

MINUTES OF HEALTH AND WELLBEING BOARD

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

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

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

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

86. Extension of the Meeting

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

87. Declaration of Members' Interests

There were no declarations of interest.

88. Minutes - 8 March 2016

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

89. Draft Primary Care Transformation Strategy

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

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

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

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

The Board raised a number of issues, including:

- Other Factors – Health and care provision alone was not the answer and other social impacts, such as jobs and quality housing all have an impact on long-term health outcomes. Matthew Cole, Director of Public Health agreed to provide some wording on this issue to the CCG.
- Delivery and Funding - How would this Strategy be aligned with other issues, such as the Better Care Fund and how would delivery be achieved? How would it be resourced, bearing in mind the £400m funding gap that exists across the BHR health and social care system?

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

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

- Document Accuracy - The details in the document also needed to be accurate, for example one GP mentioned in it had already retired a few months ago.
- Staffing Levels - LBBB was second from bottom for GP staff numbers per 1,000 population. Why was Barking and Dagenham so low in the rating and why were other boroughs better staffed when they had less health issues?

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

- GP Referrals to Outpatients - The number of GP referrals to outpatients was significantly higher at 426 per 1,000 than the London Average or 312. The range across practices locally of 320 to 680 per 1,000 was unlikely to be as a result of population factors alone. This needed to be further explored rather than just being anecdotal evidence.
- Growth Borough - LBBB was a growth borough and the population would be increasing. How were the CCG and GP services going to deal with that increase when Riverside Ward still had no GP Surgery?
- Seven Day Primary Care Service - If a seven day Primary Care Service was to be available, how were GPs going to be able to cope with the extra workload?

- Leadership of Local Health – What input would be provided both from and to other health professionals, for example collaboration between GPs and dentists?
- Data and Statistics – Data was being used to drive the LBBD's Ambition 2020 vision and decisions but there appears to be a lack of data to support the proposals and strategy.
- Implementation - Concern in regard to the implementation dates and felt that this was a little premature and was not as holistic as it should be.

Sharon Morrow responded:

- In relation to the funding issue, the rationale was that if patients have access to wider primary care services there would be less demand for more costly hospital care services.
- The CCG were aware that there were difficulties in recruiting GPs to this area and action was being taken to make it a more attractive option for them to choose to work here.
- The graphs and data were primarily to illustrate some of the variation in health measures that CCG monitor. As the Primary Care localities were progressed then the specific demographics and needs for an area would be addressed through the locality structure.
- The CCG have already attended planning meetings in regards to Barking Riverside and were looking at recruiting GPs and other health professionals for the area as it grows.
- It would be unlikely and impractical for all GPs to open and provide a 7 day service. The expectation is that weekend service would be provided through hubs.
- In regards to leadership, the proposed model recognises that GPs are the gate-keepers for healthcare services and community services are organised around their registered lists. The Localities discussions were being held through HCO/ACO to see how GP practices could work together and provide integrated services.
- Performance management and monitoring would be undertaken and achievement levels would become part of the contract.

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

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

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

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

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

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

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

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

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

The Board:

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

90. Better Care Fund 2016/17

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

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

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

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

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

The Board:

- (i) Endorsed the Better Care Fund plan, budget for 2016-17 and activity and Delegated Authority to the Strategic Director, Service Development and Integration and the Accountable Officer for the BHR CCGs, to agree and submit to NHS England the Plan as set out in Appendix A of the report, subject to the adjustments advised at the Board; and
- (ii) Delegated authority to the Strategic Director, Service Development and Integration, to extend the Section 75 agreement for the Better Care Fund, with amendments in line with the report, and in consultation with the

91. Referral to Treatment

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

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

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

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

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

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

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

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

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

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

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

The Board was extremely concerned that the Trust had suspended reporting but had not advised the Board of the difficulties for over 18 months. The Board felt that selected reporting of poor performance was totally unacceptable. Councillor Carpenter said that she felt that the not reporting of the problem to the Board had been deliberate and underhand and gave the misleading impression that BHRUT was performing well in regards to appointments, when in fact it was not. It was not right for any of the Partners to keep the Board in the dark in regards to significant or fundamental problems that they may have, as it would remove the Board's input and ability to monitor and support change. Matthew responded that as an organisation it was felt that it was wrong to continue reporting faulty and erroneous data and that before they started reporting again the data must be correct, robust and credible. The Department of Health had provided a support team in September 2015 to review the BHRUT data and consultants, Ernest and Young, had now been engaged to undertake a full review and checks.

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

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

Councillor Butt, LBBB Cabinet Member for Crime and Enforcement, was extremely

concerned that both the document and presentation referred to 'waiters' and asked that BHRUT not use the term 'waiters' in their future reports and suggested that 'patients' or 'people' was more appropriate. Councillor Butt added that it needed to be remembered that these were individuals, people, and not numbers.

Councillor Turner, LBBB Cabinet Member for Children's Social Care, indicated that the Council was extremely disappointed in BHRUT's dismissive attitude to the Board and the other Partners on it. This was borne out by BHRUT's failure to advise the Board of such a significant problem and under performance: even if they did not know numbers, they were clearly aware that there was a major problem.

Councillor Turner reminded the Board of the legal duty of candour and asked Matthew to whom they had reported the suspension of reporting data. Matthew advised that the Department of Health had been advised as soon as it became apparent that there was a significant issue.

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

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

Councillor Carpenter commented that it was necessary to ensure all those waiting more than the NHS Constitution standard were seen as a matter of priority and not just those already waiting more than six months or a year.

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

The Board:

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

Improvement (formerly NTDA) and external consultants had been engaged by BHRUT to independently verify the data accuracy and assist BHRUT in the resolution of the problem;

- (iii) The Board also wished to place on record its serious concern in regard to:
- (a) The decision of BHRUT to 'not report' nor advise the Board of the problem over the last 18 months;
 - (b) The apparent lack of urgency at BHRUT in regard to resolving the problem at an earlier point in time;
 - (c) The significant number of patients who were waiting more than the 18 weeks referral to treatment target, set out in the NHS Constitution, with some patients still waiting for over 52 weeks;
 - (d) The potential deterioration in patients' conditions and the physiological and social harm that may be caused to patients by the delays;
- (iv) Requested that the Board be provided with regular performance updates on this issue, including:
- Details of the action being taken by BHRUT to reduce patient wait times;
 - The performance achieved in the previous quarter;
 - The projected trajectory rates to achieving the 18 week referral to treatment target across all specialities;
 - The numbers of patients in each specialist area and how many of those patients were Barking and Dagenham residents;
 - Evidence to substantiate the anecdotal claim by BHRUT that patients were prepared to wait longer to be seen within BHRUT rather than being treated by other providers;
- (v) Requested that BHRUT do not use the term 'waiters' in their future reports and suggested that 'patients' or 'people' was more appropriate; and
- (vi) Recommended that the LBBB Health and Adult Services Select Committee include the issue of the Referral to Treatment in its Scrutiny Work Programme for further investigation as a matter of priority.

92. London Ambulance Service NHS Trust Improvement Plan

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

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

- Approximately 200 operational staff cover vehicles deployed in the North East London, which included stations in Dagenham, Ilford, Hornchurch, and Romford and there were also supporting resources from Newham, Hackney and Waltham Forest. The prioritisation of 999 calls was undertaken at the Emergency Operations Centres at Waterloo and Bow.
- Culture change workshops had been held on bullying and harassment.
- Recruitment of Paramedics was being undertaken across the world and the services had been particularly successful in attracting staff from Australia; some of whom would be starting work at the end of March 2016.
- An innovative 'elderly fallers' provision had been set up in partnership with NELFT. This provided an appropriate care pathway for these patients that prevented attendance at hospital.
- The Quality Improvement Plan would involve all staff in all its work streams, which would include an investigation into pathways to treatment at Urgent Care Centres etc and identifying what issues may be stopping staff from using them.
- For the year-to-date, the demand for the service (calls) in Barking and Dagenham had increased by 4.7%. The North East London sector was currently the third highest performing area across the whole LAS area. However, the target for Category A calls nationally was 75% attendance within 8 minutes and whilst this was not achieved by many national services, the LAS was only achieving 58.3% and wished to improve on this.

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

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

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

The Board:

- (i) Noted the London Ambulance Services (LAS) NHS Trust Improvement Plan and progress made to date;
- (ii) Noted the potential for joint working with the other emergency services and partners to improve service delivery; and

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

93. Care City Programme Update

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

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

The Board were pleased to see the innovative use and testing of IT that would enable people to look after themselves whilst they were still being safeguarded.

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

The Board

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

94. Public Health Programme Board Strategic Delivery Plan Update

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

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

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

The Board was surprised to hear that there was a worldwide shortage of BCG vaccinations and UK stocks were almost totally depleted and reminded Public

Health England that the duty of candour applied to them also.

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

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

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

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

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

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

The Board

- (i) Noted the report;
- (ii) Requested that Health and Social Care Commissioners provide performance updates as part of the Board's quarterly performance report on the measures being taken to prevent Health Care Associated Infections within both the hospital and community settings.
- (iii) Requested that Public Health England to provide a quarterly performance report on the actions to improve coverage figures for immunisation and antenatal screening, including the sickle cell testing rates for at risk expectant mothers by 10 weeks gestation;
- (iv) Requested that the NHS agreed clear arrangements to manage babies moving into the area without full newborn screening;

- (v) Requested NHS England provide details to the Strategic Director, Service Development and Integration, within seven working days, of a proactive plan to urgently obtain BCG vaccination supplies and details of the national and London resilience plans in regards to this and any further vaccination supply shortages;
- (vi) Reminded partners that Breast Screening provision locally had been raised previously and still need to be included.

95. Contracts: Procurement and Commissioning Plans 2016/17

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

The report also provided information on how the plans would meet with the Joint Health and Wellbeing Strategy, Partners' commissioning intentions and Legislative requirements including the Care Act 2014 and Children's Act 2014,

The Board:

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

96. Systems Resilience Group - Update

The Board received the report on the work of the System Resilience Group (SRG), which included the issues discussed at the SRG meetings held on 29 February and 30 March 2016.

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

97. Sub-Group Reports

The Board noted the reports on the work of the:

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

98. Chair's Report

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

- **Sustainability and Transformation Plans (STP)**

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

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

- **Health and Wellbeing Bard Development Session**

The Session would be held on 19 May 2016, Care City, Barking.

- **Women's Empowerment Month**

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

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

- **News from NHS England:**

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

- New whistle-blowing guidance for primary care.

99. Forward Plan

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