It meets every six weeks to review **all** cases of children reported missing in the borough, children who are

missing from education and children who are educated otherwise than at school (also known as elective home education – EHE).

Director of Children's Services challenge meeting - Missing children and children missing from education are discussed, every three months, at a quarterly Director of Children's Services challenge meeting, which includes the Divisional Directors of Education and Social Care and a representative from the police.

National Indicator 71 - Although local authorities are no longer required to adhere to the guidance set out in this national indicator, this borough continues to use it as a tool to measure itself with regard to missing children procedures and data. This is signed off by the Independent Chair of the LSCB and the Director of Children's Services.

Priorities going forward:

- BDSCB will continue to oversee performance and the actions required to support the strategy on missing children.
- BDSCB to better understand the reasons why children go missing through the intelligence gathered from the return interviews
- A closer alignment of work involving CSE and Missing children
- Further scrutiny of the process in tracking children missing education.

Local Authority Designated Officer

All LSCB's have responsibility for ensuring that there are effective procedures in place for investigating allegations against people who work with children. The Local Authority Designated Officer (LADO) should be informed of all allegations and will provide advice and guidance to ensure individual cases are resolved as quickly as possible.

The LADO role in Barking & Dagenham is held by the Group Manager Safeguarding, Quality & Reviews with the operational function delegated to the Safeguarding Manager for all non education allegations and the Safeguarding Lead for Education for all allegations against education staff. These arrangements are fully compliant with the guidance in Working Together 2015. A full analysis of how allegations have been managed during 2015/16 can be found in the LADO Annual report.

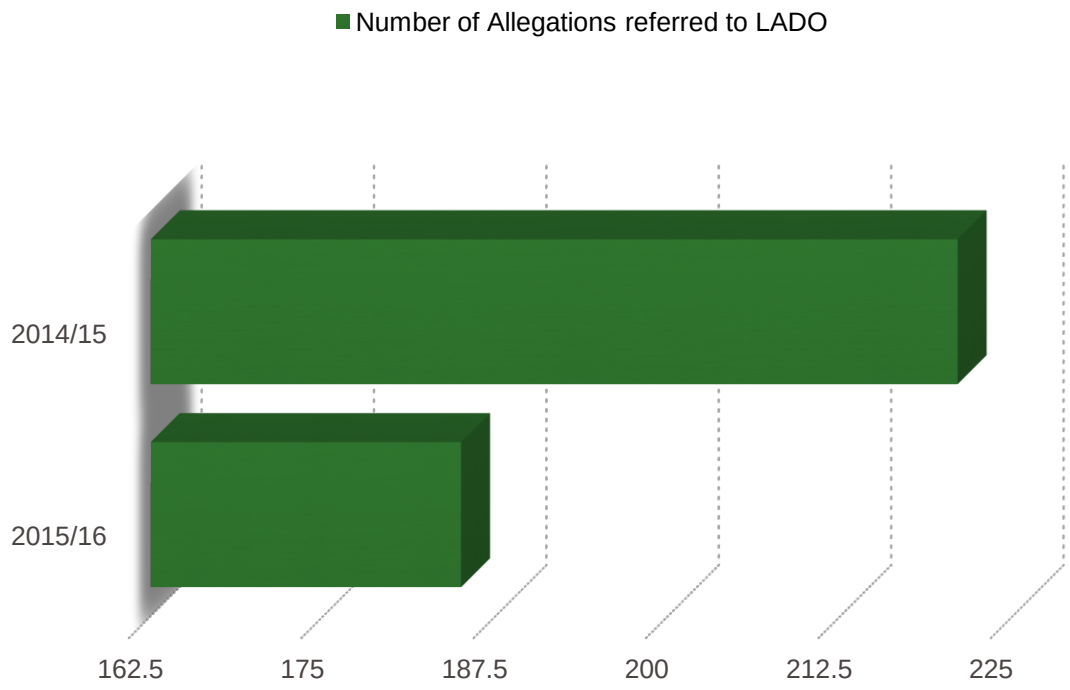
Between April 2015 and March 2016 the LADO's recorded 185 formal allegations against the children's workforce in Barking & Dagenham. This represents a 15% decrease from 2014/15 of 221 allegations.

The decrease in formal allegations could partly be explained as a result of the national emphasis on demonstration of harm, there has also been a reduction in the number of multi agency briefing sessions held.

The statistical distribution of allegations in the year indicates that professionals employed in education services account for 36% of the total referrals. The next largest professional group is Early Years settings with 15% of referrals, with Foster Carers third with 12%. The remaining 37% of referrals involved concerns about staff in the wider workforce. It is unsurprising that as a whole, the staff most likely to have allegations made against them will be those working with children directly and for significant periods of the day, (teachers and class based staff, nursery staff and foster carers).

Next Steps

- Continued awareness raising of LADO activity and ensure that all those working with children are familiar with the processes and what to do if they are concerned about an individual.



- Representation to national health bodies about registration of staff and compliance with LADO procedures

- raising awareness with faith groups of the LADO process

PREVENT - safeguarding children & young people from radicalisation

The BDSCB will hold the Community Safety Partnership to account for its effectiveness in safeguarding children and young people at risk of radicalisation.

From 1st July 2015 the 'Counter Terrorism & Security Act' (CTSA 2015) put the Prevent strategy onto a statutory footing. This places a duty on specified authorities to have *"due regard to the need to prevent people from being drawn into terrorism"* . The LSCB guidance issued by London Councils ' Safeguarding Children from Extremism' also forms part of the strategy. The Barking & Dagenham Prevent Strategy & Delivery Plan has identified the following priorities:

- improving understanding and awareness of Prevent, Extremism and recognising radicalisation
- building community resilience to identify and challenge extremism and radicalisation where this may present
- reducing the risk of vulnerable individuals to extremism
- ensuring Prevent messaging is communicated effectively both within frontline services and to the wider community

The Barking & Dagenham Prevent strategy & Delivery plan is developed and overseen by the Prevent Strategy & Steering Group, that reports to the Community Safety Partnership.

During the year there has been a major focus on training and awareness amongst frontline staff across all sectors and within the community. Schools in the borough have received workshops to raise awareness with over 1300 staff trained, with particular regard to Ofsted and DfE guidance.

Learning & Improvement

The BDSCB Learning & Improvement process provides the framework for the Board to learn from audits and to deliver its statutory function "to undertake reviews of serious cases and advise of lessons to be learned from them". Using the framework, the Board has ensured focused dissemination of learning from audit activity, Practice Learning Review and Serious Case Reviews. Training and Development needs are identified as a result of the emerging learning from practice and case review activity both at a local and national level.

Training & Development Report

What have we done?

- The Performance, Learning & Quality Assurance Committee oversees L&D on behalf of the BDSCB.
- The L&D Officer has worked hard developing local practitioners who deliver training courses on behalf of the LSCB, increasing the Board's capacity to provide learning opportunities whilst fostering expertise at single agency level.
- All courses have been developed based on learning from National Serious Case Reviews, national policy and research, local case reviews and audits.
- To enhance learning and development opportunities a series of lunch-time briefings and half day workshops have been arranged which provide a shorter and more focused training session.
- Between 1st April 2015 and 31st March 2016, 1,438 training places were available to the multi-agency workforce, 1,217 participants attended, equating to 85% attendance rates
- In addition, a range of E-Learning courses were accessible to partners via the LSCB website – this included basic awareness courses in Safeguarding, CSE, Female Genital Mutilation (FGM), Child Trafficking.

- Learning opportunities have been provided in response to identified need from learning from case audits and serious case reviews

What impact have we had

- Attendance by agency is variable as is expected given the varying size of the workforce, staff turnover, and availability of single agency training. Staff from the council, schools and Health agencies have the highest rates of attendance

- We have promoted our events to Voluntary, Community and Faith sector organisations across the period.

- Attendance rates themselves cannot be considered a measure of success, and it remains a challenge to demonstrate the impact of learning and development activity on outcomes for children and frontline practice. The BDSCB has used a 3 stage Post Course Evaluation process to evaluate the learning from events during this period and feedback has been largely positive

Next Steps

- To encourage greater attendance and less 'no shows' from all partners

- Refresh of the Learning & Development Framework and Training Programme to include learning from 2 local SCR's:

    - Hidden Adults
    - Disguised Compliance
    - Sharing Information

Child Death Overview Panel (CDOP)

CDOP is a committee of the BDSCB, it enables the Board to carry out its statutory duty relating to the review of all child deaths (0-17 years, with the exception of babies who are stillborn and planned terminations of pregnancy) so that if there is learning that may prevent future deaths this can be identified and shared with agencies and the public.

Across Barking & Dagenham during 2015-16 there were 20 child deaths notified to the CDOP of which 11 were reviewed and reported on by the panel.

- of the 20 deaths notified, 4 were unexpected deaths. The Rapid Response procedure was followed for all

- 16 deaths were classified as expected, of these 11 have been reviewed and concluded

- the highest proportion of deaths is within the neonatal period - 45%.

- children under 1 year of age represent 15% of the total number of child deaths notified to CDOP.

- 20% of deaths were white British and 20% were Black/Black British African

- 5 of the deaths reviewed had 'modifiable factors'

Modifiable factors are where there are factors which may have contributed to the Child death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

CDOP Achievements

- a clear pathway for learning between CDOP and SI's has been developed

- development of the interface between CDOP and Serious Case Reviews

- increased joint working across neighbouring boroughs to share learning and develop the effectiveness of CDOP with Barking, Havering & Redbridge Hospital Trust.

The full CDOP annual report can be found at: http://www.bardag-lscb.co.uk/Pages/CDOP.aspx

Case Review Activity - Serious Case Review's, Practice Learning Review's & Multi Agency Audits

What have we done?

- During 2015/16 four cases were referred to the SCR Committee due to concerns about how agencies had managed the case and the impact on the child. Of these, one met the criteria for a SCR.

- Of the remaining three cases two were criminal matters and being led by the Police and one was progressed to a Practice Learning Review, which remains in progress.

- This year the BDSCB have conducted two multi agency audits - the audit on CSE was conducted in line with our multi agency auditing process whereby representatives complete an audit tool and are then invited to a multi-agency focus group lead by the QA Manager from Children's Social Care who facilitates a 'conversation' about the quality of practice and the impact of collective efforts on improving outcomes for the child/young person. An audit on the quality of Multi Agency Referral Forms was completed by reviewing information sent into the MASH by referring agencies. The quality of information in the MARF was identified as 'requiring improvement' during the Ofsted inspection in 2014.

- Findings from audits are reported to Performance, Learning & Quality Assurance committee

Findings - CSE

The audit group audited 10 children which covered LAC, CP CiN and closed.

- basic recording such as the child's school was not updated

- Some inconsistency of approach to flagging cases was identified

- under half of the cases audited had evidence of the CSE risk assessment being used

❑ in cases where the CSE risk assessment used no evidence in half of those that the child had been seen

❑ multi agency plans need clarity and focus of work

❑ some agencies need greater oversight and understanding of CSE demonstrated through supervision

❑ Inconsistency in the understanding of risk levels and language was identified in some cases.

☑ two dedicated police officers for CSE are based in the MASH

☑ BDSCB training on CSE ongoing

☑ themes from this audit will be communicated to the CSE Champions

Findings - MARF

There were a total of 801 children referred via a MARF in Q1, 10% (80 records) were audited.

❑ out of 68 referrals where CAF should have been considered, only 2 had a CAF in place

❑ 56 referrals could have been worked in Tier 2 services rather than being referred to Children's Social Care.

☑ The quality of information in 58 MARFs was 'good'

☑ Reflection and analysis of information in 64 MARFs was available

Practice Learning Reviews

In Barking & Dagenham our practice learning reviews involve all partner agencies that were involved in the management of the case and the review is led by an Audit & Quality Assurance Officer.

The findings from the completed PLR involve sexual abuse and themes are:

➢ improved partnership working required

- improved information sharing required
- understanding of the Police CAIT role
- partnership understanding around the issue of consent

The learning from this PLR together with learning from multi-agency audits have been integrated into a multi-agency presentation to be delivered to Performance, Learning & Quality Assurance committee and through a workshop and newsletter.

Serious Case Reviews

LSCBs are required to undertake a review of all serious cases when abuse or neglect of a child is known or suspected; and either the child has died; or the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. The purpose of a Serious Case Review is to establish whether there are lessons to be learned from the case about the way agencies worked individually and together to safeguard and promote the welfare of children, to identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.

BDSCB has initiated two SCR's - Child H was initiated in 2013 but completed and published in 2015. Child B was initiated in 2015 and completed and published in 2016

All actions and recommendations from the Serious Case Reviews are monitored by the Performance, Learning & Quality Assurance committee. Themes arising from the SCR's are:

Child H

- supervision - reflective and clinical
- impact/risk of all family members
- professional optimism/curiosity

Child B

- information sharing
- compliance with procedures
- the ‘invisible’ father
- professional optimism
- disguised compliance

Impact of audits on practice and outcomes for children

Our case review activity has identified some opportunities for learning:

- continuous training to frontline practitioners in all agencies on threshold and consideration to completion of CAF
- regular reflective supervision to be in place
- all agencies involved with a child to be invited to strategy meetings and CiN meetings
- assessment tools such as the CSE risk assessment tool could be better understood and used more consistently to elicit early help, record concerns and measure changes
- over optimism results in a lack of rigour in undertaking assessments and focusing on the needs of the child
- sources of information were not always given appropriate significance
- information sharing was not always consistent, leading to a lot of information being available to some agencies working with the family but not others.

- parenting capacity was often judged to be poor without any formal parenting assessment being conducted to support that professional judgement
- reviews of assessment must be regularly undertaken to evidence that the desired impact of intervention is being realised for the child.
- Lack of professional challenge to the accounts provided by Parent's.
- Gaps in recording led to lack of clarity as to whether the child had been seen.
- Absence of the voice of the child in records to demonstrate that it had influenced the response of the professional
- The escalation policy was not used to challenge decision making

Key Messages for Managers

- Frequent changes in workers without adequate handovers can contribute to losses of information and a 'start again syndrome'
- Ensure that practitioners are trained and equipped to use all available risk assessment tools and that these inform referrals for early help and child protection.
- Ensure plans are child focused
- Encourage practitioners to reflect on what life is like for the child

Key Messages for Practitioners

- Take a forensic approach to assessment; consider all information regardless of the source.
- Ensure that all children are considered within an assessment regardless of how well they might appear to be doing
- Keep children at the centre of what you are doing – listen, and hear what they are saying.
- Demonstrate that the child's voice has influenced your response

- If you are uncomfortable about a decision that has been made in a case, report your concern and use the Escalation Pathway of the BDSCB.

- Ensure that all partners working with the child and family have contributed to the risk assessment

- Safeguarding is everyone's responsibility, but not someone else's. Get involved and stay involved until you are satisfied that risk has been reduced and outcomes for the child are improved.

BDSCB listens to children and ensures their voice informs our work

The Young People's Safety Group (YPSG) is a sub group of the BDSCB and meets to discuss safeguarding & safety issues that are specific to children & young people. The group meets termly and all secondary schools, the college and PRU are invited to attend with a representative group of between 8-10 pupils. Following each meeting, two key questions are raised by the young people and taken to the BDSCB meeting for a response, themes this year have covered Prevent & extremism and Rail Safety. Schools disseminate messages from each YPSG widely through assemblies and newsletters throughout their schools.

Throughout the year 111 young people attended drawn from 6 schools in the borough. The meeting themed on the Prevent agenda saw one of the largest ever attendances at a YPSG meeting

Integrated Youth Services (IYS) provides universal youth provision for 11-19 year olds, or up to 25 with a disability. Universal provision includes youth centres and pop up youth clubs in community settings. Targeted provision includes LAC youth groups and LGBT work. The service is also responsible for the statutory participation and rights of Looked after Children, including advocacy and Independent Visiting, as well

as mainstream activity such as the BAD Youth Forum. IYS is also responsible for reducing the numbers of 16-19 year olds who are not in Education, Employment or Training, the provision of work experience for young people as well as the commissioning of High Needs support for learners aged 16-25. During 2015/16 attendance at IYS groups reached 21,386.

The safeguarding of young people comes about largely through the work with Looked after Children and through 1-2-1 work referred through various multi agency panels. Generic youth work also explores the theme of safeguarding, in particular CSE, and provides a 'safe' environment for any young person to discuss this topic.

The service is by far the largest distributor of condoms in the borough with around 28,000 distributed in Q3 & Q4. This is carried out within a context of speaking to young people about healthy relationships.

Looked After young people have access to a more stable and consistent Advocacy and Independent visiting service and the Children's Rights Officer has continued to undertake return interviews with children that go missing, making links with CSE.

'Flip side' is a LGBT youth provision and is now a well established peer group with the ability to inform and influence work around promoting LGBT rights and positive outcomes. IYS also has a pivotal role in promoting positive sexual health. Teenage pregnancy figures for the borough are at its lowest level since 1998.

Listening to and responding to the voice of child is integral to practice and embedded in training and audit processes for North East London Foundation Trust (NELFT)

NELFT has a service user engagement programme in place which includes seeking the views of children, young people and their families in relation to their experience of services. Their views are considered and used to inform improvements in service delivery. There is a young people's engagement group known as "Listen". This group has contributed to a review of the CAMHs service undertaken by the Clinical Commissioning Group. Views of parents frequently inform improvements or changes in service delivery, for example a survey of The Health Visiting service resulted in the implementation of a duty system being put in place to improve access.
There are a number of forums for capture of practitioner experience, for example the annual NELFT staff survey, surveys of practitioner experience of safeguarding children supervision and support received from the safeguarding duty desk.

Youth workers play an increasing role in the reduction of NEET. This is particularly the case with vulnerable NEET who experience a number of factors such as domestic violence and substance misuse that prevent them from entering education, employment or training.

Attendance at IYS provision is consistently good with the potential to reach and work with young people at risk who may not access other services. Through the YPSG young people have worked directly with BDSCB members to outline their priorities. In November a group of young people 'tookover; the LSCB meeting and acted in key positions such as Independent Chair and Director of Children's Services. They formed the agenda and questions to the multi agency partners. This will be repeated on an annual basis.

Next Steps:

Make links with the gangs group

Continue to work with vulnerable young people in returning to education, employment & training

Strengthen the role with regards to CSE

Wider Contribution to Safeguarding from our Partners

The BDSCB strength and ability to continuously improve safeguarding practice is underpinned by our multi-agency working together. However there is a significant amount of work that our partners undertake from a single agency perspective.

This section of our annual report provides a snapshot of information on the wider contribution to safeguarding from our partners, in addition to the multi-agency partnership contribution they make

Barking, Havering & Redbridge University Hospitals NHS Trust

What we have achieved	What we aim to do in 2016/17
Full establishment of the Safeguarding Children's Team	Implement & embed the Child Protection Information System
A Safeguarding Children Training Needs Analysis approved at the Trust's Operational Group	Continue to embed the FGM, CSE and DV agenda
Supervision Policy revised	Embed a Safeguarding Children 'trigger tool' in Emergency Departments
Rolling programme of audits in place	Establish Safeguarding Children Summits to disseminate learning relating to children and through Serious Incidents
CAF now in use in Midwifery Dept and by Sexual Health & Paediatric staff	Develop a Safeguarding Children's Dashboard
All staff have access to a new CSE web page	
staff awareness of vulnerable groups - DV, LAC, CSA	
Implementation of CP Information Sharing System	

What we have achieved	What we aim to do in 2016/17
Increased evidence on consultation with children	

Children's Social Care

What we have achieved	What we aim to do in 2016/17
Reduction in open cases, resulting in less drift and lower caseloads, reflecting tighter work on assessment, planning and reviewing.	Continued analysis and understanding of increased volume of contacts.
Higher performance in visits to children subject to CP plans (97%), Core Groups (86%)	Improve and maintain performance on key areas
Significant progress with the Police to reduce the number of children entering care through Police Powers of Protection	Reduced reliance on agency staff and increased focus on permanent recruitment of social workers
Introduction of the Single Assessment and increase in performance in completing assessments within timescales	Continued focus on CSE
Reduction in referrals reflects improved gatekeeping in MASH	Co-ordinated planning to address preventative work with universal and targeted services.
	Further work on responding to high levels of domestic violence

Housing

What we have achieved	What we aim to do in 2016/17
Comprehensive training is available to all staff	

What we have achieved	What we aim to do in 2016/17
Housing staff regularly attend Child Protection Conferences	To respond to the projected increase in demand, actions will be taken to reduce homelessness: - early intervention -adopting a holistic/multi agency approach -mediation in parental ejection cases -employment, debt management & benefits advice -working closely with private landlords
Joint work with Children Centres to provide training and information on rights and responsibilities of a tenant	

North East London Foundation Trust (NELFT)

What we have achieved	What we aim to do in 2016/17
The Safeguarding children duty desk was implemented in July 2014. This is a single point of contact for safeguarding children enquiries and is co-located with adult Safeguarding team enabling a THINK family approach to safeguarding The Fabricated and Induced Illness Procedure written in partnership with the Named Doctors was ratified and published.	Work to develop the NELFT reporting CSE dataset requirements is now complete and will be available in late 2016.
The Domestic Abuse, CSE, FGM and Harmful Practice Procedure was developed, ratified and published.	Capacity and impact on practitioner workload in a time of change and service transformation
The Safeguarding Children Policy was reviewed and updated to strengthen reference to key priorities such as CSE and FGM and to reflect updating of national policies.	Sufficiency of high quality supervisory capacity
All senior leads and managers, including the executive team have received safeguarding training at the required statutory level.	Ability to release staff to attend multiple training programmes

What we have achieved	What we aim to do in 2016/17
The Safeguarding Children's team undertakes regular audits of the Trust's child protection systems and processes. The audit program includes an audit of safeguarding children record keeping, the quality of safeguarding children supervision and response to domestic violence. An additional audit of practitioner contribution to child protection core group meetings and progression of child protection plans was identified from Section 11 audit 2014	Insufficient and limited understanding of pathways to respond to those affected by these issues
NELFT has a service user engagement programme in place which includes seeking the views of children, young people and their families in relation to their experience of our services. Their views are considered and used to inform improvements in service delivery. In Barking and Dagenham's there is a Young people's engagement group known as "Listen". This group contributed to the review of the CAMHs service undertaken by the Clinical Commissioning Group.	Earlier identification and mobilisation of early offer of help – in order to reduce harm and improve outcomes for children.
There are a number of forums for capture of practitioner experience, for example the annual NELFT staff survey, surveys of practitioner experience of safeguarding children supervision and support received from the safeguarding duty desk.	Embedding CSE within the range of practitioners roles and assessment processes within children's services
	Ensure that children and young people affected by the issues associated to PREVENT are recognised and appropriate interventions are in place

Metropolitan Police Service

What we have achieved	What we aim to do in 2016/17
Significant improvement in intervention and disruption	Develop further links with Missing Children and improve identification of CSE from these young people, extracting intelligence from return interviews.

What we have achieved	What we aim to do in 2016/17
The local CSE team continue to lead the way in identifying and flagging young people who may be at risk and ensuring quality links are made with partner agencies to reduce those risks.	Develop closer links with care homes on the Borough.
The Detectives within the team remain the same in this reporting period, gaining further experience and building close working relationships	Improve the links with Schools and raise awareness in schools.
We have provided a strong training program to raise awareness across multi-disciplines.	Closer focus on perpetrators and locations of concern and use the new Dashboard to build an accurate problem profile and direct resources accordingly.
MASH processes leading up to MASE and the MASE itself has been completely overhauled to include a greater focus on perpetrators, location and prevention activity.	Trial CSE matrix system (similar to Gangs system) and consider if this is a valuable tool in identifying and prioritising those most at risk.
	Regularly review processes with MASH and other agencies to ensure they are in line with Pan London Protocol.
	Work with council partners to identify Services that may be able to be commissioned for children believed at risk of CSE to provide a wider range of intervention options.

Clinical Commissioning Group (CCG)

What we have achieved	What we aim to do in 2016/17
Developed & Strengthened safeguarding arrangements for the CCG Safeguarding children information included on the intranet site with updated policies & procedures	A case for change for the combined role of Designated Nurse for safeguarding & LAC remains outstanding & will be reviewed
A new set of reporting requirements has been agreed for the reporting organization to report on supporting the CCG to hold the provider organizations to account.	A proposal is being considered to begin a Lead GP Child Safeguarding Group to be held quarterly.
A safeguarding standard detailing the minimum standards for safeguarding children for all CQC	Achieving statutory compliance with LAC Health Assessments.

What we have achieved	What we aim to do in 2016/17
contracts has been agreed and will be placed in all contracts from 2016 onwards	
NHSE carried out a deep dive inspection across all BHR CCG's as part of an assurance process for CCG's. Barking & Dagenham was awarded a 'good' outcome with a number of good practice areas identified.	Raise the profile of LAC with GP practices.
The Designated Nurse has supported development of NELFT's FGM strategy and is working with the LSCB Faith & Culture group.	

Priorities for 2016-17

The BDSCB business plan outlines the strategic objectives that will inform the work of the Board from 2015-18. The following information was considered when the priorities were agreed:

- Children's Trust - Children and Young People's Plan
- Health and Wellbeing Strategic priorities
- BDSCB Annual Report 2014-15
- Recommendations from inspections
- Analysis of local need - JSNA
- Good practice guidance from ALDCS and Ofsted publications
- Priorities identified from the BDSCB performance management data and local quality assurance audits.
- Outcomes of national and local serious case reviews

- Five strategic priorities were agreed. These are:

    1. Board members are assured that arrangements are in place to identify and safeguard groups of children who are particularly vulnerable

    2. Board partners will own and share accurate information which informs understanding of safeguarding practice and improvement as a result

    3. The Board will see children and young people as valued partners and consult with them so their views are heard and included in the work of the LSCB

    4. Arrangements for Early Help will be embedded across agencies in Barking & Dagenham who work with children, young people and their families

    5. Board partners will challenge practice through focused inquiries or reviews based on performance indicators, practitioner experience and views from children and young people. Collectively we will learn and improve from these reviews.

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HEALTH AND WELLBEING BOARD

22 November 2016

Title:	**Update on North East London Sustainability and Transformation Plan (NEL STP) for Barking and Dagenham Health and Wellbeing Board**
Report of the Strategic Director, Service Development & Integration	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Andrew Hagger, Health & Social Care Integration Manager, London Borough of Barking & Dagenham	**Contact Details:** Tel: 020 2887 E-mail: andrew.hagger@lbbd.gov.uk
Sponsor: Anne Bristow, Strategic Director, Service Development & Integration	

Summary:

This report provides a further update to the Board on the development of the north east London Sustainability and Transformation Plan (NEL STP).

A further draft STP was submitted to NHS England on 21 October, which is attached at Appendix A. This provides a more in-depth view of the aims priorities, approaches, finances and governance of the STP. The STP team is now awaiting feedback from NHS England and details on next steps in the process.

For Barking & Dagenham, Havering and Redbridge, it remains the case that the detail of the local contribution to the Sustainability and Transformation Plan for north east London has been developed through the established programme to draft a business case for an Accountable Care Organisation.

Recommendation(s)

The Barking and Dagenham Health and Wellbeing Board is recommended to note the Draft STP attached at Appendix A

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). An STP is a new planning framework for NHS

services which is intended to be a local blueprint for delivering the ambitions NHS bodies have for a transformed health service, which is set out in a document called 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. The STP will give access to transformational funding for the health system and is a key strategic lever for the NHS.

1.2 The North East London area encompasses the CCGs, local authorities and provider organisations across Barking and Dagenham, City and Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest.

1.1 The STP aims to build upon existing local transformation programmes and supports their implementation. These are:

- Barking and Dagenham, Havering and Redbridge: devolution pilot
- City and Hackney: Hackney devolution in part
- Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme
- The improvement programmes of local hospitals, which aims to support Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust out of special measures

1.2 For Barking & Dagenham, the work to develop the detail underpinning the STP is being taken forward jointly with Havering and Redbridge through the work around devolution and wider BHR system-wide transformation approaches.

1.3 Previous report and updates have been provided to the Health and Wellbeing Board, with reports to the 26 July and 27 September meetings of the Board.

1.4 A draft STP was submitted on 30 June as a 'checkpoint', which formed the basis of a local conversation with NHS England on 14 July. Formal feedback on the submission was received at the end of August and asked that the next draft of the STP:

- Clearly articulates the impact the STP proposals would have on the quality of care
- Provides more detail, with clear and realistic actions, timelines, benefits (financial and non-financial outcomes), resources and owners
- Includes plans for primary care and wider community services that reflect the General Practice Forward View
- Contains robust financial plans that detail the financial impact and affordability of what is proposed
- Sets out plans for engagement with local communities, clinicians and staff

1.5 The next iteration of the STP was submitted on 21 October 2016 and the NEL STP team are currently awaiting feedback and next steps from NHS England.

2 Key issues in the STP

2.1 The document submitted on 21 October re-emphasised the agreed joint vision for the STP:

- 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
- Develop new ways of working to achieve better outcomes for all, focused on the prevention of ill health and out of hospital care
- Work in partnership to plan, commission (buy), contract and deliver services efficiently and safely.

2.2 Whilst each of the health and care economies within NEL has a different starting point, the STP has identified six key priorities which need to be addressed collectively across the NEL footprint. These are:

- The right services in the right place: Matching demand with appropriate capacity in NEL
- Encourage self-care, offer care close to home and make sure secondary care is high quality
- Secure the future of our health and social care providers. Many face challenging financial circumstances
- Improve specialised care by working together
- Create a system-wide decision making model that enables placed based care and clearly involves key partner agencies
- Using our infrastructure better

2.3 The STP submissions also highlights the financial challenges across the health system, with an anticipated total financial challenge of £578m in the 'do nothing' scenario. Even after all the existing approaches in place to drive savings out of the system (business as usual efficiencies of 2% p/a, transformation programmes in Hackney, WEL and BHR) there is still a gap of £92m for in 2021. By 2021 the Sustainability & Transformation Fund is expected to be £136m, which is equal to the amount assumed to be required to deliver the NHS Five Year Forward View investment priorities. All NEL local authorities and the Corporation of London have provided financial data for the STP modelling, though it is recognised that further detailed work is required to confirm assumptions and what effect local authority funding challenges and proposed services changes will have on health services and vice versa.

2.4 In addition, further work has been carried out on the governance arrangements for the delivery of the STP. The STP team have recognised that this will be an iterative process as ways of working evolve. There is an agreed route map for the development of new ways of working and decision making. A shadow governance arrangement, reflecting the current starting point, is being developed which will be reviewed and refined as further clarity about the new operating requirements and landscape emerges. A series of governance principles underpins the proposed shadow arrangements and the development of further iterations of the governance structure:

- Participation
- Accountability
- Sovereignty
- Subsidiarity
- Professional leadership
- Accessibility

- Good governance
- Collaboration
- Engagement

2.5 Further details on the STP can be found in Appendix A, which is a narrative summary of the second draft STP submitted to NHS England on 21 October 2016. It should be noted that the full STP, which contains a considerable amount of additional technical detail, is still a draft working document and is subject to change.

Observations on the Sustainability & Transformation Plan process

2.6 There is a considerable fit between the STP and the ambitions that have been agreed locally as part of the BHR level devolution work (for example closer integration, enhanced primary care provision, improved prevention). There is a degree of alignment, therefore, with the plans and approaches agreed across BHR and by this Health and Wellbeing Board. The most significant exception concerns its push towards increased provider collaboration across NEL, between Barts and BHRUT in particular, which will see the management arrangements of those Trusts increasingly integrated.

2.7 However, there are a number of national concerns about the STP process which are shared by some partners in the NEL system, which Board members should be aware of.

2.8 There have been ongoing concerns expressed by local authorities across NEL, and particularly by London Borough of Barking and Dagenham, London Borough of Havering and London Borough of Redbridge at the level of engagement of local authorities in the STP process. Notwithstanding that the basis of the BHR contribution is work that has been shaped through good engagement across BHR, nonetheless the pace and complexity of reinterpreting this at NEL level has meant that local authorities have had limited engagement in the final product. NHS England does not require that local authorities 'sign off' the plan, which is a disappointing step in a plan which is intended to address whole system functioning, and is at odds with the devolution process that BHR had embarked on based on our inability to fix system problems by working alone. There has been an effort made by the NEL STP team to address concerns of local authorities, which has been recognised and appreciated by local authorities, but there are fundamental flaws in the process that remain a concern.

2.9 In addition, there has not been full agreement around the financial savings identified by the STP, with outstanding concerns over the system's ability to achieve them in the timescales set out. Many partners, reflecting on the STP geography, share a concern that shifting resources around a system over such a wide patch will disadvantage one or more parts of that system. Moreover, the late attempts to include social care in the financial modelling demonstrate the lack of whole system thinking that underpins the STP, and relegates social care to something that helps to fix the NHS's problems, not an important service in its own right that provides some of our most vulnerable citizens with the support they need to continue their daily lives.

2.10 Whilst there is recognition that the governance arrangements will evolve, there is also concern that not enough attention has been paid in practice to the subsidiarity principle around the governance arrangements. A key principle for Barking and Dagenham, and all BHR partners, is that decision making should lie at the local system and borough level as a starting point (with localities as a core delivery

mechanism), with decisions and approaches taken at a NEL level where this is necessary. There is a concern that as the STP grows, more decisions will flow towards the NEL-level, and early sight of the governance options has reinforced this concern. Elected Members and officers continue to contribute their views in order to get a more workable result.

3 Mandatory Implications

Joint Strategic Needs Assessment

3.1 A public health profile for north east London (March 2016) is being used to help understand the health and wellbeing, care and quality and the financial challenges locally and identify priorities for inclusion in the NEL STP.

3.2 The public health profile for north east London identifies common themes that are also identified with the Barking and Dagenham JSNA, as outlined below:

- According to the updated Index of Multiple Deprivation (2010), Barking and Dagenham continues to be in the bottom 7% of most deprived boroughs. In a population weighted ranking the borough is 8th worst in England.
- In Barking and Dagenham there is predicted to be an increase in population from 203,060 to 223,185 between 2015 and 2020, an increase of 9.9%. The 2011 Census found that the population of children aged 0-4 years had grown by 49% in the previous ten years, the highest growth for this age group in England and Wales. In 2013 the numbers of children under 5 years made up 10% of the population and between the ages of 0-19 made up 32% of the population.
- By the end of March 2014, 10,797 people had been detected with diabetes in Barking and Dagenham, a 6.7% rise on the March 2013 figure (10,260) and a 28.6% rise on the March 2010 figure (8,349). The prevalence of diagnosed diabetes in the borough is 7.3%, higher than the England average of 6.2%. It is estimated that 16% of the total number of people predicted to have diabetes are currently undetected.
- Barking and Dagenham has a significantly higher prevalence of overweight and obese adults when compared with London and is similar to that of England. In 2013/14 Barking and Dagenham had the ninth highest proportion of overweight and obese children in Reception class (26.8%) and the third highest proportion in Year 6 (42.2%) in England. Provisional measurements for 2014/15 indicate that the prevalence of children in reception year that are obese or overweight increased by 1%, while the prevalence of overweight or obese children in year 6 fell by 1.9%,
- Cancer contributes significantly to the health inequalities gap. There are 352 cancer deaths per 100,000 people each year in LBBD, the second highest rate between all London CCGs after Tower Hamlet. This is over 21% higher than the England average of 290 death per 100,000 population. The one year survival rate for all cancers in 2012 was 64%, the lowest in London at 69.7% and 69.3% for England.

Health and Wellbeing Strategy

3.3 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. Many of the emerging themes of the STP are covered in the Barking and Dagenham HWB strategy including prevention; care and support; and improvement and integration.

Integration

3.4 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 include the Barking and Dagenham, Havering and Redbridge: devolution pilot (accountable care organisation).

Financial Implications

3.5 The NEL STP will include activities to address current financial challenges across the health and social care economy. The ambition is to ensure that all NHS organisations are able to achieve financial balance by the end of the five year period of the plan.

3.6 As the STP does not yet include the local authority position there are no financial implications arising from the report.

Legal Implications

3.7 As set out in the NHS Shared Planning Guidance, all NHS organisations are required to contribute to the production of a Sustainability and Transformation Plan. Local authorities and other non-NHS partners are not required to produce an STP, but have been consulted in their development.

3.8 There is currently no proscribed role for Health and Wellbeing Boards to sign off on the final STP.

Risk Management

3.9 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

3.10 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.

3.11 We are meeting with local public and voluntary stakeholders to discuss the plan. We held a successful meeting where partners, lay members and voluntary groups considered the challenges and opportunities of the STP. We have developed a website, http://www.nelstp.org.uk which shares some key points, links and

background information about the STP and draws attention to the newly developed summary plan. We are also seeking to work with the voluntary sector to commission local organisations to engage with local people.

Public Background Papers Used in the Preparation of the Report: None

Other Useful Background Information:

- 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: North East London: Sustainability and Transformation Plan (Draft Submission 21 October 2016)

http://www.nelstp.org.uk/downloads/Publications/NEL-STP-draft-policy-in-development-21-October-2016.pdf

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APPENDIX A

DRAFT- POLICY IN DEVELOPMENT

21 October 2016

North east London: Sustainability and Transformation Plan

Transformation underpinned by system thinking and local action

Contents

Guide to reading this document

- Acronyms used throughout the document are explained in the appendix, page 51.
- We assign specific symbols to each of our six key priorities, introduced on page 6. Where a section addresses a key priority, the relevant symbol is shown in the top right corner of the page.
- Deliverables are outlined at the end of each chapter or section, where applicable, and detailed deliverables are available in the appendix, pages 47-48.

1. Executive Summary

We want people in north east London (NEL) to live happy and healthy lives. To achieve this, we must make changes to how local people live, access care, and how care is delivered**. During 2016, 20 organisations across NEL have worked together to develop a sustainability and transformation plan (STP).** This builds on our positive experiences of collaboration in NEL but also protects and promotes autonomy for all of the organisations involved. Each organisation faces common challenges including a growing population, a rapid increase in demand for services and scarce resources. We all recognise that we must work together to address these challenges; this will give us the best opportunity to make our health economy sustainable by 2021 and beyond.

We have adopted a joint vision:

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

NEL is an area with significant health and wellbeing challenges. Our population is set to grow by 18% in the next fifteen years, and five out of our eight boroughs are in the lowest quintile for deprivation in the UK. Health inequalities are high, with many residents challenged by poor physical and mental health driven by factors such as smoking and childhood obesity. People frequently move around the patch and are highly dependent on secondary care. This makes our challenges unique and places significant pressure on local services.

We have developed a NEL level framework that will ensure every patient receives the same level of high quality care. Our primary ambition is to support local people to manage their own health. On this basis we have built a framework designed to deliver consistent primary care across NEL, promote out-of-hospital services, ensure good mental health, encourage preventative activities and champion interventions which tackle the wider determinants of health and wellbeing. This framework will be guided by the principle of “system thinking and local action” to enable system-wide change, while allowing for local flexibility.

We want our hospitals to provide care that is safe, effective and efficient every time. The majority of our hospitals have underperformed in recent inspections and continue to fail to meet some of the expected standards around waiting times. We want our hospitals to attain a world class reputation for services, and plan to establish this through developing ambulatory care, surgical hubs and streamlined outpatient pathways. This will help us to tackle operational challenges and provide safe and compassionate secondary care.

Providers have a unique opportunity to increase their productivity through collaboration. Cost improvement programmes will no longer be enough to achieve the scale of efficiency required to address our system-wide financial challenge. The STP has given providers the impetus to co-design new opportunities for productivity and service efficiency improvements beyond traditional organisational boundaries. This will give us the strongest opportunity to achieve savings on the scale set out in the Carter Review.

Our vision for better care and wellbeing will be supported by system reform including the development of new and more collaborative commissioning and provider models. Across NEL, we have already started to develop innovative commissioning models (for example capitated budgets in Waltham Forest and East London, WEL) and work is ongoing to explore further opportunities through our devolution pilots (Barking, Havering and Redbridge, BHR and City and Hackney, CH). Our providers are also working differently to ensure their organisational governance and staffing models can support the shift to integrated care and an emphasis on out-of-hospital interventions.

As part of this transformation, we have identified workforce, technology and infrastructure as key enablers which will require investment and development. Without this, we will not succeed in implementing better care and wellbeing for people or a sustainable system-wide position.

Our total financial challenge in a ‘do nothing’ scenario would be £578m by 2021. Achieving ambitious ‘business as usual’ cost improvements as we have done in the past would still leave us with a funding gap of £336m by 2021. Through the STP, we have identified a range of opportunities and interventions to help reduce the gap significantly. This will be aided by Sustainability and Transformation Funding (STF) funding, specialised commissioning savings and potential support for excess Public Finance Initiative (PFI) costs. Significant work has started to evaluate the savings opportunities, particularly on specialised commissioning.

We have developed our governance structures to support the next stages of planning and implementation. Our robust governance structure allows individual organisations to share responsibility while balancing the need for autonomy, accountability and public and patient involvement.

The NEL transformation journey has started. We are committed to meeting all NHS core standards and delivering progress in every priority. Together we will deliver a sustainable health and wellbeing economy across NEL. **It’s a significant challenge, but one we welcome as it provides opportunities to make a real and lasting difference to the lives of local people**.

2. NEL Care, Quality and Wellbeing Challenges

There are a number of challenges NEL is facing from a health and wellbeing as well as a care and quality perspective which are summarised below and on page 5. For a summary of the financial challenges see chapter 7.

Health and wellbeing challenges

Demographics

- There is significant **deprivation** (five of the eight STP boroughs are in the **worst Index of Multiple Deprivation quintile**). Estimates suggest differentially high growth in ethnic groups at increased risk of some priority health conditions.
- There is a significant **projected increase in population** of 6.1% in five years and **18% over 15 years**. This population is also highly mobile, with residents who frequently move within and between boroughs.
- There are significant health inequalities across NEL and within boroughs, in terms of **life expectancy** and **years of life lived with poor health.**

Wellbeing

- NEL has higher rates of **obesity among children** starting primary school than the averages for England and London. All boroughs have cited this as a priority requiring system-wide change across the NHS as well as local government.
- **Health inequalities** remain a significant issue in NEL with diabetes, dementia and obesity all disproportionately affecting people in poverty.
- NEL has generally high rates of **physically inactive adults.**

Long-term conditions

- There is an increased risk of mortality among people with **diabetes** in NEL and an increasing 'at risk' population. The proportion of people with Type 1 and Type 2 diabetes who receive NICE-recommended care processes is variable. Primary care prescribing costs are high for endocrine conditions (which includes diabetes).
- **Cancer screening uptake** is below the England average and emergency presentation is 5% higher than the national average.

Mental health

- With a rising older population, continuing work towards early diagnosis of **dementia** and social management will remain a priority. Two of seven CCGs are not hitting the **dementia diagnosis target.** Right Care analysis identified that for NEL, rates of admission for people aged over 65 with dementia are poor.
- Most CCGs, but not all, are meeting **Improving Access to Psychological Therapies (IAPT) access targets.**
- Parity of esteem has not yet been achieved across NEL.
- Acute mental health indicators in the Mental Health task force report identify good performance, however **concerns have been identified with levels of new psychosis presentation.** Further work is required to quantify and respond to challenges such as **high first episode psychosis rates.**
- There is a **low employment rate** for those with mental illness.

Care and quality challenges

The care and quality challenges outlined below exist across NEL. They are present in some CCGs, but may not necessarily be in all. We recognise there are some areas of excellent care and quality; nevertheless, the challenge remains substantial. The rest of this document presents several solution and plans that will help reduce and ultimately resolve all of our challenges across NEL.

- Two of three acute trusts failing A&E 4hr target waits.
- Two of three acute trusts failing to return monthly 18 week RTT pathway data.
- Two of three acute trusts (six out of seven hospital sites) in special measures after CQC inspections.
- All seven CCGs failing 75% Category A ambulance response times within eight minutes.
- Variation in emergency bed days and GP referral rates across all seven CCGs.

Core Standards

- Inconsistent consultant assessment for emergency admissions across specialities in NEL providers (standard two).
- Inconsistent consultant ward reviews across specialities in NEL providers (standard eight).
- A need to support patient activation and self-care.

7 Day Services / UEC reforms

- Further work is needed to improve the wider determinants of mental health.
- Inconsistent diagnosis rates of dementia in NEL GPs, with 2 CCGs failing to meet the standard
- National Standard began in April 2016 for 50% of people with first episode psychosis to begin evidence-based treatment within 2 weeks. All CCGs/providers are meeting this target.
- Submission made on 16 September, identified £2.2m of funding across 3 years for perinatal mental health across NEL.

Mental Health

- Do not currently meet National Service Model standards for patients with learning disabilities.
- Greater focus required on community and prevention services including dental care, type two diabetes, and breast screening.
- Workforce training required to equip staff with the skills and knowledge to support patients with learning disabilities and autism.
- Need to build capability and capacity within communities to support people with autism and avoid unnecessary hospital admissions.

Learning Disabilities

- CCGs below national average on Patient Survey for success in getting an appointment and ease of getting through on the phone.
- Demand for appointments is rising with GP consultation rates increasing.
- Highly mobile population and high practice list turnover generating further demand.
- Challenge in securing the primary care workforce with example of more than 25% of GPs being beyond retirement age in one borough.

Primary Care

- The increase in births presents a significant challenge to capacity for maternity services.
- There is currently under utilisation of midwifery led care pathways and birth settings.
- There is a lack of continuity of care across the maternity pathway and women's experiences of care are often reported as being poor.
- Variation in benchmarked data of UK perinatal deaths for births across NEL providers.
- Many more women with complex health needs are now becoming pregnant.

Maternity

- Inconsistent patient experience results from Friends and Family Test for A&E, inpatients, maternity and outpatients.
- Inconsistent patient experience results from Friends and Family Test for mental health providers.
- In some areas, only 22-29% of patients are dying in their preferred place of residence.

Patient Experience

- The cancer treatment pathway is very fragmented with many challenges.
- Emergency cancer presentations are 21.1% in NEL (20.6% England average indicates worse survival rates at one year).
- Lower one year survival rate for all cancers across all seven CCGs compared to all survival rates across England.

Cancer

- In cluster comparison of Right Care data, cancer survival is a key area of improvement across NEL.
- Mental health, patient experience, prevention and new models of care are other key opportunity areas for NEL commissioners.
- Potential savings through primary care prescribing:
  - £5-10m in endocrine
  - £3m in respiratory
  - £1-2m in each of CVD, GI and MSK.

Right Care

- Delivery of constitutional standards for RTT, 62 day wait for cancer.
- Resolution of local derogations for certain specialties for example chemotherapy, specialised neurology, NICU.
- Key strategic intervention in NEL is the joint work on neuro-rehabilitation.
- Service reviews for the transfer of cardiac services from UCLH, trauma, and cancer Services.
- NICU capacity.

Specialised Commissioning

- Unable to maintain services; there is a need to recruit and retain to ensure we are able to maintain services in the face of an ageing workforce.
- Over-reliance on agency use.
- A need for the development of new roles/extended scope and skills.
- A need for multidisciplinary teams working to support new care models.

Workforce

There is a need across NEL to:

- Provide the infrastructure necessary to support new, connected, ways of working.
- Provide clinicians with a full view of the patient electronic health record in real time that is editable and supports bookings across services.
- Deliver population health through real time risk stratification scoring.
- Enable patients to view their own care records and to make bookings in to their primary care providers.

Technology

Our key priorities

Whilst each of our economies has a different starting point, on the basis of the NEL-wide challenges set out we have identified six key priorities which need to be addressed collectively.

The right services in the right place: Matching demand with appropriate capacity in NEL

See Better Care (p7)

Our population is projected to grow at the fastest rate in London (18% over 15 years to reach 345,000 additional people) and this is putting pressure on all health and social care services. Adding to this, people in NEL are highly diverse. They also tend to be mobile, moving frequently between boroughs and are more dependent on A&E and acute services. If we do not make changes, we will need to meet this demand through building another hospital. We need to find a way to **channel the demand for services** through **maximising prevention**, supporting self-care and innovating in the way we deliver services. **It is important to note that even with successful prevention, NEL's high birth rate means that we may need to increase our physical infrastructure.**

Encourage self-care, offer care close to home and make sure secondary care is high quality

See Better Care (p7)

Transforming our delivery models is essential to empowering our residents to manage their own health and wellbeing and tackling the variations in quality, access and outcomes that exist in NEL. There are still **pockets of poor primary care quality and delivery.** We have a history of innovation with two of the five **devolution pilots** in London, an Urgent and Emergency Care (UEC) vanguard and a Multispecialty Community Provider (MCP) in development. However, we realise that these separate delivery models in each health economy will not deliver the benefits of transformative change. Crucially, we must **drive a system vision** that leverages community assets and ensures that residents are **proactive** in managing their own physical and mental health and receive coordinated, quality care in the right setting.

Secure the future of our health and social care providers. Many face challenging financial circumstances

See Better Care (p7)

Many of our health and social care providers face challenging financial circumstances. Although our hospitals have made significant progress in creating productivity and improvement programmes, we recognise that medium term provider-led cost improvement plans cannot succeed in isolation.
Our providers need to collaborate on improving the costs of workforce, support services and diagnostics. Our challenge is to create a roadmap for viability that is supported at **a whole system level** with NEL coordinated support, transparency and accountability.

Improve specialised care by working together

See Specialised Services (p22)

NEL residents are served by a number of high quality and world class specialist services; many of these are based within NEL, others are across London. We have made progress recently in reconfiguring our local cancer and cardiac provision. However, the quality and sustainability of specialist services varies and we need to ensure that we realise the benefits of the reviews that have been carried out so far. Our local financial gap and the need for **collaboration** both present challenges to the transformation of our specialised services. We need to move to a more collaborative working structure in order to ensure high quality, accessible specialist services for our residents, both within and outside our region, and to realise our vision of becoming a truly world class destination for specialist services.

Create a system-wide decision making model that enables placed based care and clearly involves key partner agencies

See Governance (p36)

Our plans for proactive, integrated, and coordinated care require changes to the way we work in developing system leadership and transforming commissioning. We have plans to develop accountable care systems (ACS) with integrated commissioning with Local Authorities and capitated budgets. Across NEL, we recognise that creating accountable care systems with integrated care across sectors will require joining previously separate services and close working between local authorities and other partners; our plans for **devolution** have made significant progress in meeting the challenge of integration. New models of system leadership and commissioning that are driven by real time data, have the ability to support delivery models that are truly **people-centred and sustainable** in the long term.

Using our infrastructure better

See Infrastructure (p30)

Delivering new models of primary and secondary care at scale will require modern, fit-for-purpose and cost-effective infrastructure. Currently, our workforce model is outdated as are many of our buildings; Whipps Cross, for example, requires £80 million of critical maintenance. This issue is compounded by the fact that some providers face significant financial pressures stemming from around **£53m remaining excess PFI cost**. Some assets will require significant investment, others will need to be sold. The benefits from sale of resources will be reinvested in the NEL health and social systems. **Devolution** will be helpful in supporting this vision. **Coordinating and owning a plan** for infrastructure and estates at a NEL level will be challenging; **we need to develop approaches to risk and gain share that support our vision.**

3. Better Care and Wellbeing

This is our vision for north east London. To implement this we have developed a common framework that will be consistently adopted across the system through our new model of care programmes. This framework is built around our commitment to person-centred, place-based care for the population of NEL.

Our shared framework for better care and wellbeing

How we will deliver our system vision

Promote prevention and personal and psychological wellbeing in all we do

In the first instance, we aim to prevent illness and promote personal and psychological wellbeing in our population, with a focus on tackling health inequalities. By taking a proactive approach to disease prevention, we are addressing unhealthy behaviours that may lead to serious conditions further down the line and thus reducing the burden on the healthcare system. We are committed to acting on the London Health Commission's research on prevention[1]. Through the sharing of information between the different stakeholders, we will ensure that people who are at risk are targeted and appropriate interventions are put in place before escalation.

We will also promote self management by helping people to identify resources available to them that promote personal health and wellbeing. Motivating people to take ownership of their health is crucial to our system vision. Healthy behaviours such as physical activity and leisure will be promoted through mechanisms such as social prescribing to empower people to maintain their health and wellbeing.

As environmental factors are important in influencing people's health and wellbeing, we will also work with local authorities to promote healthy environments to enhance the quality of life for people in NEL. We have significant health inequalities and deprivation, which presents an additional challenge. By linking in with housing, employment and education, we are better able to address the needs of our population.

Promote independence and enable access to care close to home

In our bid to deliver care close to home, we will use a delivery model to wrap support around the individual. This delivery model will integrate primary, community and social care.

1. People will be well informed regarding the resources and services that are available to them, empowering them to choose the most appropriate pathway for their care, reducing the number of unnecessary admissions and A&E attendances.
2. The foundation of our model is primary care collaboration at scale with hubs, networks and federations treating populations of up to 70,000 people, accessible 8am-8pm, 7 days a week.
3. For people with complex health and social care needs, we will deliver coordinated care to support their health and wellbeing.

Ensure accessible quality acute services

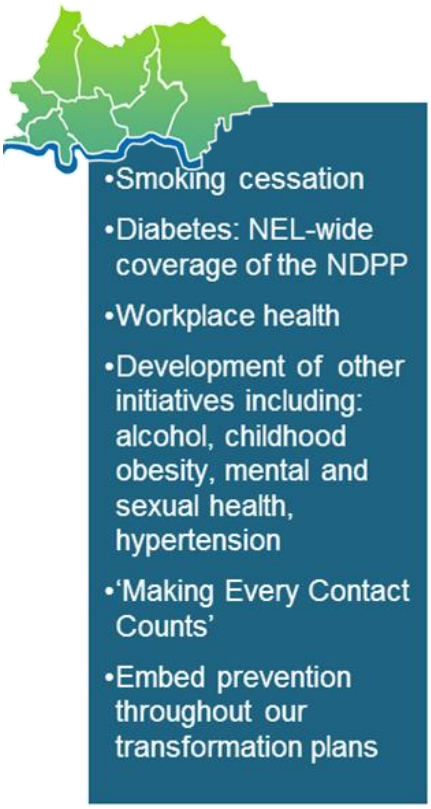
Whilst we need to ensure that people receive high quality care close to home, it is important that when people fall seriously ill or need emergency care, local hospitals provide strong, safe, high-quality and sustainable services. Given the significant population rise, our challenge is to ensure we reduce any unnecessary admissions and attendances, and have best in class length of stay for both planned and unplanned care.

In accordance with the Briggs report, 'Getting It Right First Time', our goal is to identify and administer the correct treatment at the appropriate time to standards. We also want to work towards achievement of the London Quality Standards.

1. We will enhance triage in urgent and emergency care settings so that patients receive the appropriate care at the right time according to the severity of their need. Only patients who require more intensive care are admitted, improving bed capacity.
2. If possible, we will take advantage of appropriate consolidation of planned care services to allow for better outcomes and efficiency. In this way, there will be more effective use of experienced staff and specialised equipment available, enhancing clinical productivity.
3. We want to avoid people spending more time than necessary in hospital. We aim to address this through mechanisms such as early support discharge and greater capability and capacity in the community to help people recover and return home.

[1] The London Health Commission was an independent inquiry established in 2014 by the Mayor of London to examine how London's health and healthcare could be improved for the benefit of our population. In response to its recommendations and unprecedented engagement with Londoners, all London health and care partners (Londoners 32 CCGs, 33 Local Authorities, NHS England (London) and PHE (London) and the GLA) committed to the overarching goal of making London the healthiest major global city and 10 supporting aspirations as laid out in 'Better Health for London: Next Steps'. We remain committed to this shared London vision and working with London partners in achieving this goal and aspirations.

Promote prevention and personal and psychological wellbeing in all we do



We recognise that NEL is unique in its diversity and the strength of its communities. Each part of this plan recognises that the citizen and patient are part of a vibrant neighbourhood community. We will build on our existing local health and wellbeing strategies and public health initiatives to ensure services are built around, and support neighbourhoods, so the places where people live enable good health.

These places may include home, school, the workplace or community settings.

We are committed to acting on **Healthy London Partnership's** research that suggests we can improve the lives of residents and reduce demand on services through enabling people to change their behaviours. This is especially true with smoking, drinking and physical activity.

To encourage people to help themselves and take control of their lives, we will extend social prescribing as one of the ways to recognise the value of neighbourhoods and build on the social capital that people hold, while creating less dependence on services. Staff also need to be supported to be agents of change and 'Make Every Contact Count'. This will include a system-wide focus on smoking cessation.

Wider determinants of health

Working in partnership with and through local authorities and communities in this way allows us to tackle the wider determinants of health (in line with Marmot principles):

"The conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life ... Including economic policies, development agendas, social norms, social policies and political systems" - World Health Organization

Health interventions alone cannot deliver the change required to tackle these factors and enable our population to better manage their own health and wellbeing. We will focus our work across the system to deliver this change:

1) Early years, schools and healthy families

Local government is driving the "early help offer" by integrating health visiting, children's centres, nursery education and other services so children are ready to learn. A stronger focus on nutrition and dental health in the early years will enable a reduction in childhood obesity and unnecessary hospital admissions for dental caries.

The Healthy Schools programme is being driven by schools and is making an impact on healthy choices. Schools are a major contributor in focusing on prevention including raising awareness of addictions to drugs, alcohol and smoking. Working with Child and Adolescent Mental Health Services (CAMHS), schools help to build resilience and mental wellbeing in young children and communities.

As we develop new care models across NEL, we will seek to integrate education services at a neighbourhood level and look at how social prescribing can promote education interventions, as well as aligning the early years offer to those wanting to start families. We aim to widen the roll-out of education interventions to reduce the prevalence of obesity (and Type 2 diabetes) and improve the health and wellbeing of children and young people to exceed Public Service Agreement.

2) Environment, leisure and physical activity

Green open spaces and transport systems that promote physical activity and healthy lifestyles can have a major impact on health and wellbeing. We will continue to work together to expand ways to maximise these resources and encourage their use through social prescribing.

Tailored behaviour change support will address Type 2 diabetes and obesity levels through the National Diabetes Prevention Programme. We will also address hypertension through tailored behaviour changes.

3) Housing and planning

We recognise NEL has a lack of affordable housing, and high levels of overcrowding and homelessness, which will be exacerbated as our population grows. This requires us to collaborate to better influence decisions on new building developments, ensuring health impact assessments are conducted. We already utilise the Healthy Urban Development Unit (HUDU) model to help us access Community Infrastructure Levies (CIL) that guarantee there is funding to build the facilities that ensure our developments support health and wellbeing.

We will also monitor pilots for private sector licencing schemes to understand the impact on housing quality and feasibility to roll out across NEL.

We will ensure health and housing interventions are better aligned by commissioning joint pathways to ensure that those who need support, such as falls adaptations, are able to receive it in a timely manner.

4) Employment

The link between good mental health and wellbeing in employment is well established. We will learn from pilots (planned or underway) across NEL such as wellbeing hubs, which combine health and employment services in one location. We will extend the scope of these hubs to include housing support to address the shortage of affordable housing for our key workers.

One of the success measures of substance misuse services is employment. This principle will be widened to other services. We will explore options for outcomes based commissioning in this area through the BHR Accountable Care System (ACS) work.

There are also opportunities to better link the recruitment challenges we have in health and care services with employability services in the community. This will provide an opportunity to upskill local people to fill local vacancies.

We will work together to create additional internship and apprenticeship opportunities in the health sector for young people, building on the work already underway at Barts Health. As part of the WEL Transforming Services Together (TST) programme, we are specifically exploring new courses to support people into new roles such as physician associates and advanced nurse practitioners.

Multidisciplinary primary care staff will widen access to primary care including an expanded and integrated role for pharmacists and Allied Health Professionals (AHPs).

Through these combined activities, we aim to empower people of NEL, and reduce their dependency on services.

Promote independence and enable access to care close to home

- People will be well-informed about the resources and services that are available, empowering them to choose the most appropriate pathway for their care
- Support the development of primary care collaboration at scale with hubs, networks and federations
- Improve the population mental health and wellbeing
- Enable all people to access a consistent high quality integrated urgent and emergency care

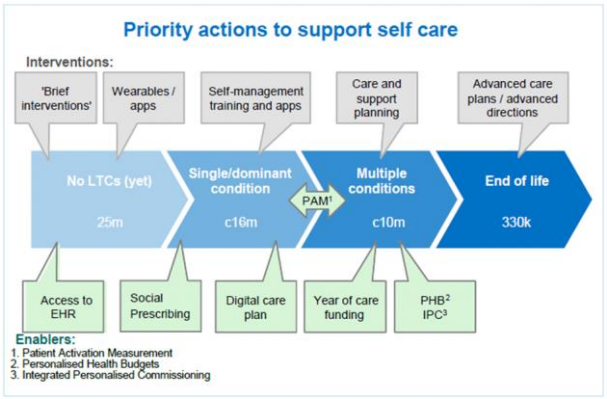
To bring alive the system-wide vision we have for NEL, we have identified a number of service transformation programmes.

Self-care management and patient activation

Self-care happens when patients are 'activated'. We will promote better self-care, not only by providing better information and resources, and easy access to advice (for example pharmacy) but also through the millions of encounters with health and social services in NEL every year.

A crucial enabler of self-care is IT literacy; residents need to have the skills and the access to technology to identify the right information at the right time and use technology as a route to proactive self-management.

Self-care approaches can be used at all stages of ill-health, with the greatest impact likely to be for those who are living with long-term conditions, frailty or at end of life (see national profile below).



Self-care has the potential to reduce activity across the pathway and can be applied for a range of conditions, as such the scope of potential impact is broad.

We intend to further develop and scale up our range of self-care schemes, based on local good practice, as well as evidence from the UK and internationally. These focus on:

- Enhancing patient education on how to self-manage.
- Peer support on a one-to-one or group basis (online or in person).
- Providing alternative care or services that facilitate self-care.
- Proactive management and planning for those with complex needs.
- Social change to promote healthy communities.

An example of how we already provide alternative care or services that facilitate self-care is through social prescribing. Through social prescribing, patients are empowered with the confidence to manage their own health so that they visit the GP only when needed. GPs therefore focus on higher risk patients and the demand for high-intensity acute services will be lowered.

Our social prescribing schemes integrate primary, community and social care, as patients are referred by their GPs to non-medical and community support services to provide psychosocial and practical support. We plan to scale up successful social prescribing schemes across the NEL patch to tackle diseases such as depression. In addition to our evidence based approach, we will also collaborate with the national Social Prescribing Network to guide the scaling-up process.

Screening and early detection

As part of our goal to achieve a step-change in uptake of screening, we plan to address the inconsistency in quality and levels of screening across the NEL patch and spread best practice. We plan to implement the NICE referral guidance, the 'faster diagnosis standard' and also increase early diagnostic capacity to reduce the number of patients with emergency cancer presentation, particularly colorectal cancer.

We are looking into integrating health screening services within our overall system framework. We would like to build on the bowel screening work in Newham, where they have been partnered with a voluntary charity, Community Links. Community Links calls every patient who has not been screened to improve screening rates. We already have local GP endorsement and it has been endorsed by the London Bowel Cancer Screening Hub.

Screening of complex diseases allows early diagnosis and detection, reducing patients with late or emergency presentation. In doing so, we aim to improve outcomes and reduce health inequalities in the long-term; this will support specialist services by reducing complexity of issues earlier.

Healthy living and smoking cessation programmes

Our prevention programmes targeted at reducing the risk factors for avoidable lifestyle conditions such as diabetes and cancer require coordination between primary and community care providers. We will proactively target at risk patients within the groups and work in a multidisciplinary way to provide support and prevent escalation of need. This is a focus of our local plans to develop place-based care models delivered through Accountable Care Systems.

Our current smoking cessation programmes have mixed results across the NEL patch. As a result of this and the impact it has on the health of our population we have targeted this as an initial priority area for our collaborative prevention work. We aim to reduce the number of people smoking by a further 5% by implementing 2021 by improving the interventions we deliver when smokers access other services – such as hospital and mental health services.

We also wish to widen the implementation of healthy living programmes such as the National Diabetes Prevention Programme to achieve Prostrate Specific Antigen obesity and diabetes targets. However, we have found it difficult to demonstrate its impact. To improve its impact, we will expand our mapping of diabetes prevalence and its risk factors to help identify at-risk patients.

Enhancing our primary care programme to deliver equality for people in NEL

The implementation of our common framework for better care and wellbeing, and the development of accountable care systems, require the radical transformation of primary care to lead the progression and development of a successful out of hospital health and care system in NEL.

Key Issues –national and local

At present primary care is under unprecedented strain, nationally demand for appointments has risen about 13% over the last five years, recently there has been a 95% growth in the consultation rate for people aged 85-89.

In response to a BMA survey of 3,000 GPs last year, over half of respondents consider their current workload to be unmanageable or unsustainable; and over half rated their morale as low or very low.

The primary care workforce is aging and facing a 'retirement bubble' which has the capability to put the system under greater strain.

Currently there is little support for struggling GP practices, with an increased number of practices facing closure or serious viability issues.

Significant unwarranted variation in outcomes between practices is a concern, there is little standardisation of practice and collaboration between GPs is very variable.

While patients have access to a number of excellent, high quality primary care services across all CCGs, as a whole, north east London needs to make significant progress to ensure equality and address these gaps.

Within north east London there are examples of how quality improvement initiatives have been used in partnership between commissioners and providers to deliver some good outcomes – e.g. some of the best outcomes nationally under Quality Outcomes Framework (QOF) in Tower Hamlets and City and Hackney and Quality Improvement (QI)initiatives supported by UCLP in Newham, BHR and East London Foundation Trust. We will work together to deliver equality for people in NEL drawing on available best practice.

Our shared vision

Our enhanced primary care offer will ensure that GPs will be able to focus on coordinating care for those with complex problems and long term conditions, providing continuity of care where that is important to patients and outcomes. This will be enabled by a greater role for other clinicians supporting those with minor illnesses. We will actively consider how the creation of new roles supports this.

There will be joint care planning to enable seamless delegation to the extended primary care team and collaboration with social care, freeing up time for patients and helping to deliver person-centred, planned and preventative care. This is already happening – for example through social prescribing models underway across north east London.

Primary care collaboration at scale is a crucial feature of our universal framework and will improve patient care experience.

Patients will also have greater accessibility to GPs, with practices working together in local networks to offer longer opening hours for appointments from 8 – 8, seven days per week, aided by e-consultations.

These are examples of how we are working together to implement the London Strategic Commissioning Framework for Primary Care, delivering proactive, accessible, and coordinated care.

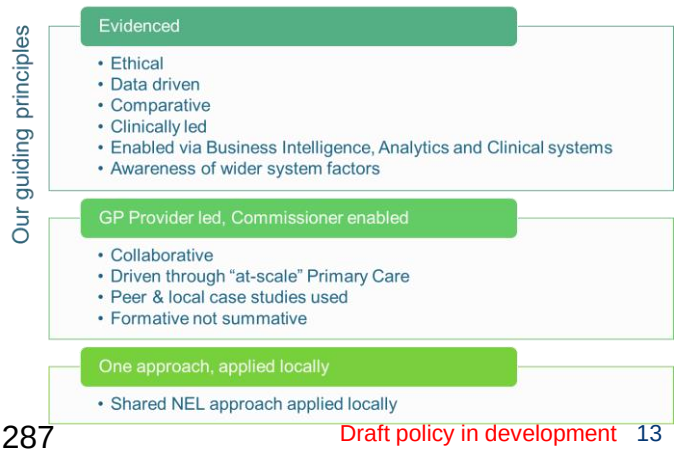
Working together

The change required to realise our common vision for primary care across NEL will be owned and driven locally, but aligned to a common set of principles:

- We need to support the stabilisation of practices in the short term to ensure continuity.
- We will develop and implement a common quality improvement approach, supported by a shared performance dashboard and peer review.
- We will steer this approach through a joint board and utilise Personal medical Services (PMS) reviews to move towards equalisation and support local delivery of the standards of the Primary Care Strategic (SCF)Commissioning Framework.
- We will look at the initiatives that are in place in CCGs to better manage demand through implementing optimal pathways across the primary and secondary care interface and at how we can support embedding this work across NEL.
- We will work together on key enablers that we need to address at a NEL level, with a focus on workforce, digital and estates.
- We need to support primary care collaboration at scale to improve quality and sustainability across practices.
- We will work together to share good practice including around primary care technology.
- We will look at options for adopting a common approach to primary care contracting across NEL.

Across NEL we are developing a programme of primary care transformation that contains three key priorities: quality improvement in primary care, organisational development of at scale primary care providers, and development of the NEL primary care workforce.

To support the delivery of our shared ambition for improving quality we will develop a NEL-wide Primary Care Quality Improvement Collaborative, underpinned by strong, dedicated clinical leadership.



Integrated health and social care

The integration of health and care services to deliver joined up care is a crucial part of our vision for person-centred services across NEL. Progress is at different stages and there are detailed borough level delivery plans in place for 2016-17. These have been developed jointly by CCGs and local authorities in order to meet the requirements of the Better Care Fund (BCF).

Each borough has a detailed action plan and stretching target for improving performance against the Delayed Transfers of Care measure, through better patient flow within secondary care and integrated discharge services. BCF plans also describe how seven days services in community and social care services will be implemented to support safe and timely discharge from hospital.

Across NEL our ambition is to go further in integrating health and social care services in order to implement person centred care models. A key part of doing this will be developing Accountable Care Systems that bring together providers of health and social care services around a single service model and a set of outcomes. There is also commitment to the integration of commissioning functions to support new population based contracting models. Through this work we will meet the national requirement for the full integration of health and social care services by 2021.

We are already making progress on the integration of health and social care at a borough level:

- In City and Hackney the One Hackney provider network uses an alliance contract to support the collective delivery of metrics and outcomes focused on integrating health and social care. This will be continued and expanded under devolution.
- As part of the ACS work in BHR there is a proposal to establish a Joint Strategic Commissioning Board between the three BHR CCGs and LAs. Pending approval this will launch in November 2016.

New models of community care

In order to deliver our vision of person centred care across north east London we will need to radically transform the way in which services are delivered in the community. This will see a shift towards the clustering of services for a geographically defined population across traditional health and social care, and primary and community care boundaries.

This will require providers to work in partnership to deliver care against population based and outcome focused contract models. This will form a core part of the plans for the development of Accountable Care Systems in each economy. It will require local providers to respond by adapting their service models, ensuring their workforce are supported and trained to deliver in new ways, and flexing their own organisation priorities to embrace a new approach to planning and contracting.

The Redbridge Health and Adult Social Care Service (HASS) is an integrated service for health and adult social care, jointly provided by NELFT and the London Borough of Redbridge, was introduced on 1/4/16. The HASS consists of four multidisciplinary community health teams which focus on early intervention and prevention to support people who are over the age of 18 and are vulnerable older people or adults with a learning disability and/or on the autistic spectrum, or a physical and/or sensory disability or a mental health issue.

Integrated urgent and emergency care (UEC)

The NHS Shared Planning Guidance set out three asks for urgent and emergency care systems by 2021:

1. All patients admitted via the urgent and emergency care pathway have access to acute hospital services that comply with four priority clinical standards on every day of the week.
2. Access to Integrated Urgent Care, to include at a minimum Summary Care Record (SCR) clinical hub and 'bookability' for GP content; with mental health crisis response in hospital and part of the Ambulance Response Programme.
3. Improved access to primary care in and out of hours.

In NEL we will work together to meet these asks through the implementation of our common framework for better care and wellbeing, in three different ways:

- At a local level the implementation of our person-centred service models will focus on meeting the eight criteria for Integrated Urgent Care and provide improved access to primary care.
- In BHR the Urgent and Emergency Care (UEC) vanguard will provide a an example of rapid movement towards our planned UEC model, with a fast-tracked timeline for meeting the eight criteria for Integrated Urgent Care.
- Across NEL we will work together to implement a 24/7 integrated 111 urgent care service that connects to clinical hubs at all levels, including dental and pharmacy hubs and CAMHS. We will also implement referral pathways between UEC providers.

The **NEL UEC** network has been reviewing our current emergency departments to evaluate whether they meet the London Quality Standards and UEC facility specifications. In 2016/17 we will be working to meet the four priority seven day standards for vascular surgery, stroke, major trauma, STEMI heart attack, and children's critical care. We will also establish a work programme and road map to meet these same standards for general admissions to achieve 95% performance by 2020, and meet all three of the asks set out above.

High quality integrated mental health care and support

Mental ill health has a very high prevalence in NEL, with inner east London CCGs in particular reporting the highest levels of new cases of psychosis in England, and very high levels of common mental health problems. Progress has been made to improve the quality of care and treatment across primary and secondary care. The STP represents an opportunity for health and care services across NEL to work together with the voluntary sector and communities to further improve health and life outcomes, and manage the projected increase in demand over the next five years.

We will do this by building community capacity and capability, including self-care and prevention and providing integrated primary and community care as close to home as possible. We will support children with and at risk of mental health problems through our Future in Mind commitments. These commitments are contained in each CCGs' Local Transformation Plan (LTP) for CAMHS. The LTPs are currently being refreshed and will reaffirm our commitment to improving the mental wellbeing of our young people, which will have a longer term impact on adult mental health prevalence. We will also improve access to dementia and perinatal mental health services, and services for people when they are in crisis.

Mental health services which **integrate primary, community and social care** support will prevent unnecessary admissions and provide a smooth transition to acute services if needed.

We know that people with mental health problems experience a range of health inequalities, and that there is significant variation in how they utilise wider health and care support. We will ensure that mental health is at the heart of our delivery model for integrated care to address this and improve the physical health of people with serious mental illness. This will also help us improve the mental health of people who are frail, or who have complex and/or long-term conditions.

To develop the excellent mental health services we want for the future, the infrastructure needs to be right. We will work together as provider and commissioner partners to ensure that improving outcomes for people with mental health problems, and developing high quality productive mental health services, are at the centre of our work on new models of care.

We are developing a five year NEL mental health strategy that will enable us to implement the Five Year Forward View for Mental Health. We have completed an analysis of demand and capacity, quantifying the affordability gap over the next five years.

Five areas have been agreed:

- Improve population mental health and wellbeing: In partnership with citizens and the voluntary sector, improve population-based approaches to mental health, tackling the wider determinants, reducing inequalities and managing demand
- Improve access and quality: Deliver 5YFV for mental health and GP 5YFV commitments regarding mental health
- Ensure services have the right capacity to manage increasing demand: Improve capacity and productivity by developing best practice urgent and community care pathways orientated around community and primary care, with a particular focus on psychosis pathways
- Supporting improved system outcomes and value: Integrated preventative mental and physical healthcare to improve outcomes and reduce utilisation of primary care, acute, community health services, social care
- Commissioning and delivering new models of care: Join up whole personal care commissioning, supported by new approaches to contracting to ensure good value, integrated services.

The strategy development addresses the mental health task force 'Must Do's' and we have work underway to:

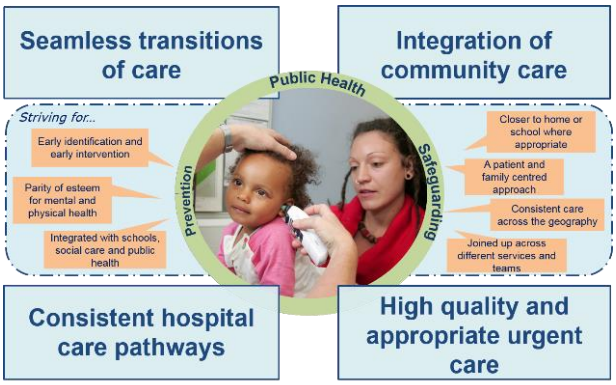
- Develop a Childrens' and Young People's (CYP) community eating disorders service
- Improve access for early intervention in psychosis. NEL has made good progress here and met the national target.
- Develop local suicide prevention plans across all CCGs to reduce suicide rates by 10% relative to 2016/17 baseline.
- Prevent child sexual exploitation.

Across partners we are committed to the principle of parity of esteem, that there is "No Health without Mental Health" and therefore it will be considered across all we do through the STP to improve quality, experience and value.

Integrated children's and young people's care:

Children and young people (CYP) are a key area of focus for NEL, given the high proportion of children and young people in NEL and the anticipated growth over the next five years. Across NEL, we aim to place children and young people at the centre of care and services in health, social care and education. Effective services from early years into adulthood will support this generation, and begin to establish healthy lifestyles and self-care as the norm for future generations. We will utilise national best practice frameworks with emphasis on local implementation and delivery.

The Transforming Services Together (TST) programme has identified four priorities which we will adopt across NEL to deliver this vision, as outlined below:



Realising the benefits in terms of improved care for children and young people will require collaboration between organisations to deliver the transformation that is needed. In accordance with the Children and Families Act (2014), commissioners and local authorities in NEL will develop local integrated care plans and identify opportunities for joint commissioning. Furthermore, local models of coordinated care have been developed, whereby multidisciplinary teams of health, social care and educational professionals collaborate to develop structured care plans, with input from parents, carers and patients. To support this we are starting to implement Integrated Personal Health Budgets for children and young people in parts of NEL from 2016-17 onwards. Care coordinators will proactively arrange and direct care.

We recognise that we need to do more of this across NEL and provide more care in the community, where it is appropriate to do so. The high numbers of referrals to general paediatrics and dermatology for conditions that could better managed in primary care, such as asthma and eczema, will be addressed through our 'patient pathway and outpatients' initiative. We plan to review referral criteria and guidelines for these conditions to identify opportunities to provide care in the community. Evidence-based clinical pathways for these conditions will be co-designed with children and young people and their families to better support them to manage their own conditions, even through the transition to adulthood.

We will work towards meeting London's Out of Hospital Standards for Children and Young People as we make these changes.

We recognise that a child's chances in life start with the conditions of their birth; we will improve maternity services to ensure that every child has the very best start.

The need to provide high quality and appropriate urgent care for children and young people will be addressed through our plans to develop integrated urgent and emergency care models across NEL. In particular through increased access to urgent appointments in primary care outside of core hours.

Integrating CYP plans locally

- Proactive care planning for younger populations with co-morbidities is being introduced in City and Hackney
- In Tower Hamlets community paediatric virtual ward service (Bridge) and a paediatric rapid access clinics have been established
- We are preparing to implement Integrated Personal Health Budgets for children and young people in City and Hackney, Tower Hamlets and Waltham Forest during 20161-7
- In Waltham Forest a 'Children's BCF' will be developed to pool budgets between the CCG and local authority and drive the integration of CYP health and social care services
- In BHR better support is being developed for looked-after children and those leaving care

Localised programmes for learning disabilities

Whilst we have relatively low numbers of people with learning disabilities in inpatient facilities, we know that we do not currently meet the National Service Model requirements for patients with learning disabilities.

The Transforming Care Partnerships in NEL are committed to working together to deliver the national service model. In particular, we will improve the resilience of our providers so that they can support people with learning disabilities who are exhibiting challenging behaviour. In doing so, we aim to reduce inpatient admissions. We will also work to increase access to local housing and education to reduce out of area residential provision.

The unnecessary admission of patients with learning disabilities can be reduced if we strengthen local support with input from primary, community and social care.

Community-based end of life care

We recognise the need for joined up care to ensure a better response from the health and social care systems to sudden, unpredictable or very gradual dying.

Nationally up to 81% of people say they would prefer to die at home. However, locally the majority of patients die in hospital - with four of our CCGs having the highest rate in England, 20% above the English average. This indicates that, among other things, we need to get better at having open conversations with families and patients around end-of-life options.

We plan to build stronger partnerships with social and voluntary sectors to increase the provision of community-based, 24/7 access to end-of-life care services. We will improve personalised care planning through better sharing of patients' preferences and care plans with other providers. We will utilise national best practice frameworks with emphasis on local implementation and delivery.

Our local plans aim to:

- Improve advanced care planning and systems for sharing of records to ensure a patient's preferences are understood by all (including exploring the use of software packages such as Coordinate My Care).
- Provide personalised care for those in last year of life, and increase the number of patients dying in their chosen place
- Improve patient and carer experience in the last year of life, and improve access to advice, support and care
- Improve information gathering on end-of-life-care to support quality improvements
- Ensure confident and competent workforce to support end-of-life-care patients

Transforming sexual health services

NEL experiences high prevalence rates for common Sexually Transmitted Infections (STIs) relative to England and London, including HIV, with some areas diagnosing HIV later than average. In addition three CCGs have above average teenage pregnancy rates and all CCGs have lower-than average prescriptions of long-acting reversible contraceptives (LARC).

We recognise that due to London's array of open access services and NEL's mobile population, a high number of our residents use services in central London. Therefore, we need to work collaboratively at scale to successfully improve access and outcomes. To do this, we are working with the London Sexual Health Transformation Programme (LSHTP), of which NEL is one of six sub-regions.

So far the NEL SHTP has been formed across Newham, Redbridge, Tower Hamlets and Waltham Forest to overcome these challenges by jointly planning and commissioning integrated sexual health services. A number of opportunities have been identified to:

- Improve access to sexually transmitted infections (STI) diagnostics outside the acute environment (for example self-sampling available online and in primary care).
- Improve access and uptake for LARC.
- Create appropriate STI treatment opportunities.
- Develop effective partner notification, which is mindful of the LSHTP model and is fit for purpose for NEL.

We will work together across NEL to ensure that we share good practice and adopt a consistent approach to the incorporation of sexual health services into local integrated delivery models.

Personalisation and Choice

As part of our commitment to deliver person-centred care we will be working with patients and health professionals to expand our offer of Personal Health Budgets (PHB) across NEL. Currently, adults and children in receipt of continuing care packages have the right to ask for Personal Health Budgets, which will help them to meet the outcomes agreed between themselves and their health professionals. PHBs operate within all individual boroughs across NEL but the number of children and adults to whom they are available varies. Changing how we commission services to offer more personalised care, whilst not destabilising services for others, is a complex challenge and individual CCGs will be looking to pilot approaches following consultation. Tower Hamlets CCG is one of the Integrated Personal Commissioning (IPC) 'demonstrator' sites, and, further to an NHS England (NHS E) request for Expressions of Interest in becoming an IPC 'early adopter' site. Newham and Waltham Forest CCGs have confirmed their intention to have a conversation with the national team about potentially making a formal application too.

Integrating beyond health and social care

We also recognise the potential to maximise the use of resources across public services by exploring opportunities beyond traditional health and social care boundaries. At a London level we have confirmed our interest in formally collaborating with the London Fire Brigade on local 'Fire as a Health Asset' initiatives. This will commence with a pilot programme based on a joint assessment of the Fire and Rescue Service initiatives that are likely to have most local impact.

Driving integration through devolution

- Both our devolution pilots in north east London are exploring the potential for integrating health services more closely with other public services.
- City and Hackney is also seeking devolved public health powers to take a more integrated approach to prevention, focusing on tackling the wider determinants of health.

Pathway redesign and best-in-class clinical productivity

To deliver the best outcomes for patients and make the best use of our resources across the health and care system in NEL we must identify and administer the correct treatment at the appropriate time to a high standard.

The importance of these principles have been established through 'RightCare' and in the 'Getting It Right First Time' Briggs Report. These show that we can reduce the need for revision surgery and reduce mortality rates. In this way we can also support the sustainability of high quality and efficient acute services across NEL.

To do this effectively it is important to take a system wide approach, recognising that there needs to be consistent, agreed procedures and guidance in place across the whole pathway to support clinicians in making the right decisions. Under the STP we are launching a NEL-wide clinical productivity programme that for the first time will take a system wide approach to identifying unwarranted variation and implementing effective care pathways.

Utilising benchmarking data to drive clinical productivity

This cross-cutting programme will utilise benchmarking data from RightCare and other sources to identify pathways and areas of spend where there is currently the greatest variation in the quality of care delivered, or the cost of its delivery. This will tell us 'where to look' in order to carry out further focused analysis to understand whether any variation is unwarranted and therefore presents an opportunity to drive out improvements in quality or savings through increased efficiency.

This system wide approach will be led by the north east London Clinical Senate, ensuring that this is a clinically led programme with a clear focus on quality improvement. We aim to learn from existing best practice throughout NEL and utilise this benchmarking approach to encourage its spread and drive greater consistency for patients.

We have agreed a process for identifying and exploring opportunities, which is designed to build on and complement existing work underway across NEL. Crucial to this will be an agreed decision tree to ensure consistent, transparent and appropriate decision making.

Identifying opportunities is only the first step in this process, and we recognise that the design and implementation of the changes required to drive out efficiencies requires collective leadership and commitment. To support this we are developing a NEL-wide approach build around the 'RightCare' Health System Reform approach:

1. A service review – to identify what is driving variation
2. A policy development process - to learn from existing practice and embed this in a deliverable policy
3. A business delivery process – taking learning from the above and translating it into a plan that can be agreed and delivered across the system
4. A programme approach to delivery – to drive through the process and behaviours change required within and across organisations.

Managing demand

Within this approach will be a focus on how we manage demand into the system as our population grows. This starts with our whole system approach to prevention and building healthy communities. It will also focus on learning from the outstanding examples within NEL of primary care clinicians being provided with the tools and information needed to make the correct referral, first time. This can both prevent unnecessary activity entering the pathway and ensure those who really need acute care most urgently get to the right place, sooner.

We are adopting the framework for demand management published by NHS England and will be conducting a review to establish the extent to which each element of the framework is in place and working effectively across NEL.

Pathway redesign

Work is already underway to improve clinical productivity within NEL through more efficient delivery of our outpatient care and optimising each clinical pathway. We plan to manage referrals to secondary care in a more effective way and streamline the referral to treatment process, including diagnostics.

In 2016-17 there is already a particular focus on the following pathways and projects:

- Ear, nose & throat 9ENT), Orthopaedics, Gastroenterology (BHR)
- Ophthalmology, Gynaecology (BHR and WEL TST)
- GP specialist advice service (WEL TST)
- Renal (NEL-wide)

Through our common approach we plan to learn from and build upon these examples to achieve a shift change in clinical productivity across NEL.

City and Hackney have put in place consultant advice lines with The Homerton Hospital for 40 clinical pathways and now have low rates of outpatient referrals. They have improved long term condition care and have low rates of admissions for conditions amenable for primary care.
In areas where we are most challenged we also have a 20% reduction target for face-to-face outpatient appointments over the next five years. This will in part in be enabled by the use of telehealth and other alternative platforms.

Improving the treatment of cancer in community and secondary settings

We recognise that we have much to do to deliver the ambitions outlined in 'Achieving World-class Cancer Outcomes, 2015-2020' written by the National Cancer Taskforce. Aside from reducing incidence through risk factor reduction (addressed earlier in 'prevention and proactive care'), we also need to raise our one year survival from c.65% to the national standard of 75% and also integrate 95% of cancer survivors with after care plans.

We will reduce variation in access and quality of service by implementing whole pathway improvements which has already begun under the leadership of the NEL Clinical Senate.

For better post-treatment care, we will accelerate the delivery of the 'recovery' package, including an agreed after-treatment plan. We will also implement stratified follow up pathways to increase the proportion of patients in long term care programmes.

NEL and north central London also have the poorest delivery of the cancer waiting time (CWT) standards out of the five London regions. By working with the Transforming Cancer Services team (TCST) and the National Cancer Vanguard, we will implement a system-wide programme to deliver sustainable CWTs.

Reduce unnecessary diagnostics

National evidence suggests that 25% of pathology testing is unnecessary and recent audit work in CH revealed that 20% of primary care initiated MRI requests could have been avoided.

Over the next five years, we plan to introduce a rolling programme of work focused on standardising the most requested tests across sites. This will reduce unnecessary testing and improve access to testing when it is most needed. We will give GPs the ability to book people in for tests directly without having to see a specialist where testing is appropriate. IT improvements will allow the sharing of test results between GPs and hospitals to reduce duplication.

Medicines Optimisation

Leading on from the Five Year Forward View, the opportunities for medicines optimisation interventions have been established through a number of national documents, including the GP Forward View and the Carter review. In NEL we recognise the potential value of these opportunities in building a sustainable health and social care system. Central to this is the role of pharmacists and their teams (community, prescribing clinical pharmacists and others across the primary and secondary care system) in improving patient care through pathway redesign, promoting patient empowerment and self-care and efficient use of NHS resources through procurement and reducing waste.

The NEL wide Medicines Optimisation Steering Group has been formed which will explore nine priority programmes, including:

- Promoting self-care, patient awareness and self-management to reduce unnecessary prescribing of medicines available over the counter.
- Developing consistent pathways and medicines usage across NEL for the management of long term conditions.
- Expanding e-prescribing in secondary care and work with other providers to avoid medicines related delayed discharges.
- Developing a pharmacy workforce strategy, to address gaps in primary and secondary care, and expand the role of prescribing pharmacists.
- Developing a common approach to decommissioning / de-prescribing with consistent responses for patients regardless of setting.
- Reviewing and optimising of biosimilar medicines.

Ensure accessible quality acute services for those who need it

- Future transformational planning and impact modelling of:
- Maternity: NEL Maternity Network
- Cancer (Board and Network)
- Surgical hubs
- Diagnostics
- Outpatient pathways: acute level improvement in addition to pathways
- Screening: uptake of national programmes

Through encouraging prevention, self-care and improved care close to home we envision that this will reduce demand. However given the significant population rise, our challenge is to ensure we reduce any unnecessary admissions and attendances, and have best in class length of stay for both planned and unplanned care. The only other alternative would be to increase the total beds across NEL significantly, which would require an additional hospital to be built. This is not practical or realistic.

As with the out-of-hospital components of our service vision, transformation is also required in our secondary care service model to improve patient experience. These are focused closely on the features of the hospital model: streamlined outpatient pathways, urgent and emergency care, ambulatory care, coordinated surgery and provider collaboration. Further details are set out below:

We will reduce long waiting times and unnecessary hospital admissions by making ambulatory care the default setting

To support our vision of urgent and emergency care being delivered in the right setting, we will develop ambulatory care hubs at each hospital. These hubs bring together clinicians and services that focus on the initial assessment and stabilisation of acutely ill patients.

A greater proportion of patients will be able to gain access to emergency consultant care, so patients with less urgent needs can be treated quickly and sent home. Only patients requiring more than 48 hours of care will be admitted to a specialised ward, thereby significantly improving bed capacity and support the flow of patients, which will help meet A&E targets.

Acute care hubs including ambulatory care will support our vision in ensuring that patients are seen at the right place in the right time. They will reduce demand on our secondary providers by ensuring that people are not admitted to hospital unless it is necessary.

Improve the quality of surgery services

We are exploring the creation of surgical centres of excellence at each site. At the moment WEL and Barts Health are more advanced in the stages of planning these changes than BHR and City and Hackney, but there is a commitment to expanding surgical centres of excellence across NEL[1].

Through consolidation of planned care across NEL, we can improve length of stay, reduce referral to treatment times (RTT) and improve clinical outcomes for our patients by standardising surgical offerings across sites. We are exploring the ability for each site to have a 'core' surgical offering, combined with a 'core-plus' set of services where safer procedures can be delivered at a higher volume. A 'complex' surgical offering would be consolidated and available in a few sites to make provision safer and more sustainable.

We are planning for patients to be able to access pre-operative appointments and low-risk surgical procedures at their local hospital, while avoiding long delays and cancellations. They will only travel if they need specialised offerings.

These surgical centres of excellence will operate in networks with strengthened cross-site working and inter-hospital transfer, leveraging the use of any free capacity to deliver emergency surgical interventions without delay. This will support the vision of **providers collaborating** to deliver efficient and high quality care and **will reduce our failure to meet quality measures such as transfer delays.**

Delivering the Seven Day Standard for Emergency Care

Across the NEL Urgent and Emergency Care (UEC) Network we have been reviewing our current emergency departments to evaluate whether they meet the London Quality Standards and UEC facility specifications.

Throughout 2016/17 we will be working to meet the four priority seven day standards (2,5,6, and 8) for vascular surgery, stroke, major trauma, STEMI heart attack, and children's critical care. We will also establish a work programme to meet these same standards for general admissions to achieve 95% performance by 2020.

[1] see: http://www.transformingservices.org.uk/downloads/Strategy-and-investment-case/TST-Part-3-High-impact-changes.pdf

Health commissioners and providers in NEL remain committed to the safe and timely transition of King George Hospital emergency department from a full admitting A&E department to a 24/7 urgent care centre in order to improve the quality and sustainability of acute services. This is in line with the original proposals and public consultation undertaken as part of the Health for north east London programme and the changes ultimately agreed by the Secretary of State.

Our operational plans for 2016/17 provide the foundation on which providers and commissioners will build towards implementing the changes by summer 2019. In order to achieve this, partners across the system will continue to work together to ensure the agreed enabling actions are executed and that the gateway process provides assurance of the required progress.

Our system plans are already delivering improvements and we have identified the following key conditions for successful implementation:

- The Independent Reconfiguration Panel (IRP) recommendations being met, including sustained performance improvement of the emergency pathway.
- Significant capital investment at both Queen's and Whipps Cross Hospitals to support the changes.
- Successful reduction in demand and length of stay at Whipps Cross hospital to create additional bed capacity.
- Effective workforce planning and recruitment to ensure that all clinical areas can be staffed safely
- Clear and effective public communication of the plans for changes, in particular to address the risk that partial closure leads to a bigger shift of activity than currently anticipated
- That the surrounding emergency care system maintains or improves its stability, in particular services at North Middlesex and Princess Alexandra hospitals.

Offer a greater choice of settings for births

We recognise that the projected increase in births is the most pressing challenge for maternity provision in NEL. To reduce the risk of needing interventions in obstetric-led wards and improve capacity management, we plan to offer expectant mothers a greater choice of delivery settings. There is currently under utilisation of midwifery led care pathways and birth settings.

We plan to increase the uptake of midwifery led births and expand home birthing services, in alignment with the National Maternity Review. Newham, Tower Hamlets and Waltham Forest CCGs are maternity choice and personalisation pioneers. Through the neighbourhood midwives pilot we will offer an expanded range of options to local women.

We are also focusing on models of care that allow continuity of care to be the normal offer for all women. With continuity of care, expectant mothers will experience better, safer care with a lower risk of intervention. To that end, we are establishing midwifery model of care pilots at Barts Health hospitals and at Queen's Hospital.

This chapter has focused extensively on introducing our system-wide vision. The remainder of this plan addresses the other critical inputs, including collaborative productivity and enablers, which will need to be simultaneously developed to fully address the NEL wide system challenges.

2016-17 deliverables	By 2021

✓ Continue implementation of TST and finalise ACS business cases in BHR and CH.
✓ Develop 24/7 local area clinical hubs, to be available to patients via 111 and to professionals.
✓ Primary Care:
  ✓ Strengthen federations.
  ✓ Develop a Primary Care Quality Improvement Board to provide oversight.
  ✓ Utilise PMS reviews to move towards equalisation and delivery of key aspects of Primary Care SCF.
✓ Extended primary care access model will be established with hubs providing extended access for networks of practices implementing the Primary Care SCF.
✓ Ensure community-based 24/7 mental health crisis assessment is available close to home.
✓ Active plan in place to reduce the gap between the LD TC service model and local provision.
✓ Establish a NEL cancer board to oversee delivery of the cancer elements of the STP.
✓ Establish a NEL-wide MH steering group and develop a joint vision and strategy.
	✓ New care models operational across NEL.
	✓ Implementation of SCF standards with 100% coverage in line with London implementation timetable.
	✓ Reduction acute referrals per 1000 population through improved demand management and primary / community services.
	✓ Access across routine daytime and extended hours (8am-8pm) appointments within GP practices and other healthcare settings.
	✓ Alignment with NHS E 2020 goals for LD transforming care.
	✓ 95% of those referred will have a definitive cancer diagnosis within four weeks or cancer excluded, 50% within two weeks ("find out faster").
	✓ Provide the highest quality of mental health care in England by 2020.
	✓ Deliver on the two new mental health waiting time standards and improve dementia diagnosis rates across NEL.

4. Specialised Services

- Development of single care models for specialist pathways (renal and cardiology)
- Review community neuro rehabilitation provision
- Earlier diagnosis and more efficient pathways in specialist cancer
- Specialist mental health planning

The provision of specialised services is a key component of the NEL health economy. Patients from across the UK are treated by our providers, and an allocated resource of more than £500m for the NEL population makes up a significant proportion of the income of our five NHS providers.

We need to transform specialised services so that our residents can receive the highest quality when they need complex care, be it at our providers in NEL or at other providers in London.

Given the challenges outlined in this document and the needs of our residents, we are focused on making specialised services a core component of our STP. Whilst we have had past successes in reconfiguring our cancer and cardiac provision across north central and east London, there is a need to address the demand, cost and quality of care challenges for all specialised services.

A number of specialised care issues must be addressed in NEL:

- A number of quality issues exist, including the meeting of waiting time targets.
- There is insufficient preventative action and active demand management.
- There is a predicted financial gap of £36m by 2020/21 due to a growing and increasingly ageing population, new technologies and new treatments. The financial gap is currently being reviewed by NHS E.
- On occasion, patients living in NEL have to travel to providers across London or nationally. While this may be reasonable where services are centralised, it is sometimes caused by capacity issues in local services.

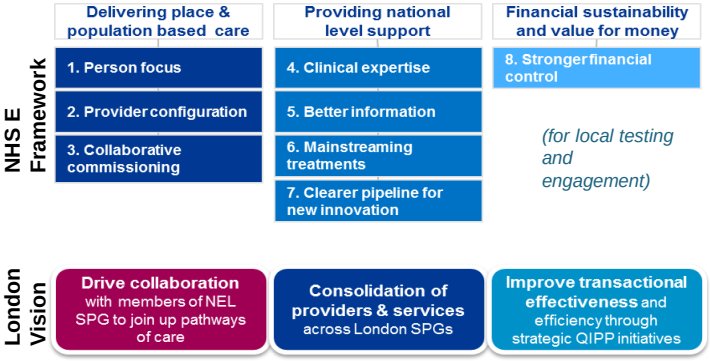
These challenges will require us to work closely with NHS E and other footprints to deliver greater productivity, better services and financial sustainability.

Our approach

The STP provides us with an opportunity to assess how our specialised services are delivered and to formulate a vision for how we expect them to look in the future. Through discussion with key stakeholders, we have subscribed to a vision for how specialised services are delivered:

"Working together to deliver evidence-based, high-quality and affordable specialised services with demand appropriately managed in the community and in secondary care through defined pathways".

We will work with NHS E's strategic framework and the London Specialised Commissioning team's supporting vision:



We have held several workshops with clinicians to identify initiatives to take forward improvements in specialist renal and cardiac care, and are now developing business cases and implementation plans.

Workshops were also held for cancer and neonatal/specialist paediatrics, which enabled some high-level opportunities to be identified. These will be worked up in due course in alignment with NHSE's pan-London programme.

We will also review the provision of neuro rehabilitation services to address pressures on the Royal London Hospital trauma centre.

Collaborative commissioning and planning

One of our key priorities is to work collaboratively with NHS E to develop the best way to commission services in NEL and for NEL residents, including supporting the development of a London wide commissioning structure. This may include developing new contractual arrangements to encourage the management of demand.

As patients in NEL move between other footprints for specialised services, we will need to work closely with other STPs to consider and plan patient flows between us.

We have already had success working with other STPs through the UCL cancer vanguard and the Barts/Royal Free renal collaboration.

We have developed a local delivery governance structure involving specialised commissioners. We will involve CCG and local authority partners in this delivery when considering opportunities to reduce demand for specialised care in the whole-system.

Prevention, demand management and early intervention

Specialised services must align with our preventative, person-centred service model. It is vital that we reduce demand for specialised services by empowering our population to self-manage their illnesses and lead healthy lives. When people develop conditions like diabetes, it is crucial that we screen them early and intervene early; this will ultimately lead to better health outcomes and will reduce pressure on specialist services.

Financial sustainability

Pathways must be reviewed and reconfigured to repatriate patients (where appropriate), resolve quality concerns, and reduce variation.

As part of our productivity programme, quality and cost improvements need to be achieved so that we can deliver specialised services in a financially sustainable manner.

Reaching our objective

To reach our objective of becoming a world-class destination for specialist services with excellent outcomes for residents, we have identified these areas of action:

- Transforming pathways (see next page for NEL 5 priority pathways)
- Drugs and devices efficiencies
- Improving value

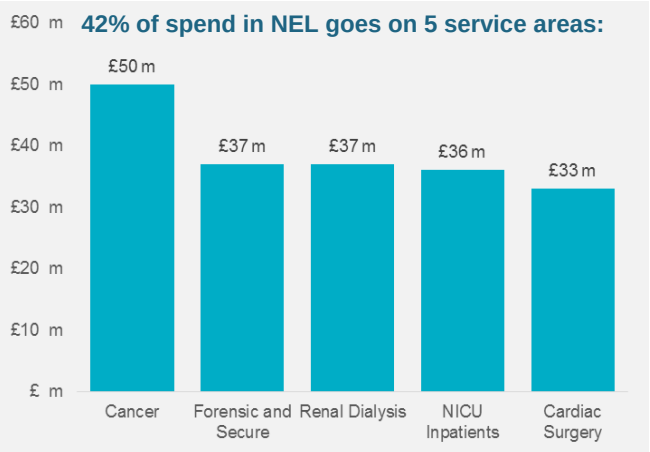
See separate appendices for a detailed chapter on specialist commissioning.

Approach to identifying priorities for Specialised Services

Any changes to Specialised Services need to be driven by evidence, targeted according to impact and feasibility, and aligned with the priorities of Transforming Specialised Services in London (TSSL).

We have identified the following NEL priorities based on five key dimensions:

- The views of the five NEL providers and the clinical senate.
- Variation and opportunities highlighted in Right Care, Commissioning for Value and Commissioning for Prevention analyses.
- Areas of high activity, high spend, and high London market share.
- Known quality issues from existing programmes/reviews.
- Feasibility in addressing the challenges within the timeframe.



The graph above illustrates the proportion of spending by service area, and the table below forms our local priorities which we will continue to align with TSSL.

These priorities will be iterated following further analysis by NHS E, and collaborative clinical planning sessions and involvement of patients to agree on a set of high impact and appropriate initiatives to improve specialised services

Cancer Realising the full benefits of the Cancer Cardiac programme; improving early identification and quicker access to treatments	• Reviewing the implementation of the Cancer Cardiac reconfiguration to ensure the full benefits of the change are being realised. • Earlier identification: enhanced diagnosis and better access to services through implementing stratified pathways in outpatient services. • Enhanced access to smoking cessation services to reduce incidence. • Improved pathways for faster identification and access to treatment, for example paediatric oncology (joint with Great Ormond Street Hospital), haemato-oncology, lung and breast cancers.
Cardiac Integrated pathways, with better prevention, identification, early intervention and access to new treatments	• Develop pathways across primary, secondary and tertiary care in order to strengthen prevention, earlier identification and quicker treatment, therefore reducing demand downstream for specialist services. For example, a primary prevention service could reduce the risk of cardiovascular disease through reducing cholesterol levels and smoking. • Improve case-finding, prevention and treatment for atrial fibrillation; in partnership with UCLP and local primary care leaders. • Ensure innovations in treatment can be accessed in the world-class Barts Heart Centre. New techniques in surgery and use of devices are being trialled to ensure better outcomes for patients.
Mental health Closer integration of specialised and secondary care pathways; repatriation and consolidation	• Step-down and step-up support for patients in forensic mental health services, and admission avoidance for Tier 4 CAMHS will be integrated through bilateral commissioning arrangements and pathways, ensuring the most appropriate use of resources across the MH pathway. • We will also develop an efficient pathway to enable patients with a learning disability in secure mental health settings to be repatriated to NEL and back into the community.
Renal Better community support, and prevention and secondary demand management improving outcomes and reducing demand	• Roll out of the community kidney services across NEL to improve identification of those with or at risk of Chronic Kidney Disease (CKD), improve patient information and education, and integrate care. Where this already exists, these services are delivered through electronic advice clinics and surveillance services offered by the Queen Mary University London (QMUL) clinical effectiveness team. This has reduced the number of new referrals to services. • Better prevention and secondary demand management through blood pressure control initiatives. • Slow the rise in end-stage renal failure by increasing identification or CKD and Acute Kidney Injury (AKI).
Neonatal Addressing the capacity gap to repatriate care and reduce use of inpatient facilities	• Providers in NEL act as neonatal centres for NEL and South Essex pathways; Royal London Hospital (RLH) is the primary neonatal surgical provider. Due to lack of capacity, 30% of neonatal surgical referrals are treated outside the STP footprint. • Admissions of patients are relatively low but there is some potential to reduce admissions through implementing a specialised services review of neonatal hypoglycaemia and jaundice management.

5. Improving Productivity

- Consolidation of corporate services: Developing a flexible and scalable shared services model for our back office functions where this will release value for NEL
- Bank and Agency: Agreeing NEL wide rates of bank and agency pay and a shared bank service
- Procurement: consolidating and standardising key consumables list and moving to NEL wide contracts where feasible e.g. on patient transport
- IT: Maximising opportunities for procuring and delivering services at scale.

Significant productivity opportunities exist across the health and social care landscape in NEL

The evolution of the health and social care landscape in the next two to five years provides opportunities for all partners to create a more productive system in NEL.

To this end, health providers in NEL have begun discussing opportunities for productivity across both clinical and non-clinical areas.

In two areas we have started early work to understand the scale of opportunities: providers have articulated CIP targets over and above the 'do minimum.'

Alongside this, for the following areas of non-clinical work, providers have developed task and finish groups aiming to reduce spend through consolidation and collaboration: pathology, back office finance and HR, procurement and IT.

This chapter gives an overview of the collaborative opportunities and detail of the work providers have recently to develop hypotheses.

NEL has undergone large changes over the past few years and we have recently seen a consolidation of acute providers, resulting in internal collaborative opportunities for the trusts in NEL due to their scale.

The internal productivity savings above the 'do minimum' from providers totals £84m of which £45m comes from Barts, £25m from BHRUT, £8m from ELFT and £6m from NELFT. The main contributors to this are: implementing Carter recommendations; theatre and Length of Stay (LoS) productivity; reducing spend on bank and agency staff; skill mix and establishment reviews; and internal clinical programmes.

There are both clinical and non clinical opportunities for productivity between providers.

1) Clinical productivity opportunities provide the most potential for collaborative gains

There are great opportunities for clinical services across NEL. We see two main stages to realising these benefits:

- Providers want to move all services in NEL to at least the current median in NEL and best in class if possible. This will be facilitated by having a data driven approach to understand drivers in differences across NEL and share best practice.
- In the longer term, a NEL wide clinical strategy developed for each service, where we may see services consolidate on fewer more specialised sites.

2) Non-clinical opportunities across the system are also being explored by providers

Through the STP development, our trusts have come together to assess the prospects for collaboration in non-clinical areas. To date these only consider a few areas of non-clinical spend but early hypotheses suggest that the benefits could total between £21m and £56m in these areas.

We could be making more productive use of estates across NEL. The output of this work will be considered alongside the overall NEL estates strategy development to make sure that they align.

There is also scope in other parts of the NEL health and care system:

1) Commissioners

For true collaboration across NEL, we need to ensure that there is equity in commissioning. This involves a system review on how the seven CCGs and their commissioning support can start working collaboratively to purchase care effectively in the best interests for the NEL population. There are efficiencies to be gained through commissioning at a more strategic level. As commissioning evolves, and an integrated and outcome based approach to contracting is developed as part of accountable care systems, more efficiencies will be released. Multi-year outcomes based contracts will have a significant impact on commissioners, as they will require different skills and potentially fewer resources.

There are further transactional savings which can be made, such as sharing estates with providers or local authorities. Commissioners are working together to identify collaborative productivity initiatives. For example the IT task and finish group mentioned above covers both commissioners and providers.

2) Primary care

Federations are developing across NEL to increase productivity and are saving money through consolidation of back office functions and procurement. There are also schemes planned to reduce variation in referrals and improve prescribing practices across NEL which will enable system-wide savings. Some of the significant opportunities in primary care are explored in the primary care annex.

3) Social care

Each of our eight local authorities has its own transformation programme. Health and social care integration means we can work together to reduce duplication in health and social care through multidisciplinary teams and joint assessments.

Collaborative opportunities

Providers in NEL have developed hypotheses for collaborative opportunities which could save between £21m and £56m

Over the past few weeks, NEL providers have come together to discuss potential opportunities and options for collaboration. This has considered some non-clinical opportunities with intent to explore other opportunities in the coming months. The result is a series of hypotheses about where collaboration could bring system-wide gain over and above internal CIP plans.

In this early phase, the savings hypotheses have been informed by NEL sector experts as well as by examples of other work across the country. Costs which could be addressed by collaboration in the next five years have been considered.

Detailed work will be done in the next phase to test these hypotheses. Internal CIP plans will be explored further as part of this to ensure that best practice is shared amongst providers. This will help support the internal work being done by the trusts themselves. Investments required for implementation will also be reviewed.

Four key priorities, outlined below, have emerged and will require detailed consideration in the next phase of this work.

1) Collaborative procurement

Our procurement leads have identified a number of areas where there may be collaborative opportunities. Initial high-level analysis suggests that our current spend across these categories is £231m.

Areas highlighted for potential collaboration by providers include:

- Soft facilities management: through consolidation of contracts across providers.
- Consumables: through the rationalisation and standardisation of catalogues, and purchasing across all trusts.
- Patient transport and home deliveries: by procuring transport services as a system, suppliers will be able to optimise their fleet over a continuous geography.

Early work suggests an indicative saving opportunity of £5-14m on this spend, equivalent to 2-5% of total spend. This broadly aligns with work the London Procurement Partnership has done with other London areas to find opportunities between providers. While this figure is lower than some estimates (such as the Carter Review), our varied provider landscape suggests our collective buying power may be less than other footprints. We should be able to realise some opportunities in the next 12-24 months as contracts come up for renewal. In other areas, more planning may be needed (and existing contracts either exited or extended) to realise full system-wide benefits.

2) Common bank and agency approach

At present, NEL spends £196m with agencies a year. Whilst each organisation has CIP targets aimed at reducing this, there are further opportunities to reduce this amount through a common approach. In particular, two solutions have emerged:

- Virtual bank: clinical staff from our trusts are doing bank and agency shifts at other trusts in NEL. A virtual bank will allow for a more data driven approach to managing bank and agency staff.
- Common approach with agencies: early conversations suggest that many of the trusts in NEL and our neighbours are using the same few suppliers. A common approach across the providers may provide a stronger platform for negotiations with agencies.

Examples in industry suggest that between 13%-25% could be saved through collaboration, demand management and better use of data. In NEL there is a potential collaborative saving of £4-12m over and above what providers do themselves (2%-7% of spend).

3) Consolidating pathology

NEL currently spends £71m on running pathology services. While some reports, such as Carter's Phase 2 Pathology report, have suggested that 10%-20% of pathology spend could be saved through consolidating services, work has already been begun in this area:

- Barts Health operates a hub and spoke model across its sites, with a major hub at the Royal London.
- BHRUT has consolidated its cold pathology to the Queen's Hospital site.
- The Homerton is currently considering options for its pathology service and will make a decision in 2016/17.

Therefore, our early hypothesis for testing is that NEL could save £2-5m (3%-7%) through consolidating services and making better use of automation. Different models need to be explored; there are precedents that NEL can learn from, such as South West London Pathology and the Kent Pathology Partnership.

4) Back office functions

NEL providers currently spend £113m on central procurement, finance, HR and IT functions. Business cases and projects developed elsewhere suggest that savings of 12%-25% could be realised by consolidating these functions.

In NEL we have realised some collaborative savings, with the Homerton, Barts Health and ELFT using a shared-service centre for payroll, and Homerton and Barts sharing their financial systems. Trusts also have aggressive internal CIP plans with regards to back office functions. We therefore hypothesise that we could save in the region of £5-16m across NEL through collaborative working (5%-14% of total spend) over and above CIP programmes.

A number of factors mean that much of this saving is likely to be realised in years 4-5 as existing long term contracts and ongoing work on the IT strategy across NEL. There are, however, shorter term actions that can be taken in the next 24 months to help maximise savings across the system. These include standardising processes, sharing best practice between the providers and beginning to evaluate potential future operating model options.

Collaboration and timescales

We are committed to exploring options for formal collaboration between providers

Formal collaboration presents an opportunity to achieve the benefits of collaboration in a way which shares risk (and rewards) amongst participating organisations while potentially reducing transactional costs. In addition to productivity advantages, formal collaboration may support the NEL health and care system to accelerate the realisation of clinical productivity gains and implementation of new system models of care. This work should not compromise either the sovereignty of the current providers or the development of future models of care such as ACSs.

Over the coming months, we will evaluate a number of options for formal collaboration between NEL providers

The focus of a NEL collaborative partnership will depend on the scale of ambition and partners involved. Practical arrangements should be as clear and simple as possible with the capacity to incorporate a wide range of schemes within a single approach.

At present, a partnership between the five provider trusts in NEL offers the most practical initial scope for the work in order both to realise economies of scale and to maintain a level of simplicity to ensure the ability to achieve gains in the short to medium term. To this end, we intend to develop a Memorandum of Understanding (MoU) between our five providers to ensure clarity of purpose and senior commitment. In the longer term, other providers such as primary care federations could contribute and share in the benefits.

The initial focus of the collaborative will be on productivity opportunities which offer the greatest potential joint benefit. In the longer term, the scope could develop to include:

- Collaborative productivity (such as procurement and back office functions).
- Infrastructure planning (such as estates and IT).
- Workforce development (such as workforce planning, leadership development and collective training).
- Service planning (such as pathway redesign across NEL).
- Identification of future productivity opportunities and best practice sharing.

We will need to develop an arrangement that is flexible and can develop over time. It is possible that a greater level of collaboration will offer greater benefit in the longer term.

We will need to review various contractual and governance arrangements to make this a reality, which could include a membership model (see South Yorkshire example) or a joint venture model.

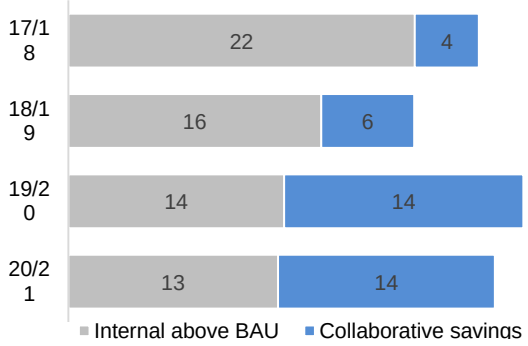
The options outlined would represent a radical shift in our thinking and approach; they are changes that have not been attempted in London yet and therefore we need to proceed sensitively. Through this STP we have the opportunity to develop our shared thinking around collaborative arrangements, and drive forward conversations that will enable the kind of transformative changes that will enable our system to be sustainable.

South Yorkshire may provide a useful guide to achieving the benefits of collaboration, bringing together seven acute providers with a collective turnover of around £3bn. This collaboration has a number of features:

- Driven by strong chief executive-level leadership enshrined in a MoU.
- Collectively funded with a total cost of around £700k per annum.
- Covers clinical and financial improvement, best practice sharing and informatics.
- Has delivered early benefits on shared procurement and shared patient records.

Phasing for realising collaborative savings

Our current hypothesis is that from 2017/18 we can realise non-structural collaborative benefits through benchmarking, sharing best practice and aligning ways of working to ease later implementation. The majority of collaborative savings, however, will be realised in 2019/20 and 2020/21 as some will require structural change and capital investment.



The more complex productivity savings, such as better use of estates and service transformation, are also likely to come in the later years of the STP delivery.

2016-17 deliverables	By 2021
✓ MoU between providers underpinned by principles of collaboration. ✓ Clear timescales for consolidating non-pay contracts. ✓ Joint approach for agencies in place with key suppliers. ✓ Options analysis of collaborative opportunities with pathology across NEL with agreement on a preferred option. ✓ Options analysis for consolidating back office functions completed with a preferred option across the system.	✓ Proactive approach to finding areas for collaborative working in NEL. ✓ Vision for shared back office approach and functions realised ✓ Joint infrastructure and workforce planning across NEL's organisations. This may be done only to inform rather than replace organisation plans. ✓ All trusts in NEL have implemented the findings of Carter and achieved agreed efficiency savings contributing to their financial sustainability.

6. Enablers for change

1. Workforce

Our workforce transformation needs to be based on the specifications of the new service models and through working closely with professional bodies and staff. As the development of these models will take time, we have focused our efforts in year one on establishing the infrastructure required to realise this change and will subsequently develop our approach in response to any changes in the models.

Developing the existing workforce is critical for the scale, pace and sustainability of the required transformation. We envision our 'workforce of the future' will have the capability to fully support the new service models. For example, the workforce should be able to work across integrated health and social care systems.

Our NEL workforce strategy recognises the local initiatives across our footprint, and seeks to agree the overarching priorities we will work on collectively. We have established a Local Workforce Action Board (LWAB) to deliver our vision.

Our current workforce is not sufficient to meet the challenges of growth in demand and system transformation.

- Given the anticipated growth in our local population, we will have varying gaps between supply and demand of professional groups, with a 30% shortfall in nursing and a surge of Specialist Training (ST3-8) doctors completing their training. The cost of meeting demand in primary care is unaffordable and we need to rethink how we work to maximise resources.
- Vacancy rates and turnover rates across secondary care are too high, leading to a strong reliance on temporary staff against a required reduction in agency spend.
- About 17.5% of registered roles in social care lie vacant, illustrating the difficulty of recruiting the right staff. We need to make NEL a better and more affordable place for NHS staff to live in.

Our five key priorities to transform the workforce are outlined below:

1) Retention of existing staff

It is more cost-effective to retain existing staff.

- We will analyse key reasons for people staying versus leaving the workforce through exit data and interviews with long-serving staff.
- We will create an action plan to maximise retention of people who plan to leave in the future and set our five year goals through our LWAB and map any savings.

2) Promoting NEL as a place to live and work

To recruit more staff, we need to make employment within NEL more attractive.

- Jointly market the benefits of living in NEL with social care to attract more health and social care workers.
- Create career opportunities via central recruitment of apprenticeships and engaging with local business partners to develop shared opportunities. Our Community Education Provider Networks (CEPN) can support this engagement with local communities.
- Keeping the NEL health and care workforce healthy.
- Address the lack of affordable housing for our health and social care workforce with the Mayor of London office.

3) Workforce integration to support new models of care

- Our Year One focus will be to standardise and promote new 'integrated' roles such as care navigators.
- We will work with local authorities and schools.
- We will transform the workforce using education initiatives to enable staff to work across all settings. As new service models develop, we will be in a position to train and deploy the required workforce.

4) Whole systems organisation development

There are operational and financial benefits of working together.

- We plan to streamline our HR functions to offer faster mobility of staff across a greater footprint, through integrated HR policies and services (for example central recruitment to support general practice).
- In year one, we will mobilise our LWAB to steer local transformation programmes. We will also break down the education and training barriers for social and health care. We will build on this work to establish clear HR and OD operational models to be deployed.

5) Primary care transformation

To support the shift of patients from hospitals, we need our primary care workforce to have the right skills.

- Our primary care practitioners will need to act as a single point of care coordination to support the new models of care. Furthermore, we will need to provide a shared resource bank to support and build GP federations.
- In year one, we will build on our existing workforce modelling work to assess new roles (e.g. care navigators and physician associates) and new ways of working. We cannot rely solely on creating new roles but need to also consider extending the skills of our existing workforce to work in multidisciplinary teams. This will include supporting the development of community pharmacists and allied health professionals. We will work with local education providers to ensure there is training available.
- We will also develop our CEPNs using the model in place in CH where the CEPN has taken the lead for workforce development planning and implementation. This will ensure they can support us in implementing the new roles and delivery of workforce development initiatives in years two to five.

2016-17 deliverables	By 2021
✓ Local Workforce Action Board. ✓ Development of retention and joint attraction strategies to promote health and social care jobs in NEL. ✓ Standardisation, testing and promotion of new/alternative roles. ✓ Preparation to maximise the benefits of the apprenticeships levy as a sector. ✓ Enhanced workforce sustainability models for our Community Education Provider Networks ✓ Preparation for the removal of bursaries through strategic engagement with HEIs. ✓ Developing the education infrastructure to realise changes with our education providers.	✓ Retention improvement targets set in year one and bank/agency reductions, delivered. ✓ Full implementation of the right roles in the right settings. ✓ Integration of roles at the interface of health/social care. ✓ All staff to have structured career pathways. ✓ Aligned/converged HR processes.

2. Digital enablement

A significant and immediate opportunity exists for digital to transform our current delivery models and seed completely new, integrated models of health and social care. We recognise the strength of both the clinical and financial case for digital and its potential impact in strengthening productivity, providing ease of access to our services, minimising waste and improving care. We will accord priority to quickening the pace of appropriate digital technology adoption, realigning the demand on our services by reducing the emphasis on traditional face to face care models.

Our current technology landscape and its direction

NEL Informatics have defined a series of key themes for the delivery of this vision. This achieves three key themes of shared care records (including care co-ordination), advanced informatics, and patient access. These themes are supported by the delivery of fit for purpose infrastructure.

NEL is signed up to the Healthy London Partnership's aims of access for clinicians and patients. We are fully engaging in the HLP digital programme which is connecting up all health and care systems across London and all of our approaches, although different, are supportive of this London-wide transformation programme.

Our system vision:

1) Shared care records enhancing collaboration

Providers will collaborate with health, social and community care. Systems will therefore need to be interoperable to allow for providers from primary, community, social and secondary care to work together. At present, fully interoperable systems across providers remains a crucial objective; we have already made some good progress towards interoperable systems through the east London Patient Record (eLPR) programme. CH and WEL, have already started to share the health records between GPs and providers. In BHR, interoperability has also made progress and the area is aiming towards a shared care record across sectors.

eLPR links between Barts Health, ELFT, GP practices and Homerton allow doctors in hospitals to view ten pages of GP held patient records and GPs to access discharge summaries, future appointments and test results for radiology and pathology. This is already used around 6000 times a week by clinicians across the system and this usage continues to rise. The integration of other care providers is planned with social care integration starting with LB Newham, LB Hackney and City of London Corporation in 2016/17 and then expanding to other councils in subsequent years. Further care settings are also planned with urgent care and GP out of hours systems to be integrated in 2016/17.

As further organisational systems are joined, the richness of patient information available to all will increase.

2) Patient Enablement

Patients require the ability to view their own health records and book appointments with their GP. This functionality is already available in GP practices across NEL but it is not widely enabled or well communicated. At present, our GPs offer very few appointments online for fear of reducing access to patients without access to technology. Currently all of the NEL CCGs are planning to enhance the availability of current technologies for patient access and booking. Bids for money from the Estates and Technology Transformation Fund (ETTF) are being made to employ extra resources to make a significant effort to increase the use in each CCG. We are also piloting the use of alternative online channels for patients' appointments including the use of video consultations. It is crucial that we share best practice and that this functionality is integrated across NEL.

3) Proactively preventing patients from escalating ill health, and evidence-based interventions

At present, each CCG has separate corporate business intelligence (BI) tools. In the future we will need advanced system-wide analytics to provide insight and prompt early interventions at both the patient and system level to enable informatics driven health management programmes.

There has been some progress on this in WEL where the Discovery Project will be used to enable real time reporting on programmes by providers and commissioners, supporting outcomes-based mechanisms and to use predictive analytics to anticipate individual patient health needs. Detailed work is underway which has seen data feeds established and the system itself created in its initial form. A Community of Interest Company is being created that will hold the application and the data from all sources. This set of capabilities will need to be delivered on an NEL level by 2021.

Looking forward

Our technology roadmap will need to progress according to the key aims of interoperability, patient access and unified analytics. A NEL local digital roadmap has been developed.

2016-17 deliverables	By 2021
✓ Gap analysis: ensuring we have sufficient capacity to deliver on the transformation objectives set out in the other work streams ✓ Further refinement of a common technology vision and strategy for NEL. ✓ Establish detailed implementation plan for 2017/18 and beyond. ✓ Improve delivery against targets in online utilisation, shared care records, e-referrals and e-discharges.	✓ Full interoperability by 2020 and paper-free at the point of use ✓ Every patient has access to digital health records that they can share with their families, carers and clinical teams ✓ Offering all GP patients e-consultations and other digital services ✓ Utilizing advanced/preventive analytics towards achieving population health and wellbeing

3. Infrastructure

Estates are a crucial enabler for our system-wide delivery model. We need to deliver care in modern, fit-for-purpose buildings and to meet the capacity challenges due to a growing population.

Our diverse population is projected to grow at the fastest rate in London (18% over 15 years to reach 345,000 additional people) and this is putting pressure on all health and social care services. Due to rapid population growth, we will need to increase our infrastructure to handle the increased number of GP attendances, outpatient attendances and an estimated additional 7,000 births p.a.

The principles underpinning our emerging strategy are:

- Better health and care outcomes assisted by delivering health and social care delivery from a fit for purpose estate
- Partnership between commissioners, providers, and other public sector organisations to align incentives for estate release and support the delivery of new models of care
- Alongside the estate currently used for health service delivery, there are significant opportunities for out of hospital services to be delivered using local authority estate, such as children's centres and libraries, e.g. BHR CCGs; WF Council, NELFT and WFCCG have mapped the health estate against the wider local authority estate, and are using this to develop local opportunities. Across NEL we want to undertake similar mapping to facilitate the delivery of our strategic aims for the health and care estate.
- Optimising the utilisation and costs of the health and care estate.
- Provide expertise and resource for the development of infrastructure programmes for NEL

We have agreed to a number of priorities for our estates roadmap

- Respond to clinical requirements and other changes in demand to put in place a fit for purpose estate
- Increase the operational efficiency of the estate and maximise utilisation of the core estate
- Enhance capability to deliver; and
- Enable delivery of a portfolio of estates transformation projects (ETTF and provider capital programmes / cross – Boundary Projects).

This covers both clinical and administrative estates, both of which will need to be rationalised.

Priorities for estates

- Implementing the changes required to support new models of care, such as surgical centres of excellence and primary care delivered at scale.

In many places services will be delivered from facilities where **primary care** practices can work together with their own access to on-site diagnostics (e.g. blood testing and ultra-sound). The smallest facility that services will be offered from will cater for 10-15,000 patients.

- Improving estates to deliver quality care.
- Development of urgent and emergency care facilities as part of the KGH reconfiguration of emergency services.

Provider organisations, together with commissioner and partner organisations are working across NEL in an ambitious programme to redesign the delivery of health and social care services across the whole footprint including Whipps Cross, King George, Queen's, St George's, Newham, Homerton and Mile End. Whipps Cross will continue to provide acute services, and major health and wellbeing community facilities are proposed for St George's, Whipps Cross, Mile End and St Leonard's sites.

- Review the location of acute inpatient mental health services to improve productivity and provide more flexibility for the delivery of other services across acute sites in NEL
- Reducing the amount of unoccupied land in NEL.
- Focusing on utilisation, reducing non-patient occupied areas

Summary of indicative investment and savings opportunities
Estimated net capital investment: £500-600m
Annual net savings: £10-20m

2016-17 deliverables	By 2021
✓ Agree common estates strategy and governance and operating model. ✓ Establish detailed implementation plan, which reflects opportunities for savings and investments as well as demand and supply implications resulting from other workstreams and demographic factors. ✓ Achieve a consolidated view for utilisation and productivity, PFI opportunities, disposals, and new capacity opportunities and requirements across the patch. ✓ Explore sources of capital, working with NHS and Local Authorities for example One Public Estate.	✓ Realise opportunities to co-locate healthcare services with other public sector bodies and services. ✓ Dispose of inefficient or functionally unsuitable buildings and sites in conjunction with estates rationalisation. ✓ More effective use of 'void' space and more efficient use of buildings through improved utilisation. ✓ Investment in capital development works to support strategy delivery.

7. Five year affordability challenge

Introduction to NEL finance and activity modelling

Since the 30 June submission, substantial progress has been made on the NEL STP finance and activity plan. However, it is important to note that further work on detailed financial modelling, especially related to solutions and investments, is still planned or ongoing at this stage.

The basis for the financial modelling has been the refreshed draft five year CCG Operating Plan and provider Long Term Financial Model templates. These have been prepared by individual NEL commissioners and providers, all of whom followed an agreed set of key assumptions on inflation, demographic and non-demographic growth, augmented with local judgement on other cost pressure and necessary investments in services.

The individual plans have then been fed into an integrated health economy model in order to identify potential inconsistencies and to triangulate individual plans with each other. Activity has been modelled across NEL utilising the TST model.

Key changes since the June submission include:

- FY17 figures are now based on M6 FOT rather than initial Operating Plans, reflecting a deterioration of the position at BHR CCGs by c£37m and at ELFT by c£6m. The Barts Health forecast remains unchanged with a deficit of c£83m though this might only be achieved through greater use of non-recurrent measures.
- 5YFV investments are now assumed to require funding equal to the entire FY21 STF allocation of £136m. However, since some of these investments are being planned for as part of the solutions, there should still be a remainder of c£26m available for direct financial support. This is significantly less than the £65m assumed in the June submission.
- Specialised Commissioning cost pressures had previously been notified as c£134m in FY21, but this figure has now been revised to c£36m. Since one of the underlying assumptions is that Specialised Commissioning cost pressures will be offset by savings of equal size, this change has no overall net impact.
- London Ambulance Services have been included and treated in the same way as Spec Comm
- For CCGs, historic carried forward surpluses are explicitly considered in the modelling and projections.
- The risk adjustment has been amended to reflect both the changes above and the latest view in relation to the level of risk in the mitigation plans.

The NEL NHS FY21 affordability challenge is £578m in the 'do nothing' scenario to break even

A number of different scenarios, based on different levels of CIP and QIPP delivery have been developed for NEL to identify the potential five year NHS affordability challenge.

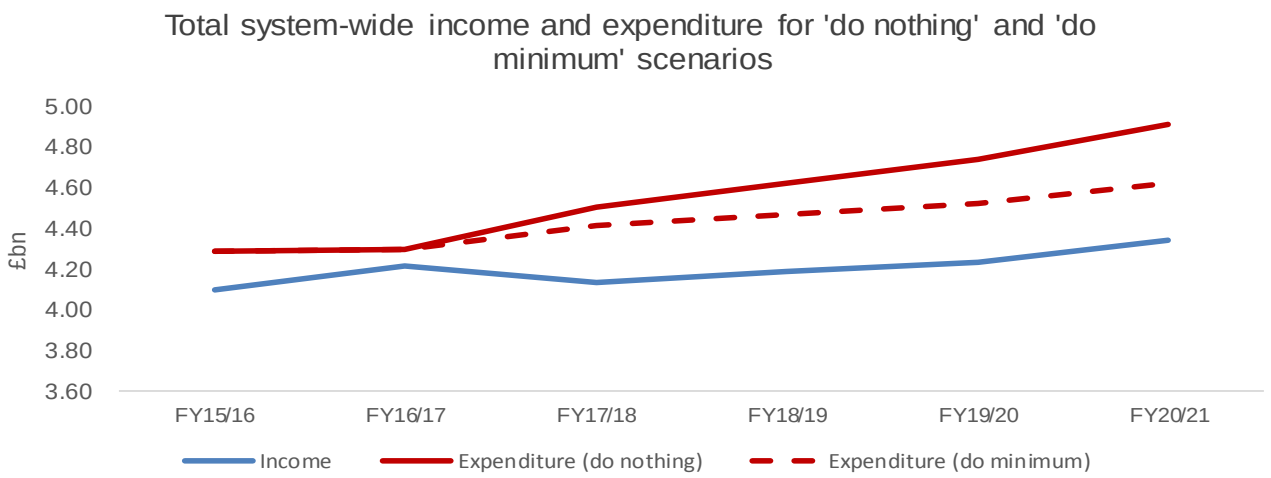
The forecast NEL FY20/21 'do nothing' affordability challenge is c£578m to break even (an additional c£30m to reach 1% surplus target for commissioners). This assumes growth and inflation in line with organisations' plans but that no CIP or QIPP would be delivered in any year.

In the 'do minimum' scenario[1], in which 'business as usual' efficiencies of 2% across all years have been included, the affordability challenge would be c£336m by FY20/21.

Specialised commissioning[2] and any differences in contract assumptions[3] are included in these projections. The local authority position is modelled separately and a summary is available in this chapter.

A number of factors are driving our rising expenditure. One significant factor is our growing and ageing population in line with GLA projections. We also face a non-demographic demand growth which are due to factors such as new technology and increases in disease prevalence; we have assumed that this growth is approximately 1% per year. Pay and price inflation have been assumed in line with NHS I guidance. This results in a steady increase in expenditure over the planning period.

We see significant increases in CCG allocations throughout the planning period. However, Sustainability and Transformation Funding (STF) and some other non-recurrent provider income (such as gains by absorption) primarily affect the initial years and have no impact in the projections of in-year movements from FY18 onwards.

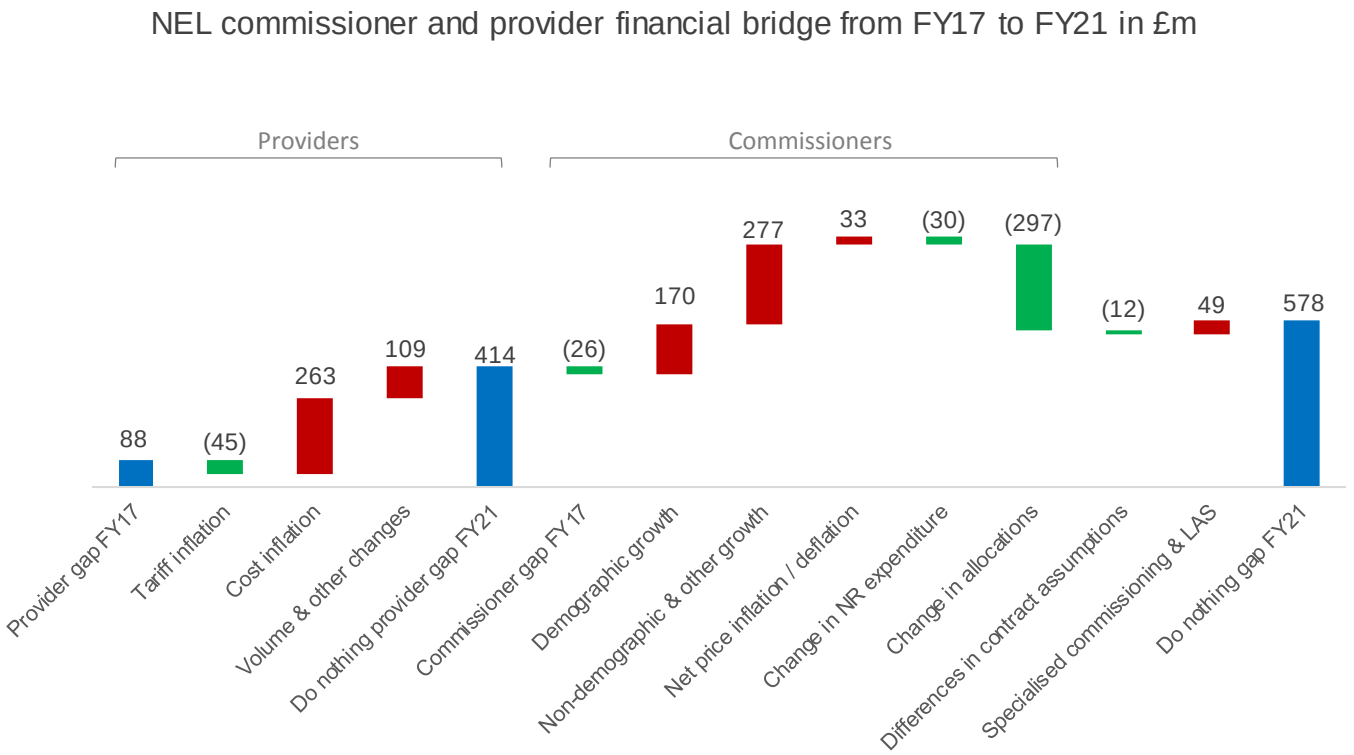


[1] *'Do minimum' scenario includes: no QIPP delivery and only 2%CIP delivery for FY18 onwards*
[2] *Specialised commissioning is estimated to be an additional pressure for NEL.*
[3] *Contract assumption differences between CCG expenditure and provider income are modelled as an additional affordability pressure to the system.*

FY20/21 bridge in 'do nothing' scenario

The forecast NEL provider deficit in FY16/17 is c£88m which will rise by £319m to £414m in FY20/21. NEL CCGs are projecting a £26m surplus (including carried over surpluses from prior years) but CCG allocations uplifts of £297m are not sufficient to offset cost pressures over the planning period. Differences in contract assumptions net out to around £12m by FY21 overall and specialised commissioning and LAS add a £49m pressure, resulting in a total financial challenge of £578m in the 'do nothing' scenario to reach a break even position.

Achieving a 1% surplus target for commissioners increases the gap by another c£30m to around £610m.



Detailed bridges for each organisation which provide further transparency about the assumptions underpinning this scenario and the challenge faced by each individual organisation are found in the finance appendix.

NEL local authority challenge

All NEL local authorities and the Corporation of London have provided financial data for the STP modelling, though it is recognised that further detailed work is required to confirm assumptions and what effect local authority funding challenges and proposed services changes will have on health services and vice versa.

For the 'do nothing' scenario, the combined FY17 Local Authority challenge is estimated as £87m reaching £238m by FY21. This figure is based on adult social care, Better Care Fund, children's services and public health at all local authorities.

If Children Services were excluded from the gap analysis, the gap in FY17 would be estimated as £60m reaching £174m by FY21.

A 'do minimum' scenario, where 'business as usual' savings are assumed, will still need to be completed.

Closing the gap – work stream view

Starting from the 'do nothing' gap of £578m, 'business as usual' efficiencies of 2% provider CIP per year would reduce the affordability gap to £336m. This assumption is aligned with the implied efficiency requirement in the tariff guidance issued by NHS Improvement (NHSI) and with the average assumptions made by the other London STPs. Furthermore, reported average CIP achievement over the last three years has been above 2% for NEL providers.

A number of providers have put forward savings plans slightly higher than 2%; these are valued at £84m and will be realised after FY16/17 and would bring the gap down to £251m. Delivery risks around these targets are being assessed and closely monitored so that a realistic risk rating can be included in our planning. The FY21 position shown in the closing the gap charts below is the recurrent position. For Barts Health, there are challenges evident in achieving the planned level of recurrent CIPs this year even though the FY17 control total remains unchanged at this point and ought to be delivered through greater use of non-recurrent CIPs.

The bridge below includes transformational savings of c£136m from the Hackney devolution pilot, the WEL TST programme, the BHR ACS programme and the Healthy London Partnership (see Better Care section). Some of the targeted savings of these programmes can only be delivered in close collaboration with local authorities and have to be considered in this context.

A further contribution of £38m to closing the gap is expected from collaborative productivity opportunities. Key areas across all categories of provider productivity include bank & agency spend, back office, procurement, theatre productivity, diagnostics, length of stay and pharmacy (see Productivity chapter). Due to the consolidated provider landscape in NEL, some efficiencies that would be considered 'collaborative' elsewhere can be captured by provider internal initiatives in NEL.

Infrastructure savings opportunities of £10m relate predominantly to the acute reconfiguration at KGH, which is reliant on capital investments of c£75m. Additional major capital investment costs relate predominantly to the Whipps Cross site, and while a range of different options are being explored, a solution will have to be found in any scenario. Business cases are under development for both KGH and Whipps Cross.

In addition to risk assumptions already made in organisations' base line plans, a further risk adjustment of 5% has been applied across all solutions.

By FY21 STF is expected to be £136m, which is equal to the amount assumed to be required to deliver the NHS Five Year Forward View investment priorities. However, c£26m of those investments were already included in existing plans.

As a result, NEL projects excluding specialised commissioning and London Ambulance Service (LAS), if additional funding for excess PFI cost (estimated at £53m) can be made available, a surplus of up to £37m by FY21, which would meet CCG business rules.

Selected key sensitivities are illustrated on the next page.

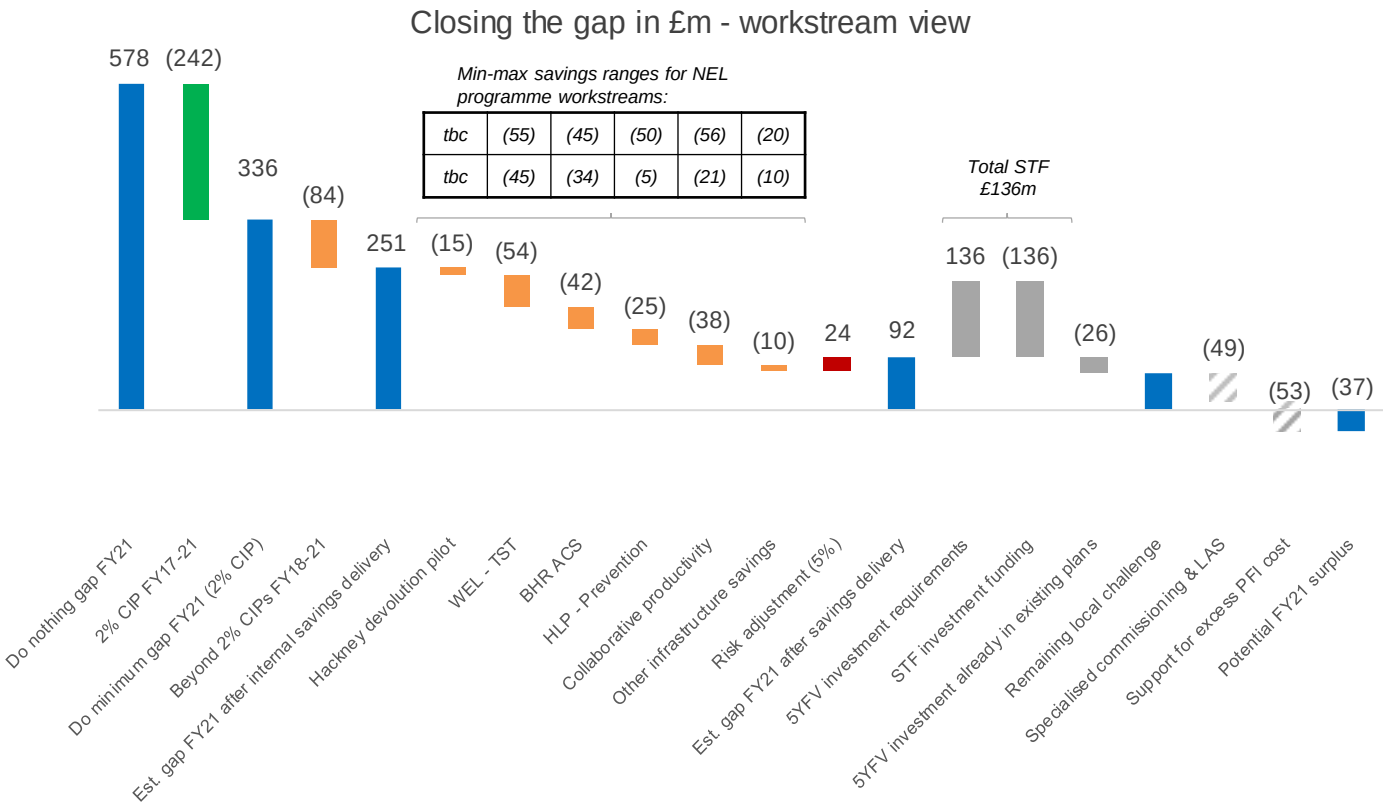


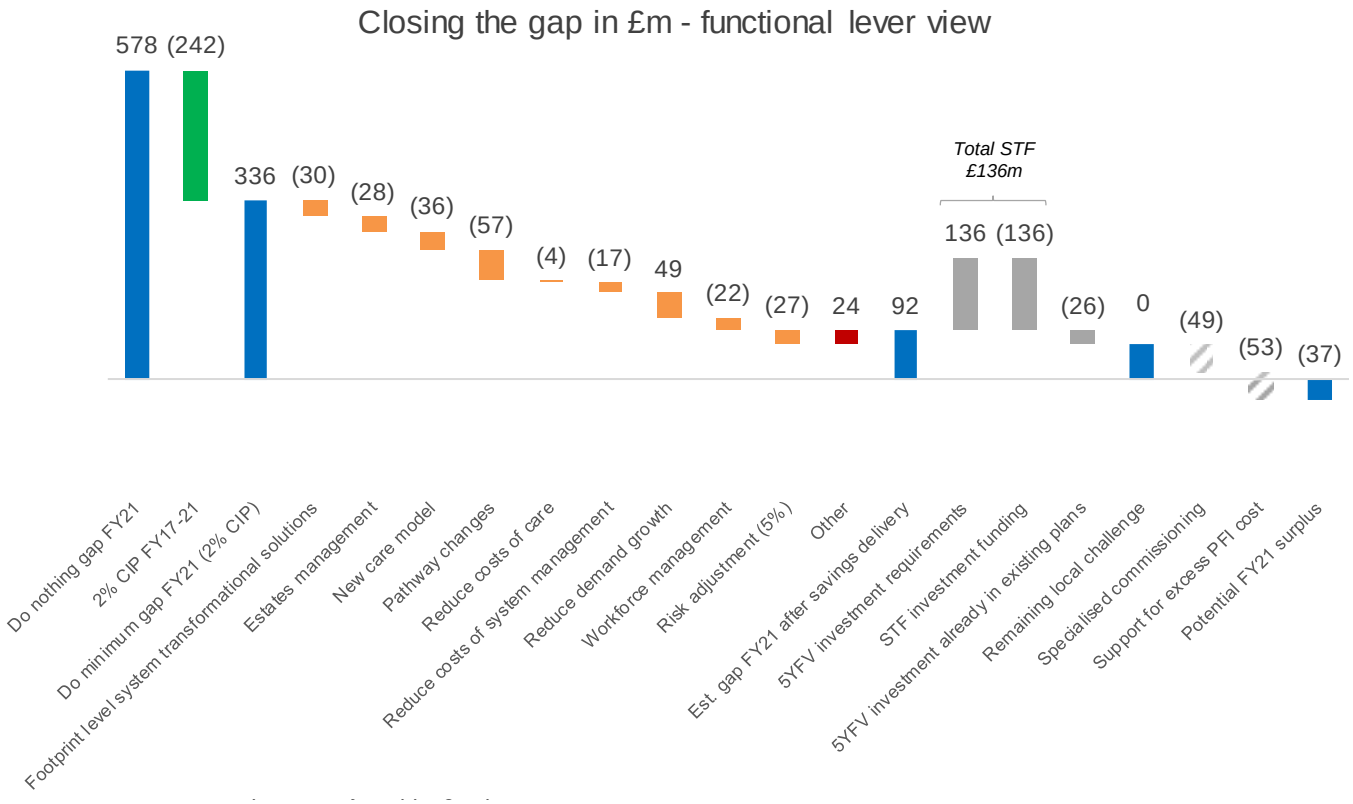
Illustration of selected key sensitivities

It has to be noted that the financial projections are to a high degree dependent on the assumptions made. For example,

- CCGs assumed average demographic growth of c1.5% p.a. Should actual growth be 0.5% p.a. above that level for FY18 to FY21, CCG spend would be around 60m higher in FY21
- CCGs assumed average non-demographic growth, other recurrent cost pressures and investments of 2.2% p.a. Should actual pressures be 1% below that level in FY18 to FY21, CCG spend would be around 122m lower than planned in FY21
- CCGs and local providers assume in total £483m in annual savings by FY21. Should delivery fall short by 25%, costs to the system would be around £121m higher

Closing the gap – functional view

An alternative analysis of how NEL aims to close the gap can be provided by describing and classifying the efficiencies along functional levers that align with the Five Year Forward View.



NEL workstreams in columns, functional levers in rows Values are in £m	2% CIP FY17-21	Hackney devolution pilot	WEL - TST	BHR ACS	HLP - Prevention	Beyond 2% CIPs					Collaborative productivity	Infra-structure	Specialised comm. & LAS	PFI support	Total
						BHR	HUH	ELFT	BH	NELFT					
BAU efficiencies – provider	(242.4)														(242.4)
Footprint system transformation									(10.1)	(1.9)	(18.4)				(30.3)
Estates management			0.0	(15.2)					(2.6)			(10.0)			(27.8)
New care model		(5.0)	(21.8)	(8.8)											(35.6)
Pathway changes		(5.0)	(20.5)	(8.8)		(14.5)			(7.3)		(0.9)				(57.1)
Reduce costs of care			(2.9)								(0.9)				(3.8)
Reduce costs of system mgmt						(6.8)		(0.6)		(1.8)	(7.6)				(16.9)
Reduce demand growth		(5.0)	(8.8)	(8.8)	(25.0)						(0.9)				(48.5)
Workforce management						(3.9)		(6.6)		(2.4)	(8.6)				(21.5)
Other								(1.0)	(24.7)		(1.0)		(49.5)	(53.0)	(129.2)
Total	(242.4)	(15.0)	(54.1)	(41.6)	(25.0)	(25.2)		(8.3)	(44.7)	(6.1)	(38.4)	(10.0)	(49.5)	(53.0)	

Finance outlook

It is recognised that a number of key questions will still need to be answered over the next months:

- Specialised commissioning gap: specialised commissioning is important for all of our providers. To date, the specialised commissioning gap is not yet fully broken down to CCG level and the opportunity analysis is in early stages. NEL recognises the importance of specialised commissioning for its providers. We welcome and will fully participate in the announced specialised commissioning programme initiated by NHS London.
- Organisation level financial balance: the bridges in the finance appendix indicate the magnitude of the financial challenge for each organisation. We appreciate that the impact of business as usual (BAU) and transformation efficiencies on each organisation and their ability to achieve financial balance needs to be worked up in more detail. In parallel, system-wide risk sharing agreements are being explored.
- Monitoring of delivery: operating plans are based on delivery of substantial savings in this financial year. We recognise the associated risks and the necessity to monitor delivery carefully to ensure plans are based on realistic assumptions and are updated without delay once the level of achievement versus operating plans becomes clearer.
- Firming up savings estimates and delivery plans: for several of the NEL work streams, savings estimates and delivery plans will be worked up in greater detail over the next months.

Next steps

The five STPs in London are working jointly to understand the implications of out of area flows on constituent STPs and ensure these implications are accounted for, and where necessary mitigated, in local plans. An approach is expected to be defined by December 2016. This is being taken forward by a working group of the STP finance leads, and will be overseen by the London Strategic Finance Group. Further work is also underway within specialised commissioning, overseen by the London Board and Executive.

8. Governance and system leadership

Developing our system level governance

We established robust governance arrangements to oversee the development of the NEL STP. However, as we move into the next phase of the programme, focusing on the mobilisation and implementation of our delivery programmes, the governance and leadership arrangements are being updated to ensure they continue to remain effective with appropriate membership.

We are developing an authentic governance framework for NEL that recognises the strengths of the sector, as well as its unique challenges. The development of effective and owned governance arrangements represents a significant piece of cultural development across the system that needs to be undertaken inclusively and with an evidenced approach.

This will be an iterative process as the ways of working evolve. We have agreed a route map that involves a consultative and deliberative approach to the development of the new ways of working and decision making. We will establish a shadow governance arrangement, reflecting our current starting point, which will be reviewed and refined as we build our method of working together and there is further clarity about the new operating requirements and landscape.

The shadow arrangements will be put in place at the end of October 2016, with a route plan to implement the refined governance arrangements that will be worked up over the course of the six months, by April 2017.

This timeframe will also enable wider engagement, with local people, clinicians, staff, and other stakeholders to help shape our method of working and governance. The benefit of this approach is that it builds on the existing good foundations and means we will develop robust governance, that is supported by all partners, has been tested and is less likely to unravel at the first challenge.

As part of this route map and consultative approach a Governance Working Group has been established with representation from across NEL including commissioners, providers, Local Authorities, patients and Healthwatch. This group has made significant progress in the development of the shadow governance arrangements, developing a draft Memorandum of Understanding, draft governance structure and initial terms of reference.

Governance principles

The Governance Working Group has agreed a set of governance principles , which are captured in the draft Memorandum of Understanding and summarised below:

Participation: Representation and ownership from health and social care organisations, patients and lay members

Accountability: Define clear accountabilities, delegation procedures, voting arrangements and streamlined governance structures to support continuous progress and timely decision making. Delegation to appropriate groups.

Sovereignty: Recognise the sovereignty of the health and social care partners. Operate in a manner that is compliant with legal duties and responsibilities of each constituent organisation and the NHS as a whole. Ensure alignment with local organisations' governance and decision making processes recognising statutory and democratic procedures

Subsidiarity: Ensure subsidiarity so that decisions are taken at the most local level possible, and decisions are only taken at a system level where there is a clear rationale and benefit

Professional leadership: Demonstrate strong professional leadership and involvement from clinicians and social care to ensure decisions have a robust case for change and support

Accessibility: Ensure complete transparency in all decision making to support the development of mutual trust and openness. Provide the necessary assurance to system partners on key decisions. Collaborative working and information sharing between working groups.

Good governance: Recognise that good system level governance will require robust planning and horizon scanning to align with local governance and decision making processes. However, where unavoidable local organisations will try to be as flexible to support the system level governance

Collaboration: All parties will work collaboratively to deliver the overall NEL STP strategy, in the best interests of the patient

Engagement: Local people will be engaged and involved in the NEL STP governance to ensure their views and feedback are considered in the decision making processes.

Governance structure

Through the Governance Working Group we have developed a shadow governance structure, and initial terms of reference for the key governance forums This draft governance structure is included in the appendices.

This governance structure recognises and respects the statutory organisations, while providing the necessary assurance and decision making capability for system level delivery. In addition to reinforcing some of the existing governance forums (i.e. re-focusing the membership of the NEL STP Board), several new bodies have been added to strengthen the level of assurance and engagement, most notably:

- **Community council** – A council of residents, voluntary sector, councillors and other key stakeholders to promote system wide engagement and assurance
- **Audit Chairs Committee** – An independent committee of audit chairs to provide assurance and scrutiny
- **Finance Strategy Group** - To provide oversight and assurance of the consolidated NEL financial strategy and plans to ensure financial sustainability of the NEL system.

Ongoing dialogue with stakeholders

Continuous and meaningful communications and engagement is central to achieving our vision to transform local health and care services and ultimately delivering the vision set out in the Five Year Forward View.

Our communications objectives are:

- To inform and involve local communities in the development of the STP and our emerging vision for health and care in NEL.
- To clarify and reassure how the STP will interface with other plans that are currently in development or delivery.
- To involve local people in the creation of plans and services.
- To reassure people that this is a piece of work which will make a positive impact on their lives and the quality of care they receive.

Since 30 June we have been engaging partners, including Healthwatch, local councils, the voluntary, community and social enterprise sector, and patient representatives. We have:

- Published the draft and summary versions of the plan on our website and published regular updates
- Offered to meet all MPs which has resulted in a number of 1:1 meetings
- Arranged for elected members from each borough to meet the STP Executive
- Actively sought involvement of the eight local authorities facilitated through the local authority representative on the STP Board.
- Local authorities are represented on the Governance Working Group and have taken part in the workshops developing the plans for transformation (with a Director of Public Health leading the work on prevention).
- Engaged the Local Government Association (LGA) to provide support to individual Health and Well Being Boards (HWBs) to explore self-assessment for readiness for the journey of integration and to a NEL-wide strategic leadership workshop to consolidate outputs from individual HWB workshops.
- Engaged with council and partner stakeholders such as the Inner North East London and Outer North East London Health Scrutiny Committees; Barking, Havering and Dagenham Democratic and Clinical Oversight Group; the eight Health and Wellbeing Boards; Hackney and Tower Hamlets councillors; and Newham Mayor's advisor for Adults and Health
- Met with local Save our NHS, 38 Degrees and Keep our NHS Public campaign groups
- Presented at meetings to discuss specific clinical aspects of the STP, for instance the NEL Clinical Senate; the NEL maternity network and maternity commissioners' alliance; mental health strategy meetings; and clinical workshops on the specialist commissioning of cardiac services and children's services. The proposals have also been discussed at a number of Local Medical Committee forums.
- Discussed the plans with NHS staff.
- Discussed the plans in open board meetings of all our NHS partners and offered opportunities to talk to patients and the public at various annual general meetings and patient group meetings.
- Held wider events on specific topics and developments, e.g. urgent care events involving patients and a wide range of stakeholder such as the London Ambulance Service and community pharmacists.

The feedback has been incorporated into the revised STP for the October 2016 submission.

We published a plain English summary version of the plan on our website www.nelstp.org.uk.

Forward plan for engagement

From 21 October to 31 December, Local Healthwatch organisations will be working together to help us gather and understand the views of patients and communities. Our joint aim is to ensure engagement is relevant to local needs.

Healthwatch organisations will focus on gauging public views on a) promoting prevention and self-care b) improving primary care and c) reforming hospital services; with a local emphasis on:

- The Barking, Havering and Redbridge devolution pilot
- The Hackney devolution pilot
- Transforming Services Together in Newham, Tower Hamlets and Waltham Forest
- The vanguard project in Tower Hamlets

We will continue to offer alternative formats for our communications materials to ensure that we are reaching groups that are sometimes missed.

We will also continue to work with clinicians, local authorities and staff to ensure they are actively involved in the development of the STP.

We will encourage patient involvement at the design stage and work jointly with local authority engagement colleagues to reduce the burden on patients and the public and to help ensure a joined up approach; undertaking formal consultation when required.

We are committed to National Voices' six principles for engaging people and communities that set the basis for good, person-centred, community-focused health and care and will embed these across our work. We also believe that staff have a crucial role to play in the success of the STP. We want them to contribute to its development, to understand and support its aims, and feel part of it, and be motivated by it.

We recognise that any changes proposed in the STP may require public consultation, and are committed to the government's principles for consultation (2016).

We will look at how to tailor consultation to the needs and preferences of particular groups, such as older people, younger people or people with disabilities that may not respond to traditional consultation methods.

Meeting our equalities duties

We are committed to ensuring that everyone has equal access to high-quality services and care, regardless of gender, race, disability, age, sexual orientation, religion or belief. We will work closely with patients, staff, partners and voluntary organisations to help reduce inequalities and eliminate any discrimination within NHS services and working environments. As part of the development of the final STP we will carry out engagement with people who have protected characteristics as set out in the Equality Act 2010. We will conduct equality impact assessment (EIA) screenings to identify where work needs to take place and where resources need to be targeted to ensure all groups gain maximum benefit from any changes proposed as part of the STP.

An overarching EIA screening is underway which will identify which work areas will require detailed EIAs.

9. System reform

Delivering our system vision through local Accountable Care Systems

A common framework to implement our shared vision is being developed. It will focus on sharing the best elements of our local plans in developing local place based accountable care systems.

We have been exploring new service models through devolution pilots and transformative models of care

Each health economy in NEL has been developing innovative service models. In CH and BHR this has been achieved through two of London's flagship devolution pilots. In WEL it has taken the form of a large scale transformation programme, within which sits the Tower Hamlets Vanguard programme

Our shared foundations

We will continue to support these programmes to develop locally, whilst ensuring we collaborate and learn from each other where it makes sense. We recognise the need to take the best from existing plans and scale the benefits. This has enabled us to come to a NEL service model founded on place-based, integrated, person-centred care delivered at scale. We have formed a NEL wide group to share learning.

An ambition for integrated community based service models

Localities, networks or hubs servicing populations of 50,000 will be the centre of integrated working in each area, providing a range of community health and social care services in the local area.

Joint accountability for care

This model requires different providers of health and care services to work together in new ways, removing the traditional barriers joint working. To enable this we will develop local systems whereby all providers are jointly accountable for the delivery of the model. This accountability will be based on a shared responsibility for improving the health and wellbeing of our local population.

New approaches to contracting and payments

To drive this change in accountability we will need new contracting models, underpinned by capitated population based budgets. We will move away from commissioning on a tariff based or block contracting approach, and towards commissioning for outcomes. Whereby payments are made based on the joint delivery of a locally agreed set of outcomes to improve the health of the population.

These systems will ultimately encompass the whole population within an area, although at first specific cohorts may be targeted during the development phase

Centring care in the community

Our systems will be underpinned by the development of high quality primary care at scale, as the foundation of an integrated community based model of care. The extended primary care offer will be supported by integrated locality based multidisciplinary health and social care teams.

We will integrate other core services such as urgent care and mental health into this model, ensuring patients experience seamless care and only need to access acute services when absolutely necessary.

We will use local delivery models to ensure care is delivered in the right setting every time. BHR is also exploring the development of health and wellbeing hubs with a range of services designed to address the wider determinants of good health.

Integrating the commissioning of care

To enable providers to work together in this way we also need to align the way in which we plan and pay for local services. To do this we will fully integrate our health and care commissioning functions between local authorities and CCGs at a borough level.

We will build strong local governance systems across providers and commissioners to oversee the transformation that is required, and establish joint decision making. We will shift the focus from organisation-based performance to system wide population outcome measures.

Our common principles

We will do all of this openly and collaboratively, actively engaging with our local partners, stakeholders, and our population. We will continue to develop these systems locally but actively seek to collaborate across NEL where it makes sense to do so, to make the best use of our combined resources and collectively drive forward the system wide transformation that will enable our local systems to flourish.

We are using the STP as a starting point to achieve system-wide change

This STP provides us with the impetus to harness the best that each area has to offer and move towards a visionary, system-wide transformation plan. This offers us our only opportunity to achieve a sustainable position as a NEL health economy and will enable a healthy population to thrive.

We will collaborate on our common challenges to give ourselves the best possible chance of success, whilst allowing local programmes to flourish.

Making our framework a reality

Plans to implement integrated place-based care were underway before we began working on the STP, with each local health economy pursuing an innovative and ambitious programme to make this a reality.

We will support and enhance these programmes by working together, but they will continue to operate independently with separate programme and governance structures which allow each area the flexibility to best meet local needs.

We are already implementing new models outlined in the Five Year Forward View including a Multi-Specialty Community Provider (MCP)

There are two vanguard programmes already underway in NEL, and each of our delivery models embraces the models outlined in the Five Year Forward View. It is only with new models of care and supporting business models that the full range of benefits from a place based service model can be achieved.

BHR's Devolution pilot

BHR are using the opportunity of devolution to bring health and wellbeing services together as an Accountable Care System. Their devolution business case outlines a plan to achieve fully integrated health, social and other LA services, which places people at the centre and achieves care at scale.

Such changes are only possible with wide-scale system reform, and therefore the plan is underpinned by the pooling of health and social care budgets, commissioning by outcomes, and an ACS business model to enable aligned incentives and collaborative working.

In this model, there will be a single leadership team accountable for both the development of the ACS and BAU activities. An ACS model represents an opportunity to address BHR's current system challenges. This will ultimately work towards the creation of a person-orientated, sustainable service model that will radically improve the lives of local people and build strong resilient communities across BHR.

BHR is already piloting a small scale ACS building on its work as Year of Care and Prime Minister's Challenge Fund (PMCF) pilots - Health 1000 is a specialist primary care provider led by a Consultant bringing together primary care, community health, and social care enabled by a capitated budget. It serves a small population of complex patients with five or more long term conditions who are supported by an integrated team to keep them well and out of hospital.

Health and wellbeing services are clustered in a locality delivery model, with boroughs divided into localities. A new staffing model is being created within localities to deliver health, social care and wellbeing services. This model will extend across traditional organisational boundaries and seek to ensure clinicians and others are able to work in the locality.

WEL – Transforming Services Together (TST)

The TST programme has developed the vision around accountable care systems for Newham, Tower Hamlets, and Waltham Forest.

- Care delivered close to home, with accessible GPs working at scale in collaborative provider networks serving at least 10,000 people. This will be combined with integrated health and social care targeted towards to at-risk patients in their own homes, helping them stay well and manage their illnesses.
- Hospitals that are strong and sustainable with the development of acute care hubs that allow patients to be seen and treated without being unnecessarily admitted. Hospitals will also work in collaborative networks, with hubs which will all deliver a core set of surgeries. Some hubs will also provide specialised surgical procedures.

WEL is taking a phased approach to capitated budgets to ensure payment is outcomes based. Within WEL, Tower Hamlets has developed an Integrated Provider Partnership called Tower Hamlets Together (THT) with Barts Health, East London NHS Foundation Trust, the London Borough of Tower Hamlets and Tower Hamlets GP Care Group, which will provide community health services and form the basis of their ACS. This is a lead provider model where payment is based on outcomes rather than activity. Newham and Waltham Forest are planning a similar model.

CH's Devolution pilot

CH are using the opportunity of devolution to develop a fully integrated commissioning function with governance across the CCG and the two LAs. Through this, they will commission for outcomes and encourage provider collaboration in order to deliver integrated, person-centred care.

They have developed a range of integrated service models and commissioning arrangements already with the help of the Better Care Fund. This includes an integrated care model underpinned by an alliance contract, a health and social care independence team that focuses on intermediate care and reablement, and a fully integrated mental health service.

CH is exploring ways to further improve the quality and coordination of out of hospital services through the "One Hackney" provider network, which uses an alliance contract to support the collective delivery of metrics and outcomes.

A priority will be to implement a single point of access for crises backed up by rapid access to clinical support, and further enhance use of proactive risk stratification and targeted actions for patients who are most at risk of admission.

In addition CH is developing a prevention strategy facilitated by devolution status that is directed towards population health priorities, exploring additional public health powers that can be devolved.

Enabling accountable care

Our ambitious vision for accountable care systems NEL-wide will require fundamental changes to how we work and operate the health and care system. Place-based care requires providers, local authorities and CCGs to work together to focus on outcomes. At present, most providers across sectors are not incentivised to work together to deliver integrated care or rewarded on outcomes.

It will also require a step-change in the development of supporting systems that enable integrated care: digital interoperability, shared care records, fit for purpose infrastructure to host community networks or hubs, and the properly trained and equipped workforce to deliver it.

Provider reform

Our plans for developing Accountable Care Systems that are person-centred can only be achieved through providers collaborating with a focus on patient outcomes and affordable high quality services. Old ways of working, in which providers are incentivised to compete for activity will no longer support this vision. We will need to enhance our collaboration with each other and with our national stakeholders to create a system of incentives that encourages providers to work towards our vision of person-centred care.

Our providers already have significant plans for improving their clinical and collaborative productivity. Overall providers will need to:

- Develop new models for joined up working. With increased accountability they will need to develop inter-organisational forums and processes for decision making and holding each other to account.
- Change their focus towards outcomes: Capitated budgets will require significant provider reform as they reorient their systems towards achieving outcomes rather than activity.
- Collaborate to deliver integrated care: Integrated care will need to depart from traditional, competitive and silo-ed behaviours by focusing on patient pathways.
- Make the most of opportunities for efficiency and productivity through collaboration, for example by sharing back-office functions.

Enablers for change

The delivery of place-based accountable care requires integrated digital systems that can talk to one another, and allow clinicians across providers to access the same information about their patients. Technology can also drive proactive care by utilising risk stratification tools that identify patients who are at high risk and enable actions to be taken to manage their care before they reach crisis.

Our new models of community care will also require estate that can house a range of providers, services, and multidisciplinary teams in the same place to encourage integrated behaviours.

This will also require a new staffing model to deliver health, social care and wellbeing services on a place basis. This model will extend across traditional organisational boundaries and seek to ensure clinicians and others are supported to access the training and development required to work in new ways.

We have grasped the opportunity of the STP to build joint infrastructure, digital and workforce plans that will enable local change by tacking system wide barriers to reform.

Our systems reform 'asks'

Our plans to reform the system through devolution and the development of Accountable Care Systems share common foundations. Taken together they are the vehicle for achieving our system vision, and as such, they are aligned with a common set of 'asks' for the STP as a whole.

Within that, we have collaborated to form a number of 'asks' that will enable our local plans. These 'asks' include:

- **Regulation:** Accountable Care Systems and integrated care require whole system collaboration and a shared commitment to patient outcomes. As such, they need consistent regulatory responses that treat the underlying partners in care as a single system. We request that where plans exist for accountable systems, the system be regulated as a whole, despite the fact that there are distinct underlying organisations.
- **Governance**: We welcome the freedoms of devolution pilots and are looking to achieve similar standards across NEL. We request flexibility on health and social care funding arrangements and freedom to break from existing regulation to deliver system-wide objectives.
- **Accountability:** We request specific governance arrangements that are agreed with the centre between NEL and our accountable care systems. We request that these arrangements cover safety, quality, finance and health and wellbeing standards and outcomes.
- **Commissioning:** We request the ability to develop and account for single system-wide budgets for all health, wellbeing, and social care services.
- **Contracting:** We request that there is flexibility around tariffs and payment mechanisms.

Taking reform forward

The challenge now is to leverage these innovations and collaborate with local, national and regional partners to achieve our system vision of integrated and joined-up-care, where local authorities and NHS providers intentions are aligned.

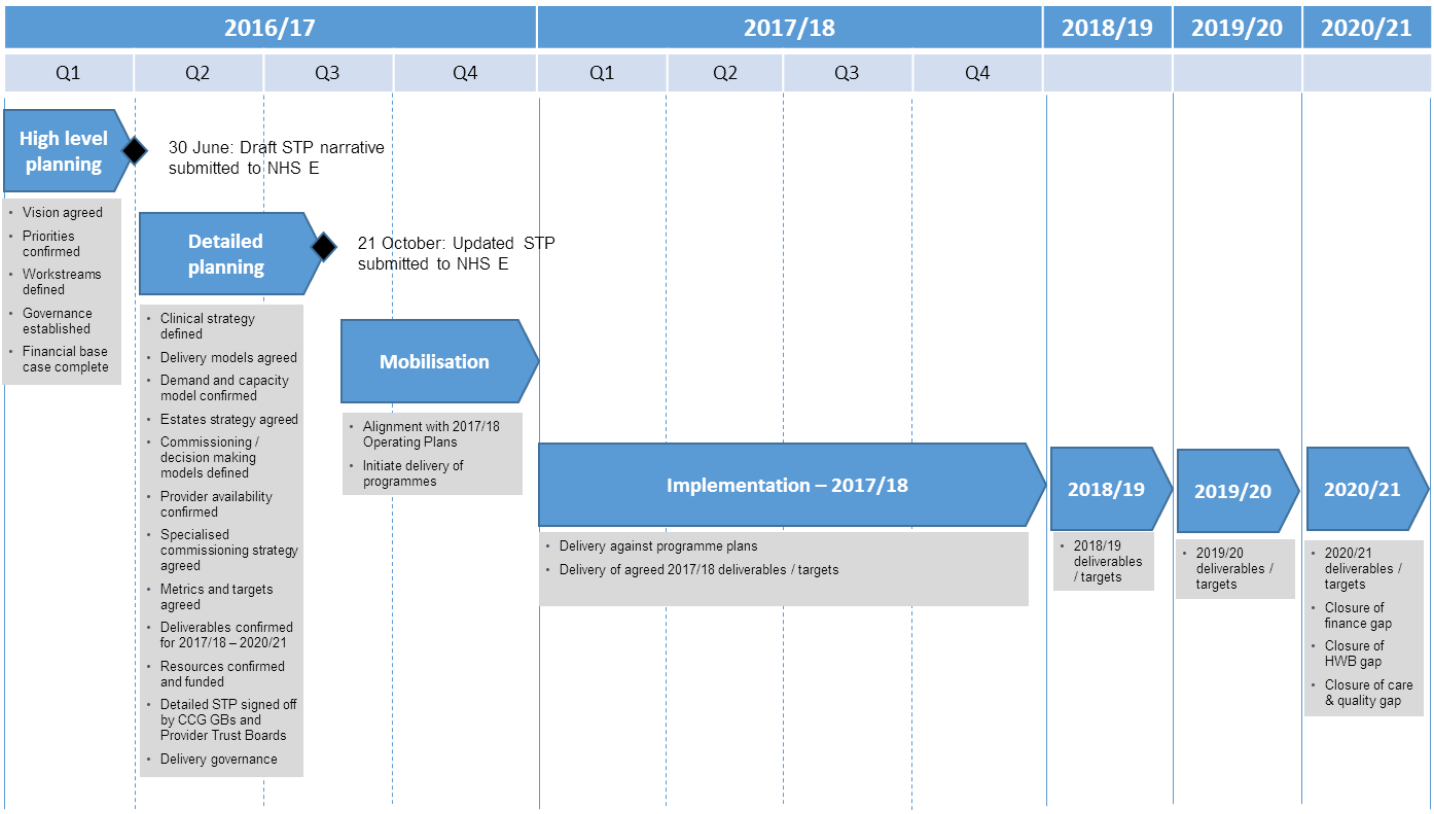
The first step towards this will be through an integrated approach to operational planning for the next two years. By taking an open-book approach to planning together we will start to break down traditional boundaries and build contracts that align to our shared objectives.

We will implement our local Accountable Care Systems over the next four years, at a pace that allows the co-design and engagement that is required to successfully embed change.

BHR are leading the way and plan to establish their ACS in April 2018. The other two systems in NEL will follow their own timetables, learning from the work in BHR, elsewhere around NEL, and across the country.

We will hold each other to account to ensure that we deliver the new models of care needed in north east London.

10. Making progress



Through our STP development process we have developed a delivery structure comprised of four work streams (transformation, productivity, infrastructure, specialised commissioning) and four supporting enablers (workforce, technology, finance, communications and engagement). Senior responsible owners, delivery leads and programme managers have been aligned to each area. The work streams have been mobilised, developed delivery plans and will drive these plans forward.

We recognise that the further development and delivery of the plans in the NEL STP involves significant financial modelling, project management and design resources. It is crucial that we secure these resources in order to ensure an appropriate level of grip and the realisation of benefits. Therefore we have agreed that all partners will contribute resources and have devised a set of core principles that will define the appropriate level of investment from each organisation.

We are implementing a robust benefits management process as part of our delivery plan to ensure that all benefits are clearly articulated, quantified, tracked and realised.

Throughout this process we will continue to ensure that there is total alignment between the five year plans outlined in the STP and the operational plans that our CCGs develop.

Managing risks to the delivery of our plans

We have established a robust proactive risk management process. The key risks to the delivery of our STP that we are currently managing are:

- The plans defined in the NEL STP may not be sufficient to address the full scale of the financial gap.
- The system partners may not able to work together collaboratively to deliver the cross-system plans to close the health and wellbeing, care and quality and financial gaps.
- Due to the size of NEL and the range of stakeholders in this area, it may not be possible to secure the required level of stakeholder buy-in for the STP.
- There may be a legal challenge to the plans outlined in the STP.
- There may be adverse media coverage of the NEL STP, leading to public suspicion of the plans.

11. Our 'Asks'

We will work together to achieve our system vision, but this will require significant collaboration with the centre and a reform of the way our system relates to national and regional bodies. These 'asks' are NEL wide and are reflective of the individual asks that support our devolution pilots.

Governance and accountability	1. In order to achieve our long term aims we need consistent accountability and governance over the next five years. We request clear and specific governance arrangements are developed and agreed between NEL and our accountable care systems, and regulators. We request that these arrangements cover safety, quality, finance and health and wellbeing standards and outcomes. 2. We welcome the freedoms of devolution pilots and are looking to achieve similar standards across NEL. We request flexibility on health and social care joint funding & commissioning arrangements (see note below) and freedom to break with existing regulation to deliver system-wide objectives.
Estates	3. This sector has a number of PFI funded arrangements including the UK's largest hospital development. To succeed, we need to have central support to cover PFI costs above normal levels. 4. We request that we are allowed to retain control of capital receipts and use them for reinvestment, including NHS Property Services, to support the STP vision. 5. We request that there is a support for a consistent NEL approach to estates management across providers/agencies, including NHS Property Services and Community Health Partnerships (CHP) for all relevant assets.
Commissioning and contracting	6. We request that the role of central commissioning arrangements is explored especially in areas of devolution. We want to develop and account for a single system-wide budget for all health, wellbeing, and social care services. 7. We request specific financial risk regulations are modified to reflect the consequences of holding health economy wide budgets and provisions are made for the first two years while transitional arrangements are executed (which may include double running).
Specialised Commissioning	8. We welcome the opportunity for collaboration with NHS E as the main commissioner of specialised services. We request the ability to review and vary clinical specifications/standards and contract for outcomes, in collaboration with NHS E, to improve value for our population.
Regulation	9. For system-wide leadership to work, we need regulators to support system accountability. We request a consistency of response across regulators so that all organisations are able to respond in a way that maximises system gain. For example when dealing with an ACS, we request the system be regulated as a whole, rather than applying a regime to the underlying organisational units. 10. We also request that all regulators and other external bodies work with us to agree the assurance criteria, accountability structures and provision relating to risk mitigation new care models.
Investment	11. To achieve transformation we will need funding, either through STF funding or through other means. We request that we have access to CCG surpluses and the 1% top slice in order to reinvest in achieving our system vision. 12. We request support to devolve some central Public Health England (PHE)budgets to strengthen public health and specialised service transformation in NEL.
Primary Care	13. We request that the resources identified in the GP Five Year Forward View to support the management of workload and care redesign are delegated to the STP to manage. We will establish a new governance arrangement that will involve our GP federations, Royal College of GPs, LMCs and UCLP to oversee the programme to deliver the support and improvements we need at pace.

Note: This is linked with devolution asks regarding amendments to existing statutory provisions, including section 14Z3 of the NHS Act 2006 (as amended by the Devolution Act 2016) to ensure that London CCGs and London local authorities can commission jointly, including via the establishment of a joint committee

12. Conclusion

We have set out a bold plan for how we intend to work together as one system to deliver outstanding health and wellbeing services for all local people. We began by recognising the six key priorities that we needed to answer as a system. A summary of the actions we are going to take in response to each question is set out below:

The right services in the right place: Matching demand with appropriate capacity in NEL

To meet the fundamental challenge of our rapidly growing, changing and diverse population we are committed to:

- Shifting the way people using health services with a step up in prevention and self-care, equipping and empowering everyone, working across health and social care.
- Ensuring our urgent and emergency care system directs people to the right place first time, with integrated urgent care system, supported by proactive accessible primary, community and mental health care at its heart.
- Establishing effective ambulatory care on each hospital site and mental health community based crisis care, to ensure our beds are only for those who really need admission, so we don't need to build another hospital.
- Ensuring our hospitals are working together to be productive and efficient in delivering patient-centred care, with integrated flows across community and social care.
- Addressing demand for acute and mental health inpatient services: streamlining outpatient pathways, introducing new technology, delivering better urgent and emergency care, coordinating planned care/surgery, maternity choice, improving psychosis pathways, and encouraging provider collaboration
- Ensuring our estates and workforce are aligned to support our population.

Encourage self-care, offer care close to home and make sure secondary care is high quality

We have a unique opportunity to bring alive our system-wide vision for better care and wellbeing. We are already working together on a system-wide clinical strategy:

- Transforming primary care and addressing areas of poor quality/access, this will include offering accessible support in localities and hubs from 8am to 8pm (seven days a week), with greater collaboration across practices to work to support localities, and address workforce challenges.
- Investing in mental health, community, Learning Disability, & substance misuse services to improve quality and tackle health inequalities. Ensuring parity of esteem and good mental wellbeing, embedding this throughout all of our services.
- Ensuring our hospitals are working together to be productive and efficient in delivering patient-centred care, maximising new technologies and pathway redesign.

Secure the future of our health and social care providers. Many face challenging financial circumstances

Our health and social care providers are committed to working together to achieve sustainability. Changes to our NEL service model will help to ensure fewer people either attend or are admitted to hospitals unnecessarily (and that those admitted can be treated and discharged more efficiently):

- We have significant cost improvement plans, which will be complimented by a strong collective focus on driving greater efficiency and productivity initiatives. This will happen both within and across our providers (for example procurement, clinical services, back office and bank/agency staff).
- The providers are now evaluating options for formal collaboration to help support their shared ambitions.
- ACS development (CH/BHR devo business cases Oct 31 2016) in development with LA and efficiencies being established.

Improve specialised care by working together

We will continue to deliver and commission world class specialist services. Our fundamental challenge is demand and associated costs are growing beyond proposed funding allocations. We recognise that this must be addressed by:

- Working collaboratively with NHS E and other STP footprints, as patients regularly move outside of NEL for specialised services.
- Working across the whole patient pathway for our priority areas from prevention, diagnosis, treatment and follow up care – aiming to improve outcomes whilst delivering improved value for money.

Create a system-wide decision making model that enables placed based care and clearly involves key partner agencies

We are committed to establishing robust leadership arrangements, based on agreed principles, that provide clarity and direction to the NEL health and wellbeing system, and can drive through our plans.

This will be achieved through genuine partnership between the health system and Local Authorities to create a system which responds to our population's health and wellbeing needs.

Using our infrastructure better

We need to deliver care in modern, fit for purpose buildings and to meet the capacity challenges produced by a growing population. We are now working on a common estates strategy which will identify priorities for FY16/17 and beyond. This will contain a single NEL plan for investment and disposals, utilisation and productivity and managing PFI, with a key principle of investing any proceeds from disposals in delivering the STP vision.

Appendix

Note that further appendices are available in a separate document.

‘Ten Big Questions’

Our approach to the ‘Ten Big Questions’ outlined by NHS E

As a whole, our STP meets the ten questions outlined by NHS E in the guidance. This is done in various sections. A tick below indicates that the section covers the relevant question.

	1. Better Care	2. Specialised Services	3. Productivity	4. Enablers	5. Finance	6. Governance
How are you going to prevent ill health and moderate demand for healthcare?	◀	◀				
How are you engaging patients, communities and NHS staff?	◀			◀		◀
How will you support, invest in and improve general practice?	◀			◀		
How will you implement new care models that address local challenges?	◀	◀		◀		◀
How will you achieve and maintain performance against core standards	◀	◀		◀		◀
How will you achieve our 2020 ambitions on key clinical priorities?	◀	◀	◀	◀	◀	◀
How will you improve quality and safety?	◀	◀	◀	◀	◀	◀
How will you deploy technology to accelerate change?	◀			◀		
How will you develop the workforce you need to deliver?	◀		◀	◀		
How will you achieve and maintain financial balance?	Financial balance runs throughout our plans. It is tackled in-depth in the finance section.					

Key Deliverables

	2016-17	By 2021
Better Care and Wellbeing	✓ Continue implementation of TST and finalise ACS business cases in BHR and CH. ✓ Develop 24/7 local area clinical hubs, to be available to patients via 111 and to professionals. ✓ Primary Care: ✓ Strengthen federations. ✓ Develop a Primary Care Quality Improvement Board to provide oversight. ✓ Utilise PMS reviews to move towards equalisation and delivery of key aspects of Primary Care SCF. ✓ Extended primary care access model will be established with hubs providing extended access for networks of practices implementing the Primary Care SCF. ✓ Ensure community-based 24/7 mental health crisis assessment is available close to home. ✓ Active plan in place to reduce the gap between the LD TC service model and local provision. ✓ Establish a NEL cancer board to oversee delivery of the cancer elements of the STP. ✓ Establish a NEL-wide MH steering group and develop a joint vision and strategy.	✓ New care models operational across NEL. ✓ Implementation of SCF standards with 100% coverage in line with London implementation timetable. ✓ Reduction acute referrals per 1000 population through improved demand management and primary / community services. ✓ Access across routine daytime and extended hours (8-8) appointments within GP practices and other healthcare settings. ✓ Alignment with NHS E 2020 goals for LD transforming care. ✓ 95% of those referred will have a definitive cancer diagnosis within four weeks or cancer excluded, 50% within two weeks(“find out faster”). ✓ Provide the highest quality of mental health care in England by 2020. ✓ Deliver on the two new mental health waiting time standards and improve dementia diagnosis rates across NEL.
Transforming Hospital Services	✓ Establish joint vision for surgical hub model across NEL. ✓ Establish midwifery model of care pilots at Barts Health and Queen’s Hospital (community hubs are already in place at Homerton). ✓ Midwifery services will be reorganised to ensure that women can be offered continuity of care and improved choice for each part of the maternity pathway. ✓ Increase numbers of women giving birth at home and in midwifery-led birth centres – with new midwifery-led unit opening at RLH. ✓ Develop a clear roadmap for the safe transfer of our existing patients from KGH and ensure that care outside of the hospital will be resilient to support this transition. ✓ Begin implementing full ambulatory care model on all Barts Health sites.	✓ Implemented phase 2 and 3 7DS standards. ✓ Establish surgical hubs at each hospital site that work together in a network. ✓ Midwifery services will be reorganised to ensure that women can be offered continuity of care for each part of the maternity pathway. ✓ Community care hubs will be established with full IT integration to allow seamless communication across the maternity pathway. ✓ Safely complete King George Hospital’s changes.
Productivity	✓ MoU between providers underpinned by principles of collaboration. ✓ Clear timescales for consolidating non-pay contracts. ✓ Joint approach for agencies in place with key suppliers. ✓ Options analysis of collaborative opportunities with pathology across NEL with agreement on a preferred option. ✓ Options analysis for consolidating back office functions completed with a preferred option across the system.	✓ Proactive approach to finding areas for collaborative working in NEL. ✓ Vision for shared back office approach and functions realised ✓ Joint infrastructure and workforce planning across NEL’s organisations. This may be done only to inform rather than replace organisation plans. ✓ All trusts in NEL have implemented the findings of Carter and achieved agreed efficiency savings contributing to their financial sustainability.

	2016-17	By 2021
Specialised Commissioning	✓ Agreed service priorities governance structure for the programme. ✓ Understand of the gap and size of the opportunities. ✓ Agreement as to level of commissioning for each service (national, London, local). ✓ Governance structure for managing any new commissioning arrangements in place. ✓ Plans in place for redesigning pathways and services by 2020/21.	
Workforce	✓ Local Workforce Action Board. ✓ Development of retention strategies ✓ Standardisation, testing and promotion of new/alternative roles. ✓ Enhanced workforce modelling based on new service models. ✓ Joint attraction strategies to promote health and social care jobs in NEL. ✓ Preparation to maximise the benefits of the apprenticeships levy as a sector. ✓ Sustainability models for our Community Education Provider Networks. ✓ Preparation for the removal of bursaries through strategic engagement with HEIs. ✓ Developing the education infrastructure to realise changes with our education providers.	✓ Retention improvement targets set in Year One and bank/agency reductions, delivered. ✓ Full implementation of the right roles in the right settings. ✓ Integration of roles at the interface of health/social care. ✓ All staff to have structured career pathways. ✓ Aligned/converged HR processes.
Infrastructure	✓ Agree common estates strategy and governance and operating model. ✓ Establish detailed implementation plan for 2016/17 and beyond, which reflects opportunities for savings and investments as well as demand and supply implications resulting from other workstreams and demographic factors. ✓ Achieve a consolidated view for utilisation and productivity, PFI opportunities, disposals, and new capacity opportunities and requirements across the patch. ✓ Explore sources of capital, working with NHS and local authorities for example One Public Estate.	✓ Realise opportunities to co-locate healthcare services with other public sector bodies and services. ✓ Dispose of inefficient or functionally unsuitable buildings in conjunction with estates rationalisation. ✓ More effective use of 'void' space and more efficient use of buildings through improved space utilisation. ✓ Investment in capital development works to support of strategy delivery.
Technology	✓ Create a common technology vision and strategy for NEL. ✓ Establish detailed implementation plan for 2016/17. ✓ Start to deliver against targets in online utilisation, shared care records, and eDischarges.	✓ Full interoperability by 2020 and paper-free at the point of use. ✓ Every patient has access to digital health records that they can share with their families, carers and clinical teams. ✓ Offering all GP patients e-consultations and other digital services. ✓ Utilizing advanced/preventive analytics towards achieving population health and wellbeing.

The Nine Must Do's

Must Do	Deliverable	Addressed in NEL STP	Reference
1. STPs	Implement agreed STP milestones, so that you are on track for full achievement by 2020/21	Yes	Included in 8 Delivery Plans
	Achieve agreed trajectories against the STP core metrics set for 2017-19		Awaiting publication of national metrics
2. Finance	Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals.		Awaiting confirmation of control totals for all organisations
	Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies	Yes	Plans defined and business cases under development
	Demand reduction measures	Yes	Finance template
	Provider efficiency measures	Yes	Finance template
3. Primary care	Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support, and the ten high impact changes	Yes	• Practice Resilience Plans outlined in NEL Primary Care Plan (and Care Close to Home Plan) • Primary Care Quality Improvement Collaboration referenced in narrative
	Ensure local investment meets or exceeds minimum required levels		Ongoing work to confirm funding sources
	Tackle workforce and workload issues	Yes	• Workforce Delivery Plan • Care Close to Home Delivery Plan (slide 5) • NEL Primary Care Plan
	By no later than March 2019, extend and improve access in line with requirements for new national funding	Yes	• Care Close to Home Delivery Plan (slide 5) • Detailed plans for extended access submitted to HLP • GP Access Fund requests for 2017-19 submitted to NHSE
	Support general practice at scale, the expansion of MCPs or PACS, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes	Yes	Care Close to Home Delivery Plan (slide 6)

The Nine Must Do's

Must Do	Deliverable	Addressed in STP	Reference
Urgent and Emergency Care	Deliver the four hour A&E standard, and standards for ambulance response times	Yes	• Care Close to Home Delivery Plan (Workstream 3 – slide 8)
	By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services	Yes	• Care Close to Home Delivery Plan (Workstream 3 – slide 8) Awaiting outcome of NWL pilot
	Implementing the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint	Yes	• Care Close to Home Delivery Plan (Workstream 3 – slide 8)
	Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department	Yes	• Care Close to Home Delivery Plan (Workstream 3 – slide 8)
	Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis	Yes	• Care Close to Home Delivery Plan (Workstream 3 – slide 8)
Referral to treatment times and elective care	Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT)		• Acute Services Delivery Plan
	Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018	Yes	• Acute Services Delivery Plan (Surgery Workstream 3a– slide 7) • Digital Delivery Plan (slide 21)
	Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups	Yes	• Acute Services Delivery Plan
	Implement the national maternity services review, Better Births, through local maternity systems	Yes	• Acute Services Delivery Plan (Maternity workstream 1 – slide 5)
Cancer	Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report	Yes	• Acute Services Delivery Plan (Cancer workstream 2 – slide 6)
	Deliver the NHS Constitution 62 day cancer standard	Yes	• Acute Services Delivery Plan (Cancer workstream 2 – slide 6)
	Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage 1 and stage 2; and reducing the proportion of cancers diagnosed following an emergency admission	Yes	• Acute Services Delivery Plan (Cancer workstream 2 – slide 6)
	Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.	Yes	• Acute Services Delivery Plan (Cancer workstream 2 – slide 6) • Acute Services Delivery Plan (Screening workstream 3d – slide 10)
	Ensure all elements of the Recovery Package are commissioned	Yes	• Acute Services Delivery Plan (Cancer workstream 2 – slide 6)

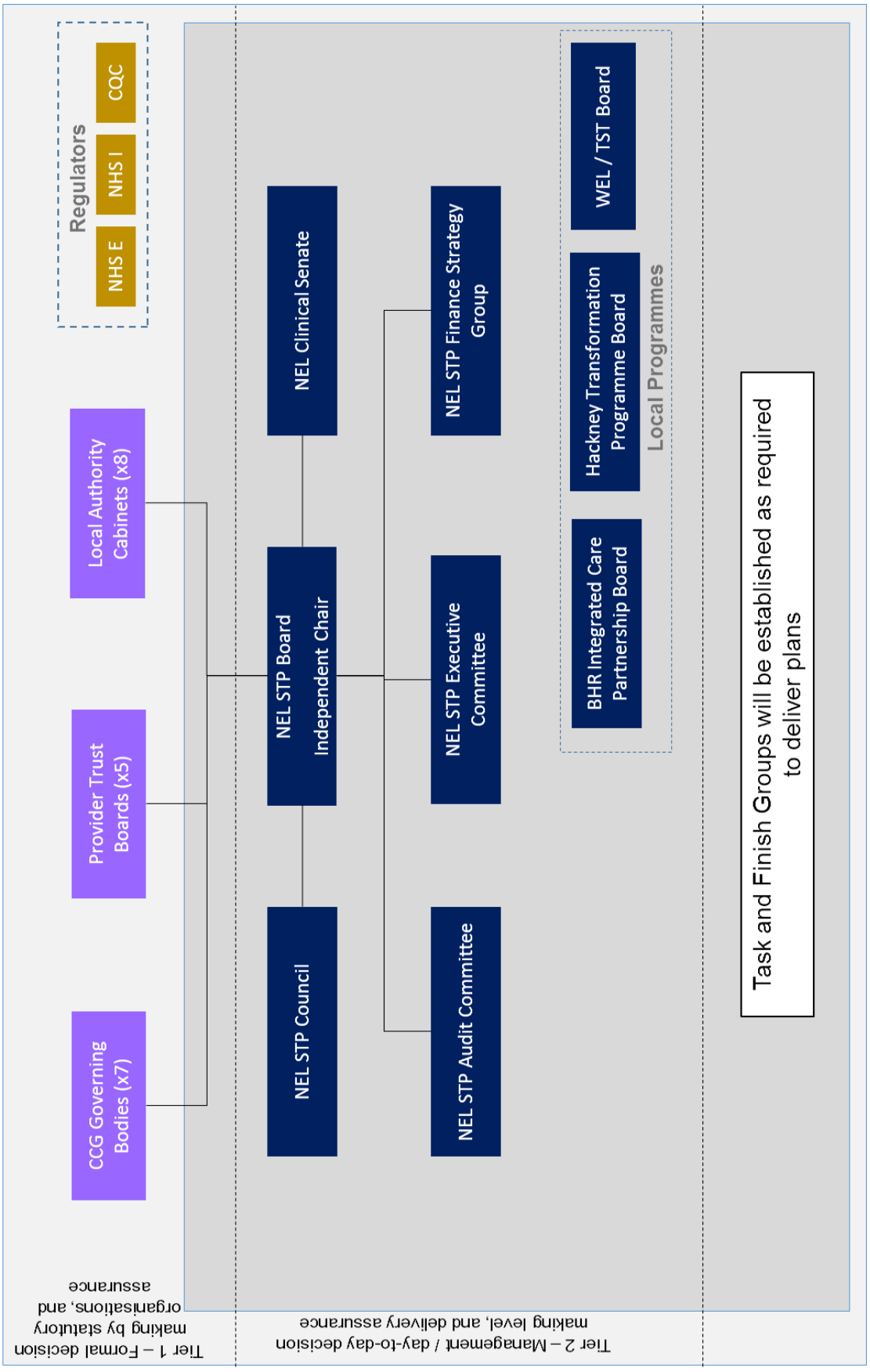
The Nine Must Do's

Must Do	Deliverable	Addressed in STP	Reference
Mental health	Deliver in full the implementation plan for the Mental Health five Year Forward View for all ages, including: including: - Additional psychological therapies - More high-quality mental health services for children and young people - Expand capacity - Increase access to individual placement support for people with severe mental illness in secondary care services - Commission community eating disorder teams - Reduce suicide rates	Yes	Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
	Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals	Yes	• Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
	Increase baseline spend on mental health to deliver the Mental Health Investment Standard	Yes	• Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
	Maintain a dementia diagnosis rate of at least 2 thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia	Yes	• Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
	Eliminate out of area placements for non-specialist acute care by 2020/21	Yes	• Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
Mental health	Deliver in full the implementation plan for the Mental Health five Year Forward View for all ages, including: including: - Additional psychological therapies - More high-quality mental health services for children and young people - Expand capacity - Increase access to individual placement support for people with severe mental illness in secondary care services - Commission community eating disorder teams - Reduce suicide rates	Yes	Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
	Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals	Yes	• Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
	Increase baseline spend on mental health to deliver the Mental Health Investment Standard	Yes	• Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
	Maintain a dementia diagnosis rate of at least 2 thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia	Yes	• Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)
	Eliminate out of area placements for non-specialist acute care by 2020/21	Yes	• Care Close to Home Delivery Plan (Mental Health workstream 2 – slide 7)

The Nine Must Do's

Must Do	Deliverable	Addressed in STP	Reference
People with learning disabilities	Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism	Yes	• Care Close to Home Delivery Plan (LD workstream 4 – slide 9) • Narrative Plan – Section 3
	Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds p/million population, and 20-25 in NHS England-commissioned beds p/million population	Yes	• Care Close to Home Delivery Plan (LD workstream 4 – slide 9) • Narrative Plan – Section 3
	Improve access to healthcare for people with learning disabilities	Yes	• Care Close to Home Delivery Plan (LD workstream 4 – slide 9) • Narrative Plan – Section 3
	Reduce premature mortality by improving access to health service, education and training of staff	Yes	• Care Close to Home Delivery Plan (LD workstream 4 – slide 9) • Narrative Plan – Section 3
Improving quality in organisations	All organisations should implement plans to improve quality of care, particularly for organisations in special measures	Yes	• Primary Care Quality Improvement Collaboration referenced in narrative • NEL organisations have own organisational quality plans in place
	Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services	Yes	• Productivity Delivery Plan (Bank and Agency Workstream 1 – slide 5)
	Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare	Yes	• NEL organisations have own organisational quality plans in place

Draft shadow governance structure



List of Acronyms

Acronym	Name
ACS	Accountable Care System
AKI	Acute Kidney Injury
Barts	Barts Health NHS Trust
BAU	Business As Usual
BCF	Better Care Fund
BHR	Barking, Havering and Redbridge
BHRUT	Barking, Havering and Redbridge University Hospitals NHS Trust
BI	Business Intelligence
CAMHS	Children and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CEPN	Community Education Provider Network
CHP	Community Health Partnerships
CH	City and Hackney
CIPs	Cost Improvement Programmes
CKD	Chronic Kidney Disease
CQC	Care Quality Commission
CWT	Cancer Waiting Time
CYP	Children and Young People
DS	Dental Services
ELFT	East London Foundation Trust
GLA	Greater London Authority
GOSH	Great Ormond Street Hospital
HEE	Health Education England
HEI	Healthcare Environment Inspectorate
HLP	Healthy London Partnership
HUDU	Healthy Urban Development Unit
HWBB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies

Acronym	Name
IMD	Index of Multiple Deprivation
IT	Information Technology
IPC	Integrated Personal Commissioning
LA	Local Authority
LARC	Long Acting Reversible Contraceptives
LoS	Length of Stay
LWAB	Local Workforce Action Board
LMC	Local Medical Councils
MCP	Multispecialty Community Provider
MDTs	Multidisciplinary Teams
MRI	Magnetic Resonance Imaging
NEL	North east London
NELFT	NELFT Foundation Trust
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
PFI	Private Finance Initiative
PHB	Personal Health Budgets
PHE	Public Health England
PMS	Primary Medical Services
PSA	Public Service Agreement
QIPP	Quality, Innovation, Productivity and Prevention Programme
QMU	Queen Mary University
QOF	Quality of Outcomes Framework
RCGP	Royal College of General Practitioners
SCF	Strategic Commissioning Framework
STB	Sustainability and Transformation Board
STI	Sexually Transmitted Infection
STEMI	Segment Elevation Myocardial Infarction
STF	Sustainability and Transformation Fund
TCST	Transforming Cancer Services Together
THIPP	Tower Hamlets Integrated Provider Partnership

List of acronyms

Acronym	Name
TSSL	Transforming Specialised Services in London
TST	Transforming Services Together (working across Newham, Tower Hamlets and Waltham Forest)
UCLP	UCL Partners
UEC	Urgent and Emergency Care
WEL	Tower Hamlets, Newham and Waltham Forest Clinical Commissioning Groups

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HEALTH AND WELLBEING BOARD
22 November 2016

Title:	**A&E Delivery Board Update**
Report of the A&E Delivery Board	
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 A&E Delivery Board. This report provides an update on the most recent meeting(s) of the A&E Delivery Board.

Some background information explaining the changes from Systems Resilience Group to its replacement the A&E Delivery Board are highlighted in the report.

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 A&E Delivery Board.

Reason(s):

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

1 Moving from the Systems Resilience Group to the A&E Delivery Board

1.1 Following a letter sent from NHS England, NHS Improvement and ADASS in the summer of 2016, which identified the need for refreshed local leadership arrangements to encourage whole system focus and accountability, as well as new regional oversight arrangements, System Resilience Groups (SRGs) have been transformed into Local A&E Delivery Boards.

1.2 The focus of Local A&E Delivery Boards is to be entirely on Urgent and Emergency Care. Initially this will all be about recovery of the 4 hour target but A&E Delivery Boards should also be working with STP groupings on the longer term delivery of the Urgent and Emergency Care Review.

1.3 The BHR A&E Delivery Board brings together senior leaders across health and social care in Barking & Dagenham, Havering and Redbridge to support resilience planning and consistent and sustained improvements in services delivered to local residents (with a clear focus on outcomes, a key measure being achievement of 95% A&E 4 hour target).

1.4 Using a system wide consolidated urgent care dashboard (that will report agreed KPIs) the Board will at every meeting:

- Review current and projected performance of urgent care.
- Focus discussion on the areas not delivering and/or demonstrating system risk agreeing actions/ responsibilities across the system to address these.
- This process will need to ensure the integrity of the contract management framework is maintained. Where relevant, actions agreed at the A&E Delivery Board will be reported into the provider relevant contractual group to ensure alignment.
- Agree process for production of demand and capacity plan across the system that takes account of CIP, QIPP and elective workload, and gives the system assurance that it can deliver constitutional targets.
- Strategic oversight: The review of current performance will also highlight how services/pathways can be developed together between commissioners and providers. The A&E Delivery Board will make recommendations for future changes to the Integrated Care Coalition. These will inform the annual commissioning and operating planning process.
- To ensure performance improvement is informed by application of best practice and the consistent application of evidence based practice. This includes having mechanisms in place to share knowledge, learning and best practice across the local health economy.
- Ensure the A&E delivery board receives assurance from the North East London Acute Reconfiguration (NELAR) group on the acute reconfiguration programme

and that any recommendations impacting on acute reconfiguration will be reported back to NELAR.

1.5 The A&E Delivery Board will be responsible for ensuring all partners deliver their contribution and developing recommendations for system wide change.

2 Membership of the A&E Delivery Board

- BHR CCGs - Conor Burke, Accountable Officer (Joint Chair)
- BHRUT - Matthew Hopkins, Chief Executive (Joint Chair)
- LBBD - Anne Bristow, Deputy Chief Executive
- LBH - Barbara Nicholls, Director Adult Social Care
- Havering CCG - Dr. Deshpande, Urgent Care lead
- LBR - TBC, Director of Adult Social Services
- Redbridge CCG - Dr. Mathukia, Urgent Care lead
- NELFT - John Brouder, Chief Executive
- BHRUT - Nadeem Moghul, Medical Director
- NHSE - Lizzie Comley, Senior Assurance Manager
- NHSI - Anna Clough, Head of Delivery and Development
- NELFT - Jacqui Van Rossum, Executive Director Integrated Care (London) and Transformation
- B&D CCG - Dr. Goriparthi, Urgent Care lead
- Patient Representative - Anne-Marie Dean, Chair, HealthWatch Havering
- PELC - Mo Girach, Chief Executive
- LAS - Ian Johns, Assistant Director Operations
- BHR Federations - Dr. Weaver, Havering Health (Havering GP Federation)
- BHR Federations - Dr. Sharma, Together First (Barking GP Federation)
- BHR Federations - Dr. Ramakrishnan, HealthBridge Direct (Redbridge GP Federation)
- BHR CCGs - TBC, Clinical Lead, UEC Transformation

3 Mandatory Implications

3.1 Joint Strategic Needs Assessment

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

3.2 Health and Wellbeing Strategy

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

3.3 **Integration**

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

3.4 **Financial Implications**

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

3.5 **Legal Implications**

There are no legal implications arising directly from the A&E Delivery Board.

3.6 **Risk Management**

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

4 Non-mandatory Implications

4.1 **Customer Impact**

There are no equalities implications arising from this report.

4.2 **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.

4.3 **Staffing issues**

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

List of Appendices

Appendix A: 2 A&E Delivery Board Briefings - 26 September 2016

APPENDIX A

A&E delivery board Summary Briefing	Meeting dated – 26 September 2016 Venue – Conference room, Barking Learning Centre
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
A&E improvement plan	Members were updated on the latest position for the ECIP review. A draft report will be provided at the October meeting.
Urgent and Emergency Care delivery plan	Key highlights from the UEC programme dashboard were reported. An update was provided against each workstream, all of which are progressing well. • Feedback expected from trialling direct booking for the Integrated Urgent Care workstream. • Evaluation from the discharge to assess pilot expected at the next meeting.
NEL U&EC network update	Members were updated on the latest work going on as part of the North East London Urgent and Emergency Care Network and the Sustainability and Transformation Plan.
Next meeting:	Monday 31st October 2016 1pm – 3pm Committee room 3a, Havering Town Hall Main Road, Romford RM1 3BB

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HEALTH AND WELLBEING BOARD

22 November 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 a full assurance report for the Learning Disabilities Partnership Board is part of the full agenda for the meeting, so no update report is provided here. There have been no meetings of the Public Health Programmes Board or Integrated Care Sub-Group since the last meeting of the Health and Wellbeing Board so there are no updates for these groups.

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 1: Children and Maternity Sub-Group report

Appendix 2: Mental Health Sub-Group report

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Children and Maternity Group

Chair: Sharon Morrow

Items to be escalated to the Health & Wellbeing Board

(a) None

Performance

Performance data for children and young people is reported in the Health and Wellbeing Board performance report.

Meeting Attendance

The group has not met since the last Health and Wellbeing Board meeting.

Action(s) since last report to the Health and Wellbeing Board

(a) Partnership working has continued outside of a formal meeting to refresh the Children and Young Peoples Mental Health Transformation Plan, which is reported on the agenda.

(b) The further development of the Children and Maternity Group and Childrens Trust was considered at a workshop held on 10 November 2016. The workshop generated some positive discussion and it was agreed that options for a future model would be discussed at the meeting on 5 December.

Action and Priorities for the coming period

(a) To develop options for the development of the Children's Trust / Children and Maternity Group for consideration at the Children's Trust meeting on 5 December 2016.

Contact: Sharon Morrow, Chief Operating Officer Barking and Dagenham CCG

Tel: 0203 1823302; **Email:** Sharon.morrow2@nhs.net

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APPENDIX 2

Mental Health Sub Group

Chair: Melody Williams, Integrated Care Director, NELFT

Items to be escalated to the Health & Wellbeing Board

(a) To note the Mental Health Strategy

(b) To note the CAMHS Transformation Plan

These have been included as main items for the November Board meeting – please see separate reports

Performance

The Section 75 Executive Group monitors the performance outcomes against the indicators for the adult mental health services. The CCG Contract performance group monitors an additional range of contractual indicators for the NELFT services. These are currently broadly performing in line with the targets. There has been significant improvement in the delayed transfer of care target. IAPT (Talking Therapies) performance has seen an improvement in access rate which is a positive demonstration of awareness of the availability and recovery rates are in line with national targets.

Meeting Attendance

Date of last meeting: 7 November 2016

Action(s) since last report to the Health and Wellbeing Board

(a) Mental Health Strategy drafted, consulted via public consultation and finalised for HWBB agreement

(b) CAMHS Transformation Plan refresh completed with partner engagement and submitted on 31 October

(c) Mapping of actions against the 15-16 plan were completed

Action and Priorities for the coming period

(a) Embed the action plan for the Mental Health Strategy across partner organisations

(b) Embed the action plan for the CAMHS transformation plan

(c) Review the function and terms of reference of the group in line with other HWBB sub groups and the establishment of ACO/partner organisation groups to ensure that there is not duplication.

Contact: [Melody Williams, Integrated Care Director]

Tel:0300, 555 1201 Ext 65075; **Email:melody.williams@nelft.nhs.uk**

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HEALTH AND WELLBEING BOARD

22 November 2016

Title:	**Chair's Report**
Report of the Chair of the Health and Wellbeing Board	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: NO**
Report Author: Andrew Hagger, Health and Social Care Integration Manager	**Contact Details:** Tel: 020 8227 5071 Email: Andrew.Hagger@lbbd.gov.uk
Sponsor: Councillor Maureen Worby, Chair of the Health and Wellbeing Board	
Summary: Please see the Chair's Report attached at **Appendix 1**.	
Recommendation(s) The Health and Wellbeing Board is recommended to: a) Note the contents of the Chair's Report and comment on any item covered should they wish to do so.	

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Chair's Report

22 November 2016

In this edition of my Chair's Report, I talk about World Mental Health Day in October and the introduction of new A&E Delivery Boards. 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

World Mental Health Day

World Mental Health Day (WMHD) was observed on 10th October 2016 by more than 100 countries. The day aims to raise awareness of mental health and promote positive wellbeing. The theme of this year's World Mental Health Day was 'psychological and mental health first aid for all' with the aim of making Mental Health First Aid a global priority on a par with physical first aid.

Barking and Dagenham is very well positioned to support this theme, having previously trained over 1100 staff across the care partnership in Mental Health First Aid. The Council was recognised nationally for 'demonstrating exemplary leadership in increasing mental health literacy in their community' with an MHFA Champion Award in 2014.

Given the theme for the day, Mental Health First Aid England (MHFA), whom the Council have previously worked closely with, created a range of content called the 'Take 10 Together' toolkit which seeks to help people to have a meaningful 10 minute conversation with a friend, family member, colleague or student about their mental health and wellbeing.

The two main engagement events took place in Asda Barking and at The Mall, Heathway. These events were well attended and enabled professionals from both the Council and NELFT Mental Health Services (Child and Adolescent Services to Services for Older Adults) to engage with residents to help people on the journey of improving their mental wellbeing and that of others around them, further signposting any resident who may require support.

These events also offered professionals the opportunity to promote their services and reduce any associated fear or stigma, which in turn helps to build confidence in residents to access the support they may need before a situation gets worse.

An additional event was held in Barking Learning Centre to enable other local services to take part in the day and promote their respective services; this included Healthwatch, IAPT, Drug and Alcohol Services, Richmond Fellowship, CAMHS, Memory Services and Carers of Barking and Dagenham. The Barking Learning Centre was also the venue for an event which focused on raising awareness about mental health issues in Black and Minority Ethnic Communities. This session formed part of the wider events being held in the borough for Black History Month and included a range of esteemed speakers.

World Mental Health Day continued…

All services involved in the events circulated their own service specific information, including a resource pack containing the 'Take 10 Together' toolkit. Flyers and posters were circulated both digitally and in printed format to facilitate the dissemination of consistent key messages across the borough by all partner organisations.

Schools were also encouraged to be involved in World Mental Health Day, and information was circulated to schools offering a range of graphics and key messages in run up to World Mental Health Day to ensure a strong and effective online presence.

In addition to the outward facing activities for World Mental Health Day, there were some good internal opportunities for the Council and partner organisations which have thematic relevance to the aims of the day. The 'Take 10 Together' toolkit includes a wall chart with a particular focus on the workplaces and highlighted some physical, emotional and behaviour indicators that colleagues can look out for. This also provided an opportunity to promote the Employee Assistance Programme as well as other initiatives aimed at supporting the health and wellbeing of staff such as Big White Wall, which has now been commissioned to support an unlimited number of users in Barking and Dagenham..

London Healthy Workforce Charter

The London Healthy Workforce Charter is a self assessment framework that rewards employers for actively promoting and investing in the health and wellbeing of their workforce. Good quality working environments improves health. Sickness absence costs an average London firm of 250 employees £250,000 per annum and the cost to an organisation as large as the Council is estimated at around £3.7 million a year. The most common cause of sickness absence is musculoskeletal injuries and stress.

The London Healthy Workforce Charter operates at three levels of award: Commitment, Achievement and Excellence – awarded by the Mayor of London. The Council has recently achieved Commitment level in the London Healthy Workforce Charter, with an award ceremony celebrating this achievement held on 15th November. The Council has also pledged to move swiftly to Achievement and Excellence level – the second and highest level of this award. To achieve this level the Council will need to address areas include corporate support, attendance management, health and safety, mental health, physical activity, smoking, alcohol and substance misuse.

I would encourage all partners on the Health and Wellbeing Board to strive to achieve London Healthy Workforce accreditation, which will show that we as a health and care system not only value providing the best services for our residents, but also value providing a healthy environment for our staff delivering those vital services.

News from NHS England

NHS to cut availability of sugary drinks in hospital

NHS England has announced details of proposed new action to cut obesity and reduce the sales and consumption of sugary drinks sold in hospitals. In doing this, England would become the first country in the world to take action across its health service in this way. A formal consultation gives details of a proposed new fee to be paid by vendors, or alternatively seeks views on an outright ban.

A recent survey found obesity to be the most significant self-reported health problem amongst NHS staff, with nearly 700,000 NHS staff estimated to be overweight or obese. Rising rates of obesity amongst NHS staff are not only bad for their personal health, but also the NHS's ability to give patients credible and effective advice about their health.

NHS premises also receive heavy footfall from the communities of which they are a part. The food sold in these locations can send a powerful message to the public about healthy food and drink consumption.

New funding to help people with a long-term condition or disability into work

NHS England, along with the Department for Work and Pensions (DWP) and the Department of Health (DH), is going to invest £70 million over the next four years to test different ways to support people with a disability or long term condition to get in and stay in work.

To kick-start this programme of work, NHS England, DH and DWP have announced that they will be working with Sheffield City Region and the West Midlands Combined Authority to develop trials that will test new ways of supporting people as they enter, re-enter and stay in work.

Sheffield City Region and West Midlands Combined Authority will receive financial investment as well as access to expert support to progress the design of their trials. The trials will focus on mental health and musculoskeletal conditions, the two conditions most commonly reported by those out of work.

Sheffield City Region are developing a trial that will test how the principles of Individual Placement and Support (IPS) could be expanded to support a broader range of patients, improve access to musculoskeletal services and improve local referrals between health and employment services.

West Midlands Combined Authority's trial is looking to expand IPS services for those with severe mental health, as well as trialling IPS in new settings for those with more moderate mental health conditions and those with musculoskeletal conditions.

Health and Wellbeing Board Meeting Dates

Tuesday 31 January 2017, Tuesday 14 March 2017, Tuesday 9 May 2017

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

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HEALTH AND WELLBEING BOARD

22 November 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) The next full issue of the Forward Plan will be published on 23 December 2016. Any changes or additions to the next issue should be provided before 2.00 p.m. on 21 December 2016.

Public Background Papers Used in the Preparation of the Report:
None

List of Appendices
Appendix A – Draft Forward Plan

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HEALTH and WELLBEING BOARD
FORWARD PLAN

DRAFT January 2017 Edition

Publication Date: DUE ON 23 December 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
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: 31.1.17	**Re-Commissioning Healthwatch** : Financial The report will seek approval to commence with the re-commissioning of a local Healthwatch for Barking and Dagenham. • Wards Directly Affected: All Wards	Open	Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)
Health and Wellbeing Board: 31.1.17	Barking and Dagenham CCG Operating Plans 2017-2019 The report will provide an overview of Barking and Dagenham CCG's operating plans covering a 2-year period from 2017 to 2019. The Board will be asked not note the report and comment as appropriate. • Wards Directly Affected: All Wards	Open	Sharon Morrow, Chief Operating Officer (Tel: 020 3644 2370) (Sharon.morrow2@nhs.net)
Health and Wellbeing Board: 31.1.17	Planning for a Healthier Future The report will provide an update on the work being carried out around the redevelopment of Barking Riverside, including progress in the Healthy New Towns programme. The report will set out current plans and visions for incorporating health and healthy lifestyles within the new Barking Riverside development, enabling the Board to discuss how partners can work together to deliver this. • 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: 31.1.17	Transforming Social Care The report will set out the Council's plans to transform social care as part of its wider transformation programme. The report will include outlines of the approaches to Adults Care & Support, Children's Care & Support, Single Disability Service, Community Solutions and an update on the work being done to reshape localities. • Wards Directly Affected: All Wards	Open	Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)
Health and Wellbeing Board: 31.1.17	NELFT Strategic Quality Improvement Plan In April 2016 the Care Quality Commission's (CQC) inspected 14 core services of NELFT and rated nine as 'Good' and four as 'Requires Improvement' and one as 'Inadequate'. This has led to an overall CQC rating of 'Requires Improvement' for the Trust. The report will provide the Board with details of the NELFT Improvement Plan to rectify the areas of deficit highlighted by the CQC Inspection. • Wards Directly Affected: All Wards	Open	Bob Champion, Executive Director of Workforce & OD (Tel: 0300 555 1201) (bob.champion@nelft.nhs.uk)
Health and Wellbeing Board: 14.3.17	**Domestic and Sexual Abuse Strategy** : Community The report will present the Board with the draft Domestic and Sexual Abuse Strategy. The Board will be asked to discuss and approve the Domestic and Sexual Abuse Strategy. • Wards Directly Affected: All Wards	Open	Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)

Health and Wellbeing Board: 14.3.17	**Contract: Healthy Child Programme (0-19) - Procurement Strategy** : Financial The contracts for the 0-5 and 5-19 Healthy Child Programmes (HCP) respectively are due to expire on 30 September 2017. This Board will be asked to approve the procurement strategy for the competitive procurement of these services 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)
Health and Wellbeing Board: 14.3.17	Health and Wellbeing Outcomes Framework Report - Quarter 3 2016/17 The report will present the Board with the Health and Wellbeing Outcomes Framework Report and the performance information for Quarter 3 2016/17. The Board will be asked to discuss and the data within the report. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
Health and Wellbeing Board: 14.3.17	**Older People's Housing Strategy** : Community The report will present the Board with the Older People's Housing Strategy for discussion and approval. • Wards Directly Affected: Not Applicable	Open	Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@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
Cllr Bill Turner, Cabinet Member for Corporate Performance and Delivery
Anne Bristow, Strategic Director for Service Development and Integration and Deputy Chief Executive
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)
Bob Champion, Executive Director of Workforce and Organisational Development (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)
Ceri Jacob, Director Commissioning Operations NCEL (NHS England - London Region) (non-voting Board Member)