

## **SUPPORTING DOCUMENTS**

### **THE HEALTH AND WELLBEING BOARD**

**Wednesday, 6 September 2017**

- Agenda Item 5. Cancer Prevention, Awareness and Early Detection Scrutiny Review 2016/17 (Pages 1 - 50)**
- Agenda Item 6. Tobacco Control Strategy: A Vision for Tobacco-Free Living (Pages 51 - 76)**
- Agenda Item 8. Stepping Up: A Narrative of Health and Social Care Integration in Barking and Dagenham (Pages 77 - 102)**
- Agenda Item 9. Response to the East London Health & Care Partnership's Consultation on Payment Mechanisms (Pages 103 - 155)**
- Agenda Item 10. Annual Safeguarding Reports 2016/17 (Pages 157 - 236)**
- Agenda Item 11. London Ambulance Service NHS Trust - Care Quality Commission (CQC) Inspection (Page 237)**
- Agenda Item 12. Update on the Work of the Integrated Care Partnership for Barking & Dagenham, Havering and Redbridge (Pages 239 - 264)**
- Agenda Item 15. Forward Plan (Pages 265 - 268)**

Contact Officer: Tina Robinson  
Telephone: 020 8227 3285  
E-mail: [tina.robinson@lbbd.gov.uk](mailto:tina.robinson@lbbd.gov.uk)

This page is intentionally left blank

Report of the  
**Health and Adult Services  
Select Committee:**

Cancer prevention, awareness  
and early detection:

**Scrutiny Review 2016/17**



Contact:

**London Borough of Barking and Dagenham**

**Scrutiny**

**Democratic Services**

**Law and Governance**

**[scrutinyinbox@lbbd.gov.uk](mailto:scrutinyinbox@lbbd.gov.uk)**





## Lead Member's Foreword

The Health and Adults Services Select Committee (HASSC) is a scrutiny committee made up of local councillors who want to help improve health and social care outcomes for the borough's residents by working with the Council and its partners to improve services and hold decision makers to account.

In 2016/17, as the Chair of the Committee, I oversaw an in-depth scrutiny review into Cancer Prevention, Awareness, and Early Detection. We chose to review this area as we were concerned that there needed to be more public awareness around the importance of early intervention in tackling cancer so that residents access the right services, in a timely manner, to have the best possible outcome. We also felt that the fear of cancer was possibly stopping people discussing their symptoms with their GP, which could mean that many people were missing out on early diagnosis.

One of our residents shared her story of surviving cancer, which was uplifting; you can read it for yourself on page 29 of this report. Her journey was a mixed picture - she felt unwell for some time but didn't immediately follow it up with her GP. Her message was loud and clear – see your GP if something doesn't feel right, eat well, exercise, drink in moderation and if you smoke, get some help to stop!

Currently, many of our residents don't know the signs and symptoms of cancer, which makes it more difficult for them to get help when they need it. We want all our residents to feel comfortable to talk about cancer, share positive messages and encourage early diagnosis through understanding the signs and symptoms. Early diagnosis means it will be more likely for the person to lead a full and active life after a cancer diagnosis. We also want to support residents to take up invitations to be screened and to assure them that it is the right thing to do. I will be pushing for screening letters to be sent to groups that fall into the at-risk band. It is also very important that we have an awareness road show that goes into churches, temples, mosques, and local schools.

Smoking is the leading cause of cancer in the borough, and we believe that the time has come to talk openly about how smoking is causing lung cancer in the borough. Sadly, a resident of Barking and Dagenham is more likely to develop lung cancer than people in other parts of England. All the evidence points to a 'healthy lifestyle' to protect against cancer, and this report encourages us all to make the healthy choice, the easy choice, by explaining how a healthy lifestyle can prevent cancer.

Barking and Dagenham must become a place where a healthy lifestyle is normal from the start, and where people who want to make healthier lifestyle choices, are supported to do so. This report sets out the local picture, recommends actions that will support residents to recognise the signs and symptoms of cancer and the importance of early diagnosis and, aims to drive the work of the borough's health and social care partners, which we hope will help reduce the prevalence of cancer in the borough, as well as improve survival rates.

**Councillor Peter Chand**

A handwritten signature in black ink, appearing to read 'P. Chand'. The signature is fluid and cursive.

Lead Member, Health & Adult Services Select Committee 2016/17 – 2017/18

## Members of the HASSC 2016/17

The HASSC members who carried out this Review were:



**Councillor P Chand** (Lead Member)



**Councillor L Zanitchkhah**  
(Deputy Lead Member)



**Councillor S Alasia**



**Councillor A Aziz**



**Councillor E Fergus**



**Councillor J Jones**



**Councillor E Keller**



**Councillor H S Rai**



**Councillor F Shaukat**

# Contents

<b>Section</b>	<b>Page Number</b>
List of Recommendations arising from this Review	<b>1</b>
Executive Summary	<b>2</b>
Section 1 - Background to the Review	<b>4</b>
Section 2 - Scoping and Methodology	<b>5</b>
Section 3 – Introduction: Understanding Cancer	<b>7</b>
Section 4 - Why are Residents of Barking and Dagenham more likely to Develop Cancer and less likely to Survive Cancer than Residents in other London Boroughs?	<b>10</b>
Section 5 - The Incidence of Lung, Bowel, Breast and Prostate Cancers and Survival Rates in Barking & Dagenham	<b>16</b>
Section 6 - The Importance of Screening, and Screening Uptake Rates in Barking & Dagenham for Breast, Bowel and Cervical Cancer	<b>18</b>
Section 7 - The Potential Reasons for Late Detection of Cancer in Barking & Dagenham, Including Reasons for Lower Uptake of Screening	<b>27</b>
Section 8 - What is Working Well and What more can be Done?	<b>32</b>
Section 9 - Next Steps	<b>35</b>
Thanks	<b>36</b>
Appendices	<b>37</b>

## List of Recommendations arising from this Review

For ease of reference, the recommendations arising from this Review are provided below.

The Committee recommends that:

1. The Health and Wellbeing Board (HWB) takes action to reduce the prevalence of smokers in the borough, to levels comparable with London;
2. The HWB sets out to the HASSC what action it is taking to reduce the number of overweight and obese individuals in the borough, to levels comparable with London;
3. The HWB takes action to increase residents' awareness of the how lifestyle, including exposure to the sun, can affect the likelihood of developing cancer, the signs and symptoms of cancer and the importance of early diagnosis, and screening;
4. The National Awareness and Early Detection Initiative informs the commissioners on what action it is taking to target specific 'at risk' groups;
5. The Barking & Dagenham Clinical Commissioning Group (BDCCG) ensures that GPs are auditing and acting on audit information to ensure that patients enter the cancer pathway appropriately, and cancer is diagnosed at as early a stage as possible;
6. The BDCCG, in partnership with Macmillan and Cancer Research UK, takes action to increase the proportion of residents returning bowel cancer screening kits, within the next year;
7. The HWB, along with MacMillan and Cancer Research UK, takes action to raise awareness of the importance of screening and to increase uptake of breast and bowel screening in the borough to a level comparable with England within the next year;
8. The HWB, along with MacMillan and Cancer Research UK, takes action to raise awareness of the importance of screening and reduce the variation in cervical screening uptake between GP practices within the next year;
9. The Committee urges NHS England to make the Cancer Dashboard available within one year;
10. The HWB takes action to raise awareness of the importance of the Health Check and reduce the variation in Health Check uptake between GP practices;
11. NHS England provides assurance to it that residents will continue to have in-borough access to breast screening; and
12. The BDCCG, working through the North-East London Cancer Commissioning Board, assures the Committee of the action it is taking to increase awareness of the signs and symptoms of cancer.

## Executive Summary

In 2016/17, the Health and Adult Services Select Committee (HASSC) undertook an in-depth scrutiny review into Cancer Prevention, Awareness and Early Detection.

Three questions were posed by the HASSC:

1. Why are residents of Barking and Dagenham more likely to develop cancer and less likely to survive cancer than residents in other London boroughs?
2. What is the reason that residents are less likely to respond to requests to screen for cancer than in other London boroughs?
3. What is the reason that residents are not as aware of the signs and symptoms of cancer as residents in other London boroughs?

Here we summarise the HASSC's findings in relation to these questions.

### **1. Why are residents of Barking and Dagenham more likely to develop cancer and less likely to survive cancer than residents in other London boroughs?**

The reason why residents are more likely to develop cancer is that they tend to have less healthy lifestyles (see Section 4). Lifestyle accounts for four out of 10 preventable deaths from cancer and there are different reasons why residents of Barking and Dagenham have less healthy lifestyles than in many other London boroughs. This suggests that more action is needed to improve lifestyle in the borough.

The evidence indicates that people in the borough are also less likely to be aware of the signs and symptoms of cancer when these do occur (see Section 7), which means that cancer is more likely to develop and less likely to be identified early. Where cancer is diagnosed late, the chances of survival are lower. This suggests that action is needed to raise awareness so that residents are more aware of signs and symptoms of cancer.

### **2. What is the reason that residents are less likely to respond to requests to screen for cancer than in other London boroughs?**

There are different reasons why residents are less likely to present for screening (see, Section 7), which includes the lack of awareness of the importance of early detection of cancer. In this report, we address the issue of screening for breast, bowel and cervical cancer. The reasons why residents do not always respond can be emotional (fear of what the screening might find), cultural (residents may not understand the information that they are sent), practical (travelling to the place of screening) or service related (difficulty getting an appointment with their GP).

A diagnosis of cancer after a resident has visited Accident and Emergency (A&E) usually means the cancer will be harder to treat because it has developed more. Rates of diagnosis of cancer through A&E in Barking and Dagenham are decreasing but are still higher than the England average. To improve this situation, it is essential that as well as raising awareness of the signs and symptoms of cancer, we work to improve screening rates and effective routes to diagnosis.

These findings suggest that assurance is needed that the providers of screening services communicate effectively and regularly with residents in Barking and Dagenham, using



appropriate languages and cultural approaches. The service commissioners, Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHRCCGs), can most effectively facilitate this approach.

Assurance can also be provided from NHS England through the Director of Public Health's Health Protection assurance process.

### **3. What is the reason that residents are not as aware of the signs and symptoms of cancer as residents in other London boroughs?**

Barking and Dagenham's residents are not as knowledgeable about the signs and symptoms of cancer as people in other London boroughs. We know that in 2009 residents in Barking and Dagenham were less aware of common signs and symptoms of cancer, such as lumps and swellings; and even less aware of less common symptoms like heavy night sweats or a persistent croaky voice.

A small survey in 2016 found that awareness of the signs and symptoms amongst residents has improved slightly but the question still stands, why do residents present so often with cancer, at the A&E department?

*Cancer is a serious disease that can impact on life in the short term, because of the effects of treatment, and in the long term, because of disability. The risk of cancer can be reduced through changes in lifestyle and the worst consequences of cancer can be reduced through early diagnosis and treatment. The findings of this report suggest that more needs to be done to raise awareness amongst residents of the importance of a healthy lifestyle in reducing the risk of cancer, the signs and symptoms of cancer and the importance of screening. This can be done through campaigns and face-to-face activities. It is important to ensure that the ability of those working in primary care to recognise the signs and symptoms is being maintained and enhanced and that healthcare staff facilitate timely access to the local cancer pathways. In addition, it is important that healthcare staff, who are not routinely in touch with people who develop cancer, can recognise its potential signs and symptoms and can sign-post them to the right services.*

# 1. Background to the Review

**Why did the Health and Adult Services Select Committee (HASSC) choose to undertake an in-depth scrutiny review on Cancer Prevention, Awareness and Early Detection?**

- 1.1 The Council's scrutiny committees decide what topic to undertake an in-depth review on based on the 'PAPER' criteria. The section below explains why according to these criteria, 'Cancer Prevention, Awareness and Early Detection' was a good topic to review.

## **PUBLIC INTEREST**

The residents of Barking and Dagenham are more likely to develop cancer and less likely to survive than residents in other London boroughs and England. Overall, the borough has the lowest net survival amongst London and West Essex Clinical Commissioning Groups (CCGs).



## **ABILITY TO CHANGE**

More than 40% of all cancers are linked to behaviour and environmental exposures which could be avoided or reduced. Factors that also contribute to poor outcomes in Barking and Dagenham include poor awareness of the signs and symptoms, and late detection and diagnosis. Members considered that there was potential to improve people's knowledge around lifestyle and risk of cancer and the signs and symptoms of cancer.



## **PERFORMANCE**

As well as ranking the lowest out of 33 CCGs for net survival, one in every four cancers is diagnosed in the A&E department. This is high compared to London and England.



## **EXTENT OF THE ISSUE**

As of the end of 2010, around 3,600 people in the borough were living with and beyond cancer up to 20 years after diagnosis. This could rise to an estimated 7,000 by 2030. People living with cancer can have complex and varied needs which require holistic support.



## **REPLICATION**

Local partners are focusing on pathways to early cancer diagnosis via screening or primary care. This review focuses on prevention of cancer and early diagnosis through awareness in residents, local authority staff and health staff.



## 2. Scoping & Methodology

- 2.1 This Section outlines the scope of the Review which includes the areas the HASSC wished to explore and the different methods the HASSC used to collate evidence for potential recommendations.

### Terms of Reference

- 2.2. Having received a scoping report at its meeting on 7 September 2016, the HASSC agreed that the Terms of Reference for this Review should be:
1. Why are residents of Barking and Dagenham more likely to develop cancer and less likely to survive cancer than residents in other London boroughs?
  2. What is the reason that residents are less likely to respond to requests for to screen for cancer than in other London boroughs?
  3. What is the reason that residents are not as aware of the signs and symptoms of cancer as residents in other London boroughs?

As there are over 200 types of cancer, the HASSC agreed to focus on the four most prevalent cancers in the borough which are cancers of the breast, prostate, lung and bowel, which are also the most common cancers nationally. In addition, the report discusses cervical cancer as there is screening for this and it is important to review how the borough's rates compare to others.

### Overview of Methodology

- 2.3 The Review gathered evidence during the Committee's meetings held between 7 September 2016 and 11 January 2017. Details of stakeholders and their contributions to this Review are outlined below.

### Presentation – National and Local Context on Cancer Awareness and Early Diagnosis

- 2.4 On 7 September and 2 November 2016, the Council's Public Health team delivered presentations which considered:
- The National Challenge;
  - Cancer Taskforce Strategy Priorities and Ambition for 2020;
  - Barking and Dagenham Cancer Numbers;
  - Prevention and Early Diagnosis; and
  - Barking and Dagenham – what are the problems and what is happening to overcome them.

### Talk Cancer Workshop

- 2.5 Nurses from Cancer Research UK delivered an engaging workshop on 12 October 2016 to members of the HASSC as well as community health champions, which raised awareness of the risk factors for cancer and the signs and symptoms.

## Report on the Pilot for Healthy Lifestyle Services

- 2.6 At the HASSC meeting of 11 January 2017 members considered a report on a pilot project for Healthy Lifestyle Services in the borough and how such services could help raise awareness of cancer and its prevention locally.

### A Resident's Journey

- 2.7 On 2 February 2017 members of the HASSC met with a resident who previously had cancer to hear about the resident's journey and take her views into consideration as part of this Review.

### Submissions

- 2.8 During the Review, Dr Kanika Rai (a GP in the borough), Kate Kavanagh (NHS England Commissioning Manager), and Jane Burt (Primary Care Research Facilitator, Cancer Research UK) submitted statements to the HASSC expressing views about current provision, pathways and potential areas for service improvement.

### Research

- 2.9 During the Review, Council Officers considered the following pieces of research and evidence:
- Independent Cancer Taskforce (2015) Achieving World-Class Cancer Outcomes: A Strategy for England 2015 -2020. [http://www.cancerresearchuk.org/sites/default/files/achieving\\_world-class\\_cancer\\_outcomes\\_-\\_a\\_strategy\\_for\\_england\\_2015-2020.pdf](http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf)
  - NHS England (2016) Five Year Forward View – cancer. Achieving World Class Outcomes: Taking the strategy forward.
  - <https://www.england.nhs.uk/wp-content/uploads/2016/05/cancer-strategy.pdf>
  - London Borough of Barking and Dagenham, Joint Strategic Needs Assessment; cancer. <https://www.lbbd.gov.uk/wp-content/uploads/2015/09/7.22-Cancer.pdf>
  - Moller, H., Henson, K., Luchtenbor, M et al (2016) Short-term breast cancer survival in relation to ethnicity, stage, grade and receptor status: national cohort study in England. British Journal of Cancer 115, 1408-1415
  - Austoker J., Bankhead C., Forbes L. J L., Atkins L., Martin F., Robb K., Wardle J., Ramirez A. J (2009) **Interventions to promote cancer awareness and early presentation: systematic review**
  - Moffat, J., Hinchcliffe, R., Ironmonger, L., Osborne, K. Identifying anticipated barriers to help-seeking to promote earlier diagnosis of cancer in Great Britain (2016) Public Health 141, 120-125.

### 3. Introduction – Understanding Cancer

#### What is Cancer?

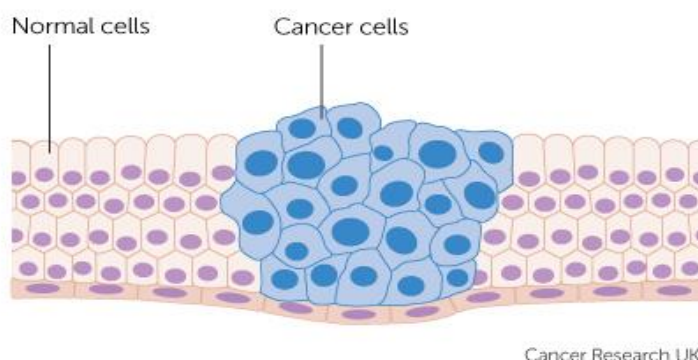
- 3.1 There are more than 200 different types of cancer, and each is diagnosed and treated in a particular way.

One common fact about cancers is that all cancers begin in cells. Our bodies are made up of more than a hundred million, million (100,000,000,000,000) cells. Cancer starts with uncontrolled changes in one cell or a small group of cells.

Usually, we have just the right number of each type of cell because cells produce signals to control how much and how often the cells divide. However, if any of these signals are faulty or missing, cells may start to grow and multiply too much and form a lump called a tumour. Where the cancer starts is called the primary tumour.

Some types of cancer, called leukaemia, start from blood cells. They don't form solid tumours. Instead, the cancer cells build up in the blood and sometimes, the bone marrow.

**Figure 1: Cancer Cells**



Source: Cancer Research UK (CRUK)<sup>1</sup>

#### Common Signs and Symptoms of Cancer

- 3.2 The common signs and symptoms of cancer are:

- A lump in your breast;
- Coughing, chest pain and breathlessness;
- Changes in bowel habits;
- Bleeding;
- Moles
- Unexplained weight loss; and
- Any changes unusual or persistent changes.

Source: NHS website and CRUK<sup>2</sup>

<sup>1</sup> <http://www.cancerresearchuk.org/about-cancer/what-is-cancer>. Accessed on 4 April 2017

<sup>2</sup> <http://www.nhs.uk/Conditions/Cancer/Pages/Symptoms.aspx> and <http://www.cancerresearchuk.org/about-cancer/cancer-symptoms>. Accessed 22 March 2017

## How is Cancer Treated?

3.3 Four common treatments for cancer include:

- Surgery;
- Radiotherapy;
- Chemotherapy; and
- Hormone therapy.

Source: CRUK<sup>3</sup>

## The Impact of Cancer

3.4 Cancer is a serious disease that can take life, and impact on life in the short term, because of the effects of treatment, and also in the long term, because of disability as a result of the cancer.

Cancer that is found early is more easily treated than if it is found late. We look at the importance of early detection in Section 6 of this report. The consequences of cancer and its treatment may mean that people are unable to take part in activities that had been a normal part of their life before, such as going to school or college, shopping, working, socialising, being physically active, going on holiday and enjoying sexual intimacy. This leads to a significant knock-on effect on family and friends, which in turn may cause breakdown of relationships, mental health problems and further isolation.

Source: MacMillan<sup>4</sup>

## Cancer Taskforce

3.5 The Independent Cancer Taskforce<sup>5</sup> established four priorities for improving cancer outcomes:

1. A radical upgrade in prevention and public health – focus on reducing smoking and obesity;
2. Achieving earlier diagnosis;
3. Patient experience on a par with clinical effectiveness and safety; and
4. Transformation in support for people living with and beyond cancer.

The HASSC decided to focus on the first two of the above priorities as part of this Review.

---

<sup>3</sup> <http://www.cancerresearchuk.org/about-cancer/cancer-in-general/treatment> accessed on 4 April 2017

<sup>4</sup>

<http://www.macmillan.org.uk/documents/aboutus/research/researchandevaluationreports/throwinglightontheconsequencesofcanceranditstreatment.pdf>. Accessed 22 March 2017

<sup>5</sup> Independent Cancer Taskforce (2015) Achieving World-Class Cancer Outcomes: A Strategy for England 2015 -2020 available at [http://www.cancerresearchuk.org/sites/default/files/achieving\\_world-class\\_cancer\\_outcomes\\_-\\_a\\_strategy\\_for\\_england\\_2015-2020.pdf](http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf) accessed 2 Feb 2017

Based on these priorities, the Taskforce recommended six evidence-based outcomes:

1. Adult smoking rates should fall to approximately one in 10;
2. Three out of every four screening opportunities offered should be taken up;
3. Approximately six out of 10 people should be surviving 10 years or more after a cancer diagnosis;
4. More than seven out of 10 people should be surviving for one year;
5. The cancer waiting time standard of two weeks, 31 days and 62 days to be achieved; and
6. 95% of people to have a definitive cancer diagnosis within four weeks, and 50% within two weeks.

**Figure 2 - Barking and Dagenham outcomes against the Cancer Taskforce's Targets**



Barking and Dagenham is performing less well than we could be as a borough on some of these indicators. Two in 10 people in the borough smoke and less than two of all those invited attend screening. In the next sections of the report we consider the reasons for this.

## 4. Why are Residents of Barking & Dagenham more likely to Develop Cancer and less likely to Survive Cancer than Residents in other London Boroughs?

- 4.1 The reasons why residents are more likely to develop cancer and less likely to survive in the borough are that they tend to have less healthy lifestyles, and are less aware of cancer signs and symptoms. Therefore, residents are more likely to present at their GP surgery at a later stage of cancer development, or even to present at the A&E department because their cancer has developed so far. Once residents are in the healthcare system, the time that they survive (the survival rate) is the same as the survival rate across London and England.
- 4.2 Members of the HASSC spent the afternoon of the 12 October 2016 taking part in a 'Talk Cancer workshop' run by Cancer Research UK. Members felt that it was an excellent opportunity to hear experts in the field talk about some of the myths around cancer and to present the facts about incidence, diagnosis and treatment, in a positive way. All the attendees found the session, which was presented in an enjoyable way, very helpful in increasing their knowledge and changing the way they think about cancer from a negative, to a more positive way. The words which occurred to their minds before the session were quite different to the ones which came to mind after the session, as Figure 3 below demonstrates. This gave the HASSC great confidence that it is possible to change how people think and feel about cancer, and therefore influence their behaviours and outcomes.

**Figure 3: Pre-workshop and Post-workshop Word Association**

### Pre-workshop word association

A word cloud representing pre-workshop word associations. The words are in shades of grey and black. The most prominent words are 'alone', 'suffer', 'death', 'pain', 'tumour', 'disease', 'weak', 'scared', 'hospital', 'fear', and 'lump'.

### Post-workshop word association

A word cloud representing post-workshop word associations. The words are in shades of pink, purple, and orange. The most prominent words are 'awareness', 'risk', 'diagnosis', 'healthy', 'treatable', 'lifestyle', 'services', 'educate', 'survival', 'control', 'early', and 'help'.

The session also busted a number of common cancer myths (see Appendix 1), and gave an excellent insight into just how important a healthy lifestyle is to preventing cancer.

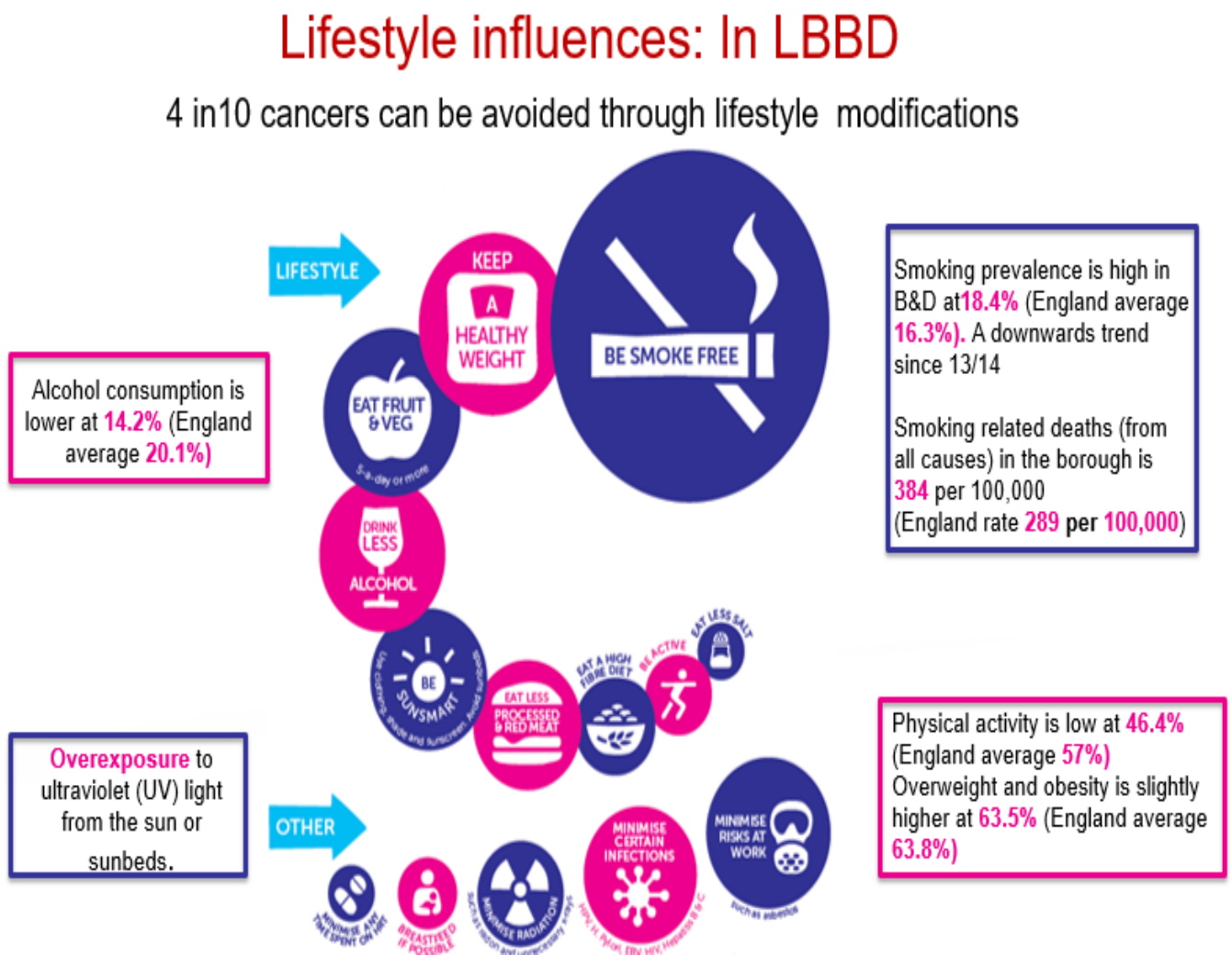
Cancer specialists estimate that four out of 10 cancer cases could be prevented largely through lifestyle changes. Many people believe that getting cancer is purely down to genes, fate, or bad luck. However, as members discovered at the Talk Cancer session, our risk depends on a combination of genes, age, environment, and lifestyle, the last two of which we are more able to control.



## Lifestyle Influences

- 4.3 Members learnt that lifestyle factors that we can control such as smoking, how much alcohol we drink, what we eat, how heavy we are, how much exercise we get, and how long we expose our unprotected bodies to the sun, can affect the chances of developing cancer. A decision to smoke and continue smoking, for example, will increase a person's risk of developing cancer. By choosing not to do anything about being overweight, a person is also increasing their risk.

**Figure 4: Lifestyle Influences on Cancer Development**



- 4.4 However, the ability to choose to live a healthy lifestyle is harder and more limited if you are poor than if you are affluent. You may feel unable to afford healthy food, which is more expensive than unhealthy, more refined food and you may feel unable to afford to belong to a club that will encourage you to exercise. In fact, you may feel depressed and lacking in motivation anyway and find it hard to break a habitual cycle of unhealthy behaviours, unless there is access to the means to change, which won't cost money. Members therefore made recommendations in this report to support local people make these choices.

## Smoking

- 4.5 **Smoking remains the most important preventable cause of cancer Barking and Dagenham.** We all know that smoking increases the risk of developing lung cancer, but it also increases the risk of developing cancer in many other areas of the body including breast, bowel, stomach, bladder, prostate and cervix. It is in fact fair to say that there isn't a part of the body that the damaging effects of smoking do not reach.



Smoking prevalence in Barking and Dagenham is 18.4% and higher than both the London (14%) and national (16.3%) average.<sup>6</sup> The numbers of smokers in Barking and Dagenham have steadily been going down, as have the national averages, particularly since the 2007 smoking ban in public places. However, we know that there are certain pockets of the population where smoking prevalence is above the averages that are cited. This is because the poorer the area, the higher the prevalence of smoking. In these communities and amongst the unskilled and manual working groups, smoking remains an acceptable, social activity. Stop smoking services have attempted through various targeting strategies, to actively engage these resistant smokers in quitting attempts with some degree of success. However, it is difficult and intensive work to break down these barriers and support the breaking of habits that are long established and often perpetuated through family and friendship networks.

### RECOMMENDATION 1

The HASSC recommends that the Health and Wellbeing Board takes action to reduce the prevalence of smokers in the borough, to levels comparable with London.

## Alcohol

- 4.6 Alcohol intake is a potential cause of some cancers in Barking and Dagenham. The level of alcohol consumption in Barking and Dagenham is difficult to measure; however, the number of deaths where alcohol is a secondary cause is comparatively high.



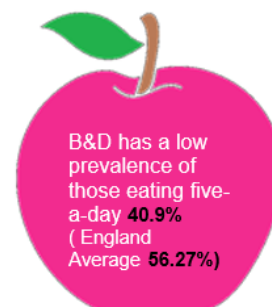
The majority of alcohol-related cancer deaths are expected to be from cancers of the oesophagus, bowel, mouth and throat,

<sup>6</sup> PHE (2017) Public Health England Fingertips data. Available at <http://fingertips.phe.org.uk/search/smoking>  
Accessed 2 Feb17

breast and liver. In Barking and Dagenham, it is estimated that 14.2% of the population binge drink at least one day a week, which is not as high as the national average of 20.1%.<sup>7</sup> However, with poor rates of other healthy lifestyles and poorer outcomes on cancer compared to national and London averages, we should not be complacent and should aim to bring about a decrease in drinking levels.

## Diet

- 4.7 Eating a healthy, balanced diet helps maintain a healthy body weight, which is important because obesity is the second biggest preventable cause of cancer after smoking. However, in areas of deprivation, like Barking and Dagenham, it can be harder to afford a healthy diet and some residents feel that money will go further in buying sugary, refined food than buying fruit and vegetables.



Food access, particularly to healthy food, is a problem in some areas of Barking and Dagenham. The borough also has a high number of takeaway food outlets in residential areas and intake of fruit and vegetables is low with four in 10 people eating fruit and vegetables every day, compared to 5.5 in 10 across England.<sup>8</sup> It is clear that these things impact on the healthy weight of people in the borough.

## Weight

- 4.8 **One in four reception children and one in three Year 6 children are overweight or obese** (2014/15 statistics).<sup>9</sup> This prevalence sets Barking and Dagenham as the fifth highest prevalence of excess weight in reception (26.6%) in London, above the London and national prevalence of 23% and 22.5% respectively. Barking and Dagenham also has the third highest prevalence of excess weight in Year 6 children (42.2%) in London, above the London and national average prevalence of 37.6% and 33.5% respectively.



**Nationally, 64.6% of adults nationally are overweight. In Barking and Dagenham this figure is 68.4% and is the highest of all the London boroughs.**<sup>10</sup> Research shows that, sadly, many types of cancer are more common in people who are overweight or obese. This is essentially because fat cells affect the level of hormones and proteins in the body. These chemical messengers can then cause cells to change and divide abnormally, and so become cancerous.

<sup>7</sup> PHE (2017) Public Health England Fingertips alcohol profile. Available at <https://fingertips.phe.org.uk/profile/local-alcohol-profiles> Accessed 2 Feb 17.

<sup>8</sup> LBBDD (2016) Joint Strategic Needs Assessment

<sup>9</sup> ibid

<sup>10</sup> ibid

## Exercise

- 4.9 An inactive and sedentary lifestyle can increase the risk of cancer. The risk of getting bowel and breast cancer can be reduced if people increase their physical activity. Physical activity of adults in Barking and Dagenham is low (46.4%),<sup>11</sup> with less than one in two residents taking 150 minutes of physical activity per week. The England average is six out of 10 people doing this amount of activity. A Healthy Weight Strategy for Barking and Dagenham to address lifestyle issues in the borough, such as diet and physical activity, was approved by the Health and Wellbeing Board in September 2016.<sup>12</sup>



### Extract from Barking and Dagenham's Healthy Weight Strategy

**VISION**

- Barking and Dagenham to be a place where residents can make a change to help enable them to achieve or maintain a healthy weight

- ❖ **Enable families and individuals to take responsibility for achieving and maintaining a healthy weight.**
- ❖ **Make an active lifestyle and healthy eating the easier choice.**
- ❖ **Address causes that put particular groups of families and individuals at a greater risk of obesity.**
- ❖ **Ensure the built and natural environment support families and individuals to be more healthy and active.**

## RECOMMENDATION 2

The HASSC recommends that the Health and Wellbeing Board set out to the HASSC what action it is taking to reduce the number of overweight and obese individuals in the borough, to levels comparable with London.

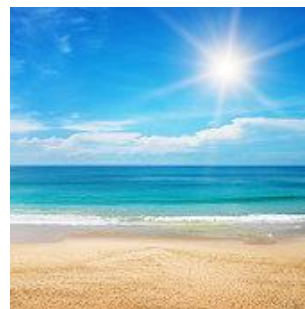
<sup>11</sup> ibid

<sup>12</sup> <https://www.lbbd.gov.uk/council/priorities-and-strategies/corporate-plans-and-key-strategies/health-and-wellbeing-strategy/81738-2/> Accessed on 22 March 2017

## Exposure to Sun

- 4.10 Melanoma is the most serious type of skin cancer and in the UK more than eight in 10 cases could be prevented through enjoying the sun safely and avoiding sunburn.

Residents are exposed to the sun particularly during heatwaves. The borough takes an active role in advising residents particularly those at high risk.



### RECOMMENDATION 3

The HASSC recommends that the Health and Wellbeing Board takes action to increase residents' awareness of how lifestyle, including exposure to sun, can affect the likelihood of developing cancer, the signs and symptoms of cancer and the importance of early diagnosis, and screening.

(See Section 6 for more information on the importance of early diagnosis and screening).

## 5. The Incidence of Lung, Bowel, Breast and Prostate Cancers and Survival Rates in Barking & Dagenham

This Section compares the incidence of the four most common cancers in Barking and Dagenham against national rates.

In this report when we discuss survival periods, we talk about one and five-year survival periods, which are the periods of time of survival that are measured. It is important to note that residents, happily, often survive for much longer periods than five years after diagnosis and treatment for many cancer sites.

### Lung Cancer

- 5.1 **A resident of Barking and Dagenham is one and a third times more likely to develop lung cancer than people in other parts of England.**<sup>13</sup> The incidence of lung cancer in Barking and Dagenham is higher than the national average, which is in keeping with the fact that it is the third most deprived borough in London and that smoking rates are higher than the London national average.

However, after treatment, a resident is more likely to survive up to one year. The one year survival rates at 37.6% are better than the England average (35.4%).<sup>14</sup>

### Bowel Cancer

- 5.2 A resident in Barking and Dagenham is slightly more likely to develop bowel cancer than a person living in the rest of England.

Once diagnosed and treated, a resident is equally likely to survive at least one year as other people living in England.

### Breast Cancer

- 5.3 A resident in Barking and Dagenham is less likely to develop breast cancer than the England average. This is in keeping with the fact that it is less common in the most deprived areas.

Once diagnosed, a resident is likely to survive for at least one year, and this is good news. In Barking and Dagenham, nine out of 10 people survive for one year. Across England, the rate is also nine out of 10 people.

There is increasing evidence that Black African and Black Caribbean women have a higher risk of particular types of breast cancer and are more likely to get breast cancer in an aggressive form ('triple negative cancer'), and so have a much worse prognosis. The survival rate for women aged 15 - 64 years, after both one and three

---

<sup>13</sup> CRUK Local stats site. The 2013 European age standardised rate for 2012-14 is 109.9 per 100,000 where the England average is 79.8.

<sup>14</sup> LBBD (2016) JSNA

years, is significantly lower in Black African/Caribbean women than in White women.<sup>15</sup>

## Prostate Cancer

- 5.4 A resident of Barking and Dagenham has the same chance of developing prostate cancer as someone in another area of London. **However, a person who does develop prostate cancer is sadly, more likely to die when compared to the England average.**<sup>16</sup>

Black men have a higher risk of developing prostate cancer than other ethnic groups. Prostate cancer is three times more common in Black ethnic groups.<sup>17</sup>

Barking and Dagenham has a larger than average young population of men of Black African and Caribbean ethnic origin and the number of cases of prostate cancer is likely to rise in the future. For this reason, it is important to raise awareness of the signs and symptoms in this group particularly.



### RECOMMENDATION 4

The HASSC recommends that the National Awareness and Early Detection Initiative informs the commissioners on what action it is taking to target specific 'at risk' groups.

---

<sup>15</sup> Moller, H., Henson, K., Luchtenbor, M et al (2016) Short-term breast cancer survival in relation to ethnicity, stage, grade and receptor status: national cohort study in England. British Journal of Cancer 115, 1408-1415 (22 November 2016).

<sup>16</sup> Mortality rates for prostate cancer are higher than England average – 52.4 per 100,000 as opposed to 45.9. This follows logically from the higher incidence rate.

<sup>17</sup> Cancer Research UK. Cancer incidence for common cancers: Ten most common cancers in males (2011) [Internet]. 2014. Available from: <http://www.cancerresearchuk.org/cancer-info/cancerstats/incidence/commoncancers/#Ten>. Accessed 24 March 2017

## 6. The Importance of Screening and Screening Uptake Rates in Barking & Dagenham for Breast, Bowel and Cervical Cancer

Now that we have considered the prevalence of the common cancers and survival rates in the borough, in this Section, we look at the importance of screening and screening rates in the borough. In the next Section, the possible reasons why residents do not always respond to screening invites are explored.

### Late Cancer Presentation

- 6.1 If a cancer diagnosis is made early, it is better than if it is made late. **A resident who is diagnosed with Stage 1 or Stage 2 cancer is more likely to survive one or five years, than someone diagnosed at Stage 4.**

The reason for this is that although early cancers that are smaller and not entangled with healthy cells are harder to find, they are easier to treat. These cancers are generally stage 1 and stage 2 cancers. As cancer grows, it gets bigger and entangled with other, healthy cells. Staging is a way of describing how big a cancer is and whether it has spread into surrounding tissues.

**Figure 5: Cancer Diagnosis by Stage in LBB in 2014<sup>18</sup>**

Cancer type	1	2	3	4	Known Stage total	X - Unknown stage	Grand Total
Breast	62	51	9	4	126	23	149
Proportion diagnosed by known stage	49%	40%	7%	3%	85%	15%	
Colorectal	8	11	20	17	56	14	70
Proportion diagnosed by known stage	14%	20%	36%	30%	80%	20%	
Lung	7	7	20	57	91	27	118
Proportion diagnosed by known stage	8%	8%	22%	63%	77%	23%	
Prostate	27	12	12	6	57	24	81
Proportion diagnosed by known stage	47%	21%	21%	11%	70%	30%	
Grand Total	104	81	61	84	330	237	418
<b>Proportion diagnosed by known stage all cancer total</b>	32%	25%	18%	25%	79%	57%	

*\* Note - be aware of small numbers when looking at percentages*

<sup>18</sup> 2014 Cancer Staging Statistics by Clinical Commissioning Group



Breast cancer is the most common cancer in England, and most common in Barking and Dagenham. Most breast cancers are diagnosed at an early stage in Barking and Dagenham, with nine in every 10 known cancers diagnosed at stages 1 and 2. This rate of diagnosis is as good as the England average.

Colorectal cancer is often diagnosed at a late stage in England, and in Barking and Dagenham. We find currently that one in every three colorectal cancers is diagnosed at stage 1 or 2. Residents of Barking and Dagenham are, currently, slightly less likely than residents in other boroughs to be diagnosed at stages 1 and 2.

Lung cancer is, again, often diagnosed at a late stage in England, and in Barking and Dagenham. We find, currently, that two in 10 lung cancers are diagnosed at stages 1 and 2. Residents of Barking and Dagenham are, currently, slightly less likely than residents of other boroughs to be diagnosed at stages 1 or 2.

Prostate cancer is the most common cancer in men. It is often diagnosed at an early stage in England, and in Barking and Dagenham. We, currently, find that seven in every 10 prostate cancers are diagnosed at stages 1 and 2. This rate of diagnosis is as good as the England average.

- 6.2 Emergency presentation refers to residents attending Accident and Emergency (A&E) with symptoms who are then diagnosed with cancer. This is usually when the person’s cancer has developed to Stage 3 or 4.

**The number of cancers diagnosed at a later stage, Stages 3 and 4, in the borough is higher than in England.** Nearly one in every four (22.8%) cancer diagnosis in Barking and Dagenham are made through emergency routes, as compared to the England average, which is one in every five (20.1%) of cancer diagnoses.

**Figure 5: Number of Emergency Presentations in Barking and Dagenham**

	Barking and Dagenham	London	Year
Number of Emergency Presentations per 100,000 population	73.68	64	2015/16

Late, emergency diagnosis results in poorer outcomes for residents because Stage 3 and 4 cancers are much harder to treat. The chances of a resident surviving for one year after a cancer is diagnosed at A&E is significantly lower than all other routes to diagnosis because this generally correlates with late stage diagnosis. The impact of this can be demonstrated by looking at the rates of survival when cancer is diagnosed at different stages. For example, in bowel cancer, an early diagnosis usually means nine out of 10 residents will survive for five years or longer, whereas a late diagnosis often results in less than one in 20 surviving five years or longer.

## **The Importance of Screening**

- 6.3 Screening can help detect cancer before the person has symptoms or has become aware of any signs. It is important to note that people should still be alert to signs and changes described earlier in Section 3, as cancer can develop between screening rounds. However, attending screening is a good way to save lives, by finding cancer at an early stage. The earlier cancer is detected in a person and is treated, the longer his or her survival after diagnosis is likely to be. People need to be registered with a GP with an up-to-date address to receive screening invitations. GP practices are advised when their patients fail to attend cancer screening tests.

There are three national cancer screening programmes - bowel, breast and cervical cancer. There are no screening programmes for lung and prostate cancer. However, for prostate cancers, GPs are encouraged to review the following men who may be at higher risk:

- Black men;
- Men who have a family history; and
- Men who are overweight or obese.

(See also 5.4 of this report and the recommendation at the end of that Section).

Residents of Barking and Dagenham have access to the three cancer screening programmes; breast, bowel and cervical.

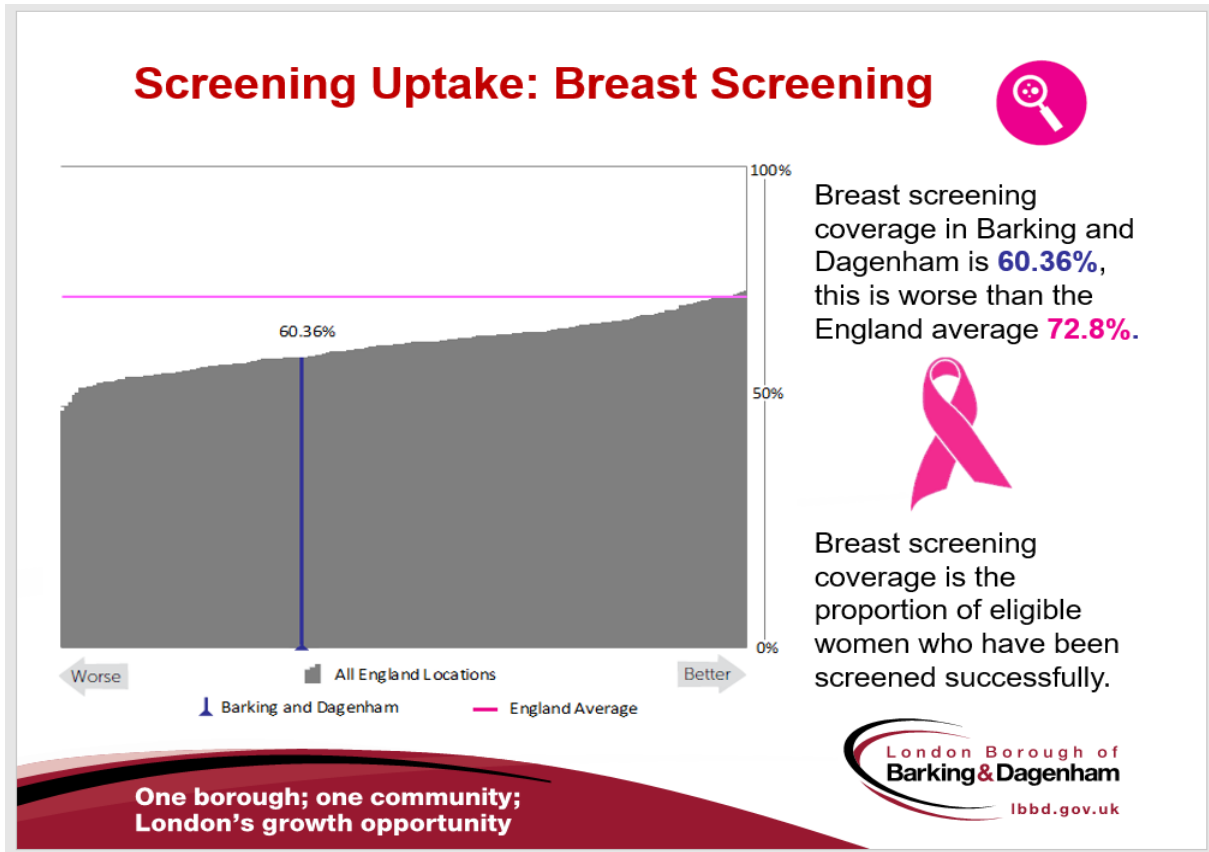
The cancer screening services for the borough are commissioned by NHS England, and the services are quality assured by the Council's Director of Public Health.

## **Breast Cancer Screening**

- 6.4 Breast cancer screening uses a test called a mammography which involves taking x-rays of the breast which can help find cancers early when they are too small to see or feel. Screening is offered to women between the ages of 50 and 70, though people over the age of 70 can request a screening.

For breast cancer, early diagnosis results in nine out of 10 residents surviving five years or longer, but late diagnosis means only one in 10 surviving five years or longer. It is, however, important to note that there is a slightly lower than expected uptake of breast cancer screening in relatively high numbers of people of Black ethnic origin in the general England population, and this is likely to also be the case in LBB. (See also 5.4 of this report and the recommendation at the end of that Section).

Figure 6: Screening Uptake: Breast



The uptake of breast cancer screening in the borough is decreasing. In 2012 the offer was taken up by 64% of those offered. In 2014/15 this had decreased to 60%.

There is considerable variation in uptake by patients across GP practices. Some GP practices in the borough have an uptake that is higher than 64%; others need support and have an uptake that is considerably lower than 64%.

## RECOMMENDATION 5

The HASSC recommends that the Barking and Dagenham Clinical Commissioning Group ensures that GPs are auditing and acting on audit information to ensure that patients enter the cancer pathway appropriately and cancer is diagnosed at as early a stage as possible.

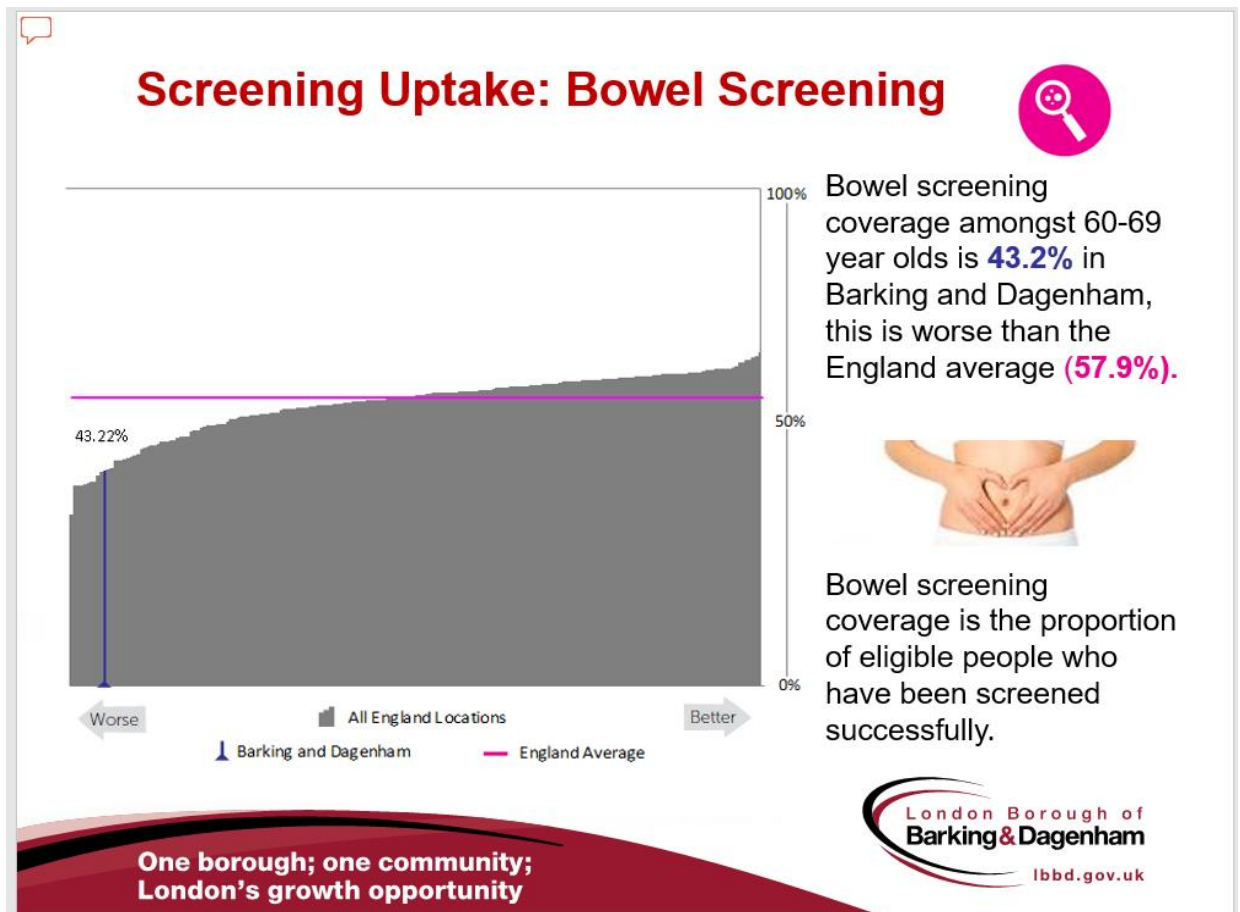
## Bowel Cancer Screening

- 6.5 Bowel screening is offered every two years to people between the ages of 60 and 74, however; those over the age of 74 can request a screening kit. The screening can detect cancer at an early stage and also help cancer from developing in the first place. GP registered lists are used to send the bowel screening kit, shown in Figure 7, a service which is provided through NHS England.

Figure 7: Bowel Screening Kit



Figure 8: Screening Uptake: Bowel



**A much lower proportion of residents, than is usual for England, respond to requests to act on and return bowel cancer screening kits.** The uptake of bowel cancer screening in the borough is low and steady.

In 2012 the offer was taken up by 43% of those offered. In 2014/15 this was still 43%, compared to the England average of 57.9%.

Barriers to taking the test include lack of awareness of the function of the test, and cultural objections to handling faeces. Barking and Dagenham is now seeing five out of 10 people sending off kits. This has happened since the start of a local scheme, developed by the Clinical Commissioning Group (CCG), to increase bowel screening uptake. There remains considerable variation in uptake by patients across GP practices with some practices achieving an uptake of 53.7% and others 31%. Once residents are referred to the diagnostic unit at the local hospital, the 'did not attend' rate is low at 0.42%.<sup>19</sup>

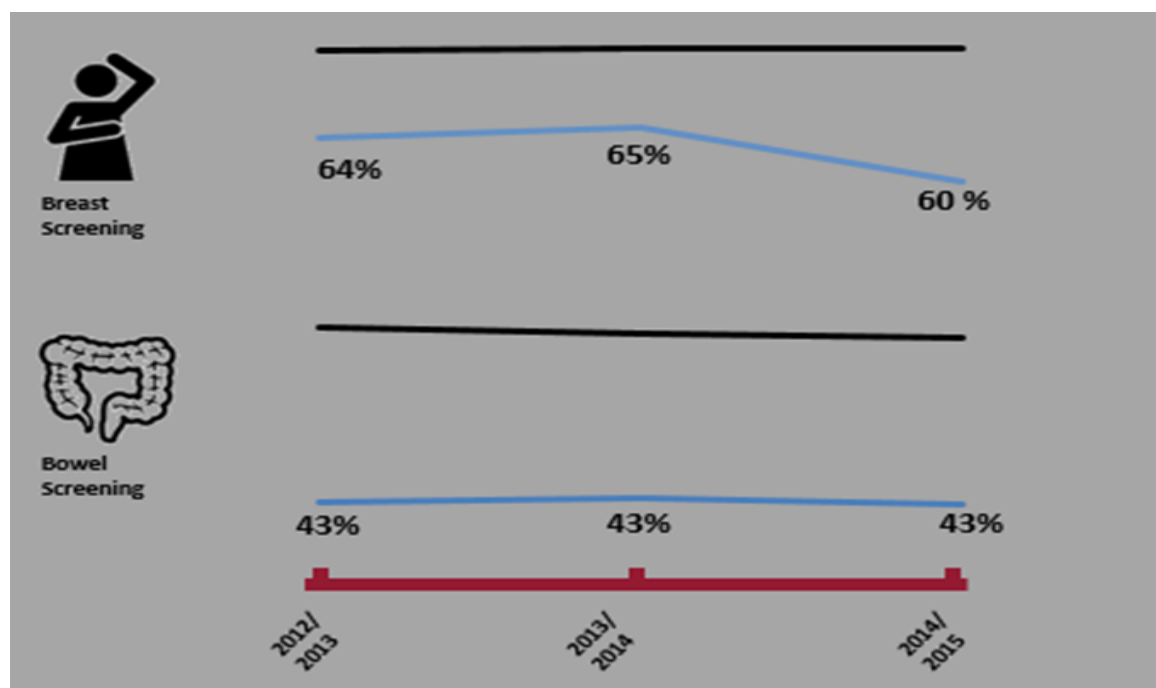


## RECOMMENDATION 6

The HASSC recommends that the Barking and Dagenham Clinical Commissioning Group, in partnership with MacMillan and Cancer Research UK, takes action to increase the proportion of residents returning bowel cancer screening kits within the next year.

**Figure 9: Changes in Breast and Bowel Cancer Screening Uptake in Barking and Dagenham 2012 – 2015.**

There is significant variation across the borough in the numbers of residents that access breast and bowel screening.



<sup>19</sup> BHRUT (2017) DNA data sigmoidoscopy unit.

The trend across the years 2012 – 2015 is for less residents to attend breast screening, and for the uptake in bowel screening to be low.



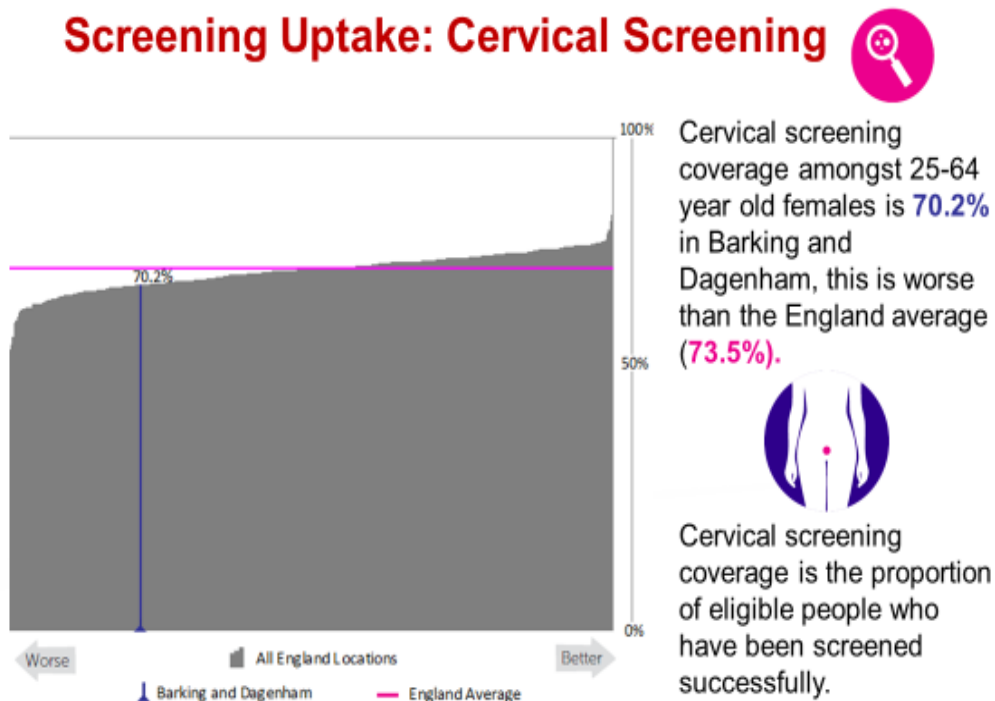
## RECOMMENDATION 7

The HASSC recommends that the Health and Wellbeing Board, along with MacMillan and Cancer Research UK, takes action to raise awareness of the importance of screening to increase uptake of breast and bowel screening in the borough to a level comparable with England within the next year.

### Cervical Cancer Screening

- 6.6 Cervical cancer screening is offered to women aged 25 – 64. Women aged 25 – 49 are invited every three years. After 50, women are invited every five years until they are 64 years old.

Figure 10: Screening Uptake: Cervical



One borough; one community;  
London's growth opportunity



The uptake of cervical screening in the borough is 70.2% of all eligible women compared with 73.5% across England. Less than five cases of cervical cancer were diagnosed in Barking and Dagenham 2012-2014. There remains considerable variation in uptake of cervical screening by patients across GP practices with some practices achieving an uptake of 78% and others 55.4% of eligible population.



## **RECOMMENDATION 8**

The HASSC recommends that the Health and Wellbeing Board, along with MacMillan and Cancer Research UK, takes action to raise awareness of the importance of screening and reduce the variation in cervical screening uptake between GP practices within the next year.

## **Cancer Dashboard**

- 6.7 The Cancer Strategy for England<sup>20</sup> recommends that NHS England work with other arm's length bodies to develop a cancer dashboard of metrics at the CCG and provider level.

The proposed cancer dashboard will measure how well different areas of the country are performing. They will record performance in four areas - early diagnosis, one year survival, 62 day wait for treatment and overall patient experience. The dashboard will enable the comparison and improvement of cancer outcomes in Barking and Dagenham.

It is proposed that this dashboard includes information on screening uptake across GP practices.



## **RECOMMENDATION 9**

The HASSC recommends that the Committee urges NHS England to make the Cancer Dashboard available within one year.

---

<sup>20</sup> Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020', [Online] Available from: [https://www.cancerresearchuk.org/sites/default/files/achieving\\_world-class\\_cancer\\_outcomes\\_-\\_a\\_strategy\\_for\\_england\\_2015-2020.pdf](https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf) [Last accessed: 15th of August 2016]

## Health Checks

- 6.8 The Health Check is a different type of screening that all GPs offer. It is a programme designed to screen for heart disease but it also reviews residents' lifestyles and is an opportunity to point residents toward improved lifestyle behaviour or to pick up unintended weight loss.

All the borough's GPs have signed up to deliver the Health Check; however, there is considerable variation on the numbers of health checks delivered by GP practices, with some practices delivering 0% and some 100% of eligible health checks. (See Appendix 2).



### **RECOMMENDATION 10**

The HASSC recommends that the Health and Wellbeing Board takes action to raise awareness of the importance of the Health Check and reduce the variation in Health Check uptake between GP practices.



## 7. The Potential Reasons for Late Detection of Cancer in Barking & Dagenham, including reasons for Lower Uptake of Screening

Barking and Dagenham residents are not as knowledgeable about signs and symptoms of cancer as people in other London boroughs. We know that in 2009 residents in Barking and Dagenham were less aware of the common signs and symptoms of cancer, such as lumps and a long-term cough.

### The Cancer Awareness Measure – Signs and Symptoms

7.1 Members learnt that in 2009/2010 residents were asked a number of questions as part of national research to find out if people could recognise signs and symptoms of cancer. This research used the Cancer Awareness Measure (CAM). This survey found that while people are generally aware that smoking can cause cancer, only one in three residents of Barking and Dagenham were aware that a persistent cough can be sign of cancer.

Similarly, **one in three residents could not recall any other sign or symptom of cancer** including:

- An unexplained lump or swelling;
- Persistent unexplained pain;
- Unexplained bleeding; or
- A persistent change in bowel habits.

At the same time, across England, two in three residents could recall a classic cancer symptom.

Local information<sup>21</sup>, from a small number of residents who answered a questionnaire, suggests that in 2016, four in five residents knew that an unexplained lump or swelling could be a sign of cancer.

#### Figure 11: 4 of 5 Residents Recognise a Lump as a Sign of Cancer



In the same survey, we found that three in five residents were aware that a persistent cough, persistent change in bowel habit or change in appearance of a mole is a sign or symptom of cancer.

<sup>21</sup> LBBB (2016) Small survey of residents.

Less residents were aware of other signs and symptoms such as persistent difficulty in swallowing; a sore that does not heal; or persistent unexplained pain. Awareness of the signs of cancer is particularly low in men, teens and ethnic groups.

## **Other Barriers to Getting Diagnosed**

- 7.2 The lack of awareness of the signs and symptoms of cancer, combined with the factors below, could mean that some residents face a number of barriers to getting diagnosed early.

### **Emotional**

Cancer has many negative connotations, which can make it difficult to talk about. People may be embarrassed by a symptom they are having, feel fearful of what the doctor may suspect, or simply not quite know how to bring the topic up with the doctor.

### **Cultural**

Difficulty in talking about cancer may also be a cultural issue; for example, for some residents, English is not a first language. There may also be cases where individuals are not taking tests such as bowel cancer screening because handling faeces is culturally offensive.

### **Practical**

Both for screening and diagnosis, residents need to tackle practical issues such as making an appointment, and arranging or taking transport. These issues can disproportionality affect people from vulnerable groups in the community including people from minority ethnic groups, people with mental health issues, people living with learning disabilities and people living with physical disabilities.

The breast screening unit has not been easily accessible to the borough's residents, which may have acted as a barrier to screening for some residents. Recently, a unit has been placed in the borough temporarily. The Committee need to be assured by NHS England that residents will continue to have in-borough access to breast screening.



## **RECOMMENDATION 11**

The HASSC recommends that NHS England provides assurance to it that residents will continue to have in-borough access to breast screening.

## Service

Sometimes residents simply worry that they are wasting the doctor's time with their concerns or may find it difficult to make an appointment with their GP, leading them to put off making an appointment.

- 7.3 However, if awareness of the signs and symptoms of cancer and the importance of early diagnosis could be raised, more people will understand the importance of overcoming the barriers and seeing their doctor, leading to a better early detection rate.

### The Two Week Urgent Referral System

- 7.4 For those patients who do go to their GP, where the GP suspects cancer, the patient is directed to the two-week urgent referral system. The number of cases referred to the two-week wait system varies between GP practices. There is no right or wrong number of referrals, and 96% of residents have a diagnosis within 30 days.

The conversion rate gives an indication of the number of cancers diagnosed as a result of the referral to the two-week referral system. For most practices in the borough, the conversion rate is 10%, which means that 10% of referrals have a cancer diagnosis. This is in line with the England average. One practice falls below this rate, which indicates that some GPs in this practice would benefit from updating in primary cancer signs and symptoms.

## Cast Study

- 7.5 Members of the HASSC met with a resident, Mary (not her real name), to talk about her cancer journey to see what they could learn from her story and how they could apply this to their Review.

### Mary's Story

Three years prior to being diagnosed, Mary had a persistent cough. She eventually visited her GP who sent her for some tests which showed a shadow on her lung. After further tests she was informed that it was not cancer which she was assured by. She was not sent for further tests to look for markers for cancer. In hindsight, she personally felt this should have been done to ensure she was in the all clear.

Soon before she was diagnosed Mary had another persistent cough and had lost weight but at the time this did not seem relevant to her. It was when she developed severe joint pains that she became concerned and went to see her GP. A test result showed a high marker for cancer in her liver and an X-ray later confirmed that there was a mass in her lung. She was an ex-smoker but at the time of her diagnosis she had not been smoking for over eight years.

Queen's Hospital was initially not able to confirm a cancer diagnosis due the positioning of the mass in her lung and eventually, she was referred to a consultant in Bart's for this. Three weeks later she had an operation to remove the cancer. Following her treatment for lung cancer, Mary noticed that one side of her mouth had dropped so she visited her GP again.

Her GP initially suspected Bell's Palsy but sent her for tests to be sure, and it was after this that she found out that she had a tumour in her brain, which meant that the cancer had spread. Mary started treatment at the chemo unit in King George Hospital for this, which she found a comfortable environment. She felt it was very positive that there was cancer nurse who she could contact when she needed.

Mary shared that her faith played an important part in her emotional state while she had cancer. She also went to a retreat in Bristol with her sister which she found very helpful as she learnt more about cancer and the importance of diet in preventing cancer.

Mary felt her immune system was very poor prior to her developing cancer as she kept getting infections. She personally felt that this may have had part to play in her developing the tumour. Mary felt there are a lot of messages already out there in the borough about diet and other lifestyle changes; however, these are not always linked to cancer. Local services could be more explicit in their messages about the link between lifestyle and cancer but it would be important to do this in a positive way by emphasising that these measures are preventative. Mary also felt a possible reason people in the borough don't always attend screening is fear, so she considered it important to explain to people what cancer is and that it can be beaten more easily if it is caught early.

HASSC took from Mary's story:

1. Early identification and referral by a GP is key to the outcome of a cancer diagnosis;
2. It is important to raise awareness of signs and symptoms of cancer in residents in a positive way;
3. It is important that residents have good access to local services for both diagnosis and treatment; and
4. It is important to raise awareness of the importance of attending screening for cancer in a positive way.



## **RECOMMENDATION 12**

The HASSC recommends that Barking and Dagenham Clinical Commissioning Group, working through the North-East London Cancer Commissioning Board, assures the Committee of the action it is taking to increase awareness of the signs and symptoms of cancer.

(See also Section 4 and the recommendation at the end of that Section).

## **8. What is Working Well and What more can be Done?**

### **What is Working Well?**

8.1 The HASSC received a report on the Mayesbrook Park Pilot, an exciting piece of local work designed to increase awareness of healthy lifestyles, including signs and symptoms of cancer. This piece of work is particularly exciting because, through community engagement, many of our local residents are involved. Some are involved as community champions, and have been trained to engage with their own community, whether that be an ethnic community, a faith community or simply their neighbours. If this piece of work evaluates well, it will be rolled out across the borough.

Barking and Dagenham health partners have also been successful in introducing positive change through communities, GP practices and St George's and Queen's Hospital. This is detailed below.

### **8.2 In the Community**

- Taking a local slant on NHS awareness campaigns;
- Using social media and posters such as 'Be Clear on Cancer';
- Some community talks to local groups; and
- Physical activity schemes for cancer patients.

### **8.3 In GP Practices**

- A Cancer Research Facilitator is in post to support primary care to develop skills and knowledge in cancer awareness and treatment;
- Practice visits by Macmillan GPs and primary care facilitator;
- Local Enhanced Scheme from bowel cancer screening;
- GP education programme to increase awareness of common and vague signs and symptoms of cancer;
- Education programme for practice staff to support patient care locally;
- Improved patient awareness of signs and symptoms of cancer, particularly within hard to reach groups; and
- Work plan to increase the uptake of screening services.

### **8.4 King George and Queen's Hospital**

- Audit of emergency department presentations of cancer to identify potential opportunities for early diagnosis and improved patient experience. The results are not yet available but must be acted on when they are available.

### **8.5 Across Barking & Dagenham, Havering and Redbridge**

- Collaborative working with secondary care clinicians to develop direct access to pathways for diagnosis.

## What More can be Done?

- 8.6 Throughout this report, the HASSC has made recommendations to help improve outcomes for the borough's residents. Below are further areas for the Health and Wellbeing Board and local health partners to consider, some which may overlap with the recommendations.

More can be done to support action to increase community awareness of importance of lifestyle. **If the Mayesbrook pilot project work is deemed successful, consideration should be given to rolling this approach out across Barking and Dagenham.**

- 8.7 The Council could introduce targeted social media campaigns linked to the national 'Clear on Cancer' NAEDI campaigns, with the aim of increasing uptake of screening and awareness of signs and symptoms, including:

- Encouraging attendance at the Cancer Research UK roadshow;
- A targeted approach to increase screening in vulnerable groups e.g. increasing the uptake of bowel screening in people with learning disabilities and
- A targeted approach to increasing awareness and the uptake of screening in Council staff and other staff in the workplace can be encouraged through the London Work Place Health initiative.

- 8.8 There should be support for staff to develop skills in talking about cancer to residents, particularly community health champions, Community Solutions, social care and health staff.

One form of awareness training is making Every Contact Count (MECC). This training is designed to educate staff about early signs and symptoms of cancer. Staff who are in face-to-face contact with residents can help the residents to recognise early signs and symptoms of cancer and sign-post them to health services.

### 8.9 In GP Practices

- Continued and extended engagement with the Cancer Research Facilitator to support primary care to develop skills and knowledge in cancer awareness and treatment;
- Continued Practice visits by Macmillan GPs and primary care facilitator;
- Continued support for the Local Enhanced Scheme from bowel cancer screening;
- Continued and extended GP education programme to increase awareness of common and vague signs and symptoms of cancer;
- Continued and extended education programme for practice staff to support patient care locally;
- Improved patient awareness of signs and symptoms of cancer, particularly within hard to reach groups;
- Work plan to increase the uptake of screening services, particularly bowel screening;
- Support and encourage residents to register with a GP practice;

- Encourage health partners to audit and act on practice level uptake of cancer screening; and
- Encourage health partners to put in place actions that are known to improve uptake of screening, such as:
  - Phone reminders;
  - Case note reminders; and
  - Local enhanced services agreements.

8.10 The Council should further strengthen its partnership with health providers to provide a consistent approach to awareness and early intervention. For example, it could:

- Encourage health partners to audit and act on variation in practice level early identification of cancer;
- Strengthen links through the North-East London Cancer Commissioning Board; and,
- Strengthen local CCG and public health contracts through specifications that include a requirement to increase awareness and early intervention in cancer.



## 10. Next steps

10.1 This report and its recommendations will be submitted to the Health and Wellbeing Board and relevant health partners, who will decide whether to agree the recommendations. If the recommendations are accepted, the Health and Wellbeing Board and health partners will be asked to draw up an action plan describing how the recommendations will be implemented. In approximately six months' time, the HASSC will request a monitoring report explaining the progress of the implementation of the recommendations and whether anything could be said of the early impact they have had.

## **The HASSC would like to extend its thanks to the following for contributing to this Review:**

Members thank the following for their support during this Review:

- Resident who spoke to members on 2 February 2017
- Dr Kanika Rai: MacMillan GP
- Jane Burt: Primary Care Facilitator, Cancer Research UK
- Katherine Kavanagh: Cancer Commissioning Manager (BHR & West Essex)
- Sue Lloyd: Public Health Consultant, LBBD
- Mary Knowler: Public Health Strategist, LBBD
- Masuma Ahmed: Democratic Services Officer, LBBD

# Appendices

### Cancer Myths

#### Stress causes cancer

- ❖ Some people think that stress can cause cancer but the evidence for this is poor.
- ❖ Stressful events can alter the levels of hormones in the body and affect the immune system but there is no evidence that these changes could lead to cancer.
- ❖ Stressful situations can make some people more likely to take up unhealthy behaviours such as smoking, overeating and drinking alcohol. We know these behaviours increase the risk of developing cancer.

#### Mobile phones cause cancer

- ❖ So far, the scientific evidence shows that it's unlikely that mobile phones could increase the risk of cancer, but we do not know enough to completely rule out a risk.
- ❖ The use of mobile phones has skyrocketed since the 1990's. If mobile phones increase the incidence of brain cancer, increasingly people should be developing this disease. In the UK, the incidence of brain cancer has been constant for years.
- ❖ Source: Talk Cancer, Cancer Research UK

## Appendix 2

### Barking and Dagenham: Variation in health check by invitation and completion

Name	Centre	Total Eligible (5 year)	Total Invitations (annual)	Total Completions (annual)
Dr A Adedeji	Quansah & Ptnrs Halbutt St Surgery	1,357	256	258
Dr M Fateh	2 First Avenue	876	232	57
Venkat Health Centre		2,200	279	360
Dr M Goyal	Church Elm Lane	1,129	463	399
Five Elms Medical	Five Elms Health Centre	1,133	1,152	452
Dr S N Ahmad	Hedgemans Medical Centre	1,136	16	19
St Albans Surgery	Urswick Medical Centre	1,583	147	69
Barking Medical Group		2,199	1,028	334
Dr S Pervez	Third Avenue Surgery	1,037	48	51
Dr B K Jaiswal	Julia Engwell Health Centre	820	109	114
Faircross Health Centre		655	143	95
Dr N Niranjana	Victoria Medical Centre	807	14	15
Dr M J B Finnegan	Valence Medical Centre	1,149	12	9
Chilvers	John Smith House (Chivers)	498	33	36
King Edwards Medical Centre	King Edwards Medical Centre		13	8
Laburnum Health Centre		1,984	329	132
Dr K Kashyap	Marks Gate Health Centre	772	131	68
Dr B K Sharma & K	The White House	917	90	86
Dr C Ola	36 Dewey Road	528	14	12
Dr M F Haq	Abbey Medical Centre	1,133	61	73
Lawns Medical Centre		424	1	4
Heathway	Heathway Medical Centre	746	295	115
The Gables Surgery	The Gables Surgery	732	105	73
Dr Gupta & Partner	Dr R Chibbers Practice	770	140	133
Dr A A Ansari	Ripple Road Medical Centre	1,192	302	192
Dr V Goripathi	Tulasi Medical Centre	1,667	334	374
Dr Teotia & Partner	Green Lane Surgery	829	320	136
Dr V K Chawla	The Surgery	434	148	147
Dr A K Mittal	Markyate Surgery	587	2	0
Dr G S Kalkat	Thames View Health Centre	1,184	112	108
Dr A Moghal	Becontree Medical Centre	1,245	143	131
Drs K Alkaisy & F I	Urswick Medical Centre	790	152	150
Dr Dinesh Shah	Parkview Medical Centre	961	352	174
Highgrove Surgery	Lawrence JP	1,300	316	198
Dr A Arif	620 Longbridge Road	811	145	139

<b>Dr Y Rashid</b>	Shifa Medical Practice, Orchards Surgery	464	66	<b>62</b>
<b>Broad Street Medical Centre</b>	Prime Practice Partnership, Broad St Resource Centre	965	50	<b>29</b>
<b>Oval Road Practice</b>		635	93	<b>88</b>
<b>Concordia Health</b>	Porters Avenue	1,310	76	<b>71</b>
<b>Concordia Health</b>	Child & Family Centre	1,232	245	<b>254</b>
		2	0	<b>0</b>
		<b>41,479</b>	<b>7,967</b>	<b>5,225</b>

*Source: NHS Health Checks, local data.*

**HASSC Cancer review action plan**

Page 45

<b>HASSC Cancer review action plan</b>				
	<b>Cancer awareness and early intervention recommendation</b>	<b>Action</b>	<b>Target date</b>	<b>Lead agency</b>
1.	<b>The Health and Wellbeing Board (HWB) takes action to reduce the prevalence of smokers in the borough, to levels comparable with London;</b>	<p>Collate and review current implementation of lifestyle behaviour advice interventions including smoking cessation</p> <p>Share best practice and local examples of implementation</p> <p>Promote RGCP's online learning for Very Brief Advice (VBA) for lifestyle issues inc. smoking</p>	<p><b>December 2017</b></p> <p><b>January 2018</b></p> <p><b>December 2017</b></p>	<ul style="list-style-type: none"> <li>• LBBD (public health/ lifestyles)</li> <li>• BHR / B&amp;D CCG</li> </ul>
2.	<b>The HWB sets out to the HASSC what action it is taking to reduce the number of overweight and obese individuals in the borough, to levels comparable with London</b>	<p>Support Healthy Weight strategy action plan</p> <p>Monitor implementation and outcome of Healthy Weight Strategy action plan</p>	<p><b>September 2017</b></p> <p><b>December 2017</b></p>	<ul style="list-style-type: none"> <li>• LBBD (public health/ lifestyles)</li> </ul>
	<b>Cancer awareness and early</b>		<b>Action (with dates)</b>	<b>Lead agencies</b>

HASSC Cancer review action plan				
intervention recommendation				
3.	<b>The HWB takes action to increase residents' awareness of the how lifestyle, including exposure to the sun, can affect the likelihood of developing cancer, signs and symptoms of cancer and the importance of early diagnosis, and screening;</b>	<p>Work with key stakeholders to agree a local strategy and budget.</p> <p>Review collaborative paper on signs and symptoms</p> <p>Develop strategy with consideration for hard to reach groups</p>	<p><b>September 2017</b></p> <p><b>November 2017</b></p> <p><b>March 2018</b></p>	<ul style="list-style-type: none"> <li>• LBBD (public health)</li> <li>• BHR / B&amp;D CCG</li> </ul>
4.	<b>The National Awareness and Early Detection Initiative informs the commissioners on what action it is taking to target specific 'at risk' groups;</b>	<p>Review and report on action to target 'at risk' groups in the borough</p>	<p><b>March 2018</b></p>	<ul style="list-style-type: none"> <li>• LBBD (public health)</li> </ul>



**HASSC Cancer review action plan**

5.	<p><b>The Barking &amp; Dagenham Clinical Commissioning Group (BDCCG) ensures that GPs are auditing and acting on audit information</b></p>	<p>Review practice profiles for each GP area          Identify outliers for targeted approach during 2017-18</p> <p>Access and analyse 'routes to diagnosis' particularly via A&amp;E data to target practice work</p> <p>CRUK facilitators to work with practices to encourage review of internal systems</p> <p>Encourage Barking and Dagenham practices to complete audits / SEAs to understand patients' diagnosis via A&amp;E</p>	<p><b>September 2017</b></p>	<ul style="list-style-type: none"> <li>• BHR / B&amp;D CCG</li> </ul>
----	---------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------	-----------------------------------------------------------------------

**HASSC Cancer review action plan**

	Cancer awareness and early intervention recommendation		Action (with dates)	Lead agency
6.	<p><b>The BDCCG, in partnership with Macmillan and Cancer Research UK, takes action to increase the proportion of residents returning bowel cancer screening kits, within the next year;</b></p>	<p>Begin process to develop an NEL-wide strategy with key stakeholders</p>	<p><b>December 2017</b></p>	<ul style="list-style-type: none"> <li>• BHR / B&amp;D CCG</li> <li>• Cancer Research UK</li> <li>• Macmillan</li> </ul>
7.	<p><b>The HWB, along with MacMillan and Cancer Research UK, takes action to raise awareness of the importance of screening and to increase uptake of breast and bowel screening in the borough to a level comparable with England within the next year;</b></p>	<p>Begin process to develop an NEL-wide strategy with key stakeholders</p>	<p><b>December 2017</b></p>	<ul style="list-style-type: none"> <li>• LBBD (public health)</li> <li>• BHR / B&amp;D CCG</li> <li>• Cancer Research UK</li> <li>• Macmillan</li> </ul>
	Cancer awareness and early		Action (with dates)	Lead agency

**HASSC Cancer review action plan**

Page 49

<b>HASSC Cancer review action plan</b>				
	<b>intervention recommendation</b>			
8.	<b>The HWB, along with MacMillan and Cancer Research UK, acts to raise awareness of the importance of screening and reduce the variation in cervical screening uptake between GP practices within the next year;</b>	Develop a GP education strategy	<b>January 2018</b>	<ul style="list-style-type: none"> <li>• LBBD (public health)</li> <li>• BHR / B&amp;D CCG</li> <li>• Cancer Research UK</li> <li>• Macmillan</li> </ul>
9.	<b>The Committee urges NHS England to make the Cancer Dashboard available within one year;</b>	Review and report on action to target 'at risk' groups in the borough	<b>September 2017</b>	<ul style="list-style-type: none"> <li>• LBBD (public health)</li> <li>• BHR / B&amp;D CCG</li> <li>• NHS England</li> </ul>
10.	<b>The HWB takes action to raise awareness of the importance of the Health Check and reduce the variation in Health Check uptake between GP practices;</b>	Review current performance Create joint action plan, CCG and PH, to improve quality and uptake of NHS health checks	<b>September 2017</b> <b>September 2017</b>	<ul style="list-style-type: none"> <li>• LBBD (public health)</li> <li>• BHR / B&amp;D CCG</li> <li>• Primary care networks</li> </ul>
	<b>Cancer awareness and early</b>		<b>Action (with dates)</b>	<b>Lead agency</b>

HASSC Cancer review action plan				
intervention recommendation				
11.	<b>NHS England provides assurance to it that residents will continue to have in-borough access to breast screening; and</b>	Begin process to develop an NEL-wide strategy with key stakeholders	<b>September 2017</b>	<ul style="list-style-type: none"> <li>• LBBD (public health)</li> <li>• BHR / B&amp;D CCG</li> <li>• NHS England</li> </ul>
12	<b>The BDCCG, working through the North-East London Cancer Commissioning Board, assures the Committee of the action it is taking to increase awareness of the signs and symptoms of cancer.</b>	Begin process to develop an NEL-wide strategy with key stakeholders	<b>September 2017</b>	<ul style="list-style-type: none"> <li>• BHR / B&amp;D CCG</li> </ul>



# Tobacco Control Strategy

A vision for tobacco-free living

## **Structure**

- **Foreword**
- **Vision and priorities**
- **Tobacco control: a local priority**
- **The Barking and Dagenham picture**
- **Key strategies that support the Barking and Dagenham plan**
- **Tobacco control workshop 2017**
- **Local approaches for tobacco control**  
(1.Prevention, 2.Protection, 3.Treatment)
- **Implementation and the Tobacco Control Strategy and action plan**
- **References**



## Foreword

Tobacco control remains central to achieving Barking and Dagenham's purpose and objective - to become a healthy borough. To achieve this objective, we need to remove the burden of ill health as an outcome of smoking.

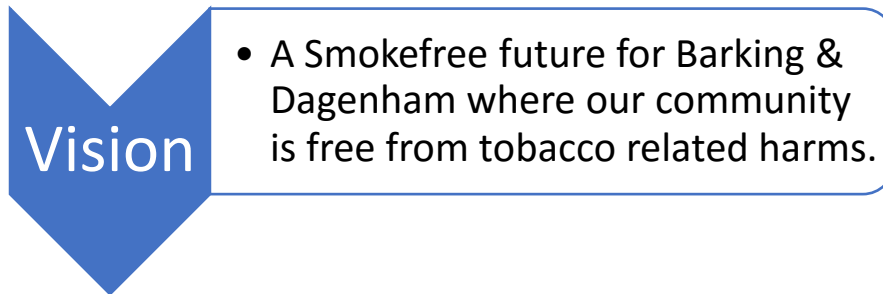
The residents of Barking and Dagenham are not as healthy as they should be. Compared to other parts of the country they are not living as long, with many dying earlier from cancer, heart disease or other long-term conditions. Tackling the health inequality and the underlying causes is part of a collective responsibility to advance the right to life and to increase life expectancy, taking steps to protect all our residents, particularly children.

At present the smoking prevalence in Barking and Dagenham is 20.4% which equates to approximately 35,337 smokers. This is high compared to the prevalence of smoking in London and England, and it highlights huge inequalities in the borough with smoking contributing to other major health issues. Each year smoking costs the local economy approximately £52.8 million.

To address the health inequalities and reduce the smoking prevalence, we need to reduce the numbers of young people taking up smoking and help existing smokers give up. This current strategy sets out a vision for improving the health and wellbeing of residents and reducing inequalities by implementing a robust and effective Tobacco Control Plan. This will be guided and monitored by the Local Tobacco Control Alliance.

## Vision & Aims

Through this strategy, we aim to secure a Smokefree future for all residents of Barking and Dagenham; where the community is free from the harms caused by smoking. We will achieve this by reducing the number of people who are affected by tobacco related harm, and to create a borough where people live long and healthy lives.

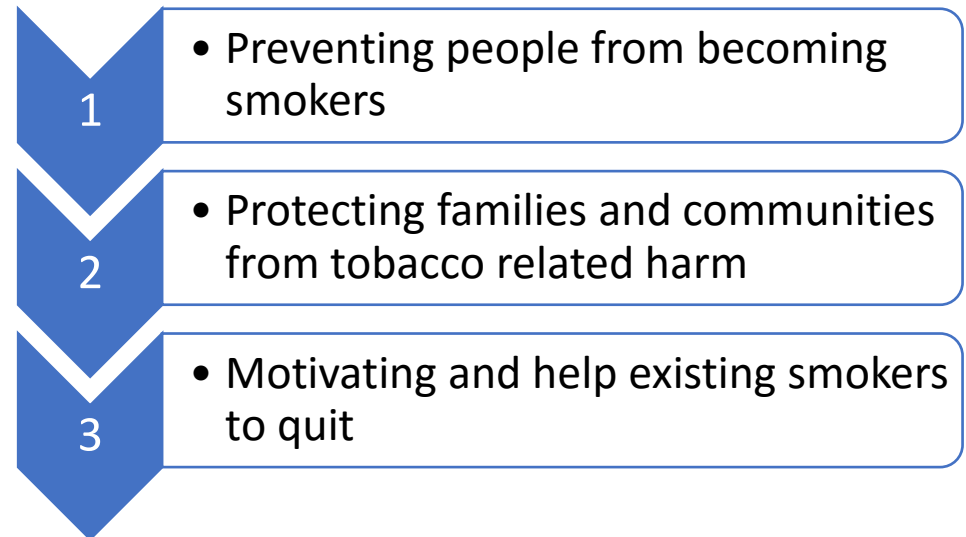


The strategy aims to:

- Reduce health inequalities by working in partnership to reduce the smoking prevalence in Barking and Dagenham
- Encourage people to see not smoking as being normal
- Protect people from the dangers from the second-hand smoke
- Target the groups who are most likely to smoke

We recognise that tackling health inequalities is key to enabling this vision, three specific areas will help streamline this vision

### 3 Priorities to secure a Tobacco-free future





## Tobacco Control: A national & local priority

Tobacco use remains one of our most significant public health challenges across England. Although smoking rates have decreased over recent years, smoking remains the single biggest cause of preventable premature death and disability.

Groups where prevalence are higher or there is more risk of harm from smoking includes: young people, routine and manual workers, pregnant women, those with mental illness, and single parents on benefits<sup>i</sup>. Locally smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups.

Additionally, smoking is the largest contributor to poor physical health outcomes for people with mental health problems. National data indicates that smoking prevalence amongst this group is notably higher than in the general population with rates as high as 32% amongst people with a common mental health disorder, and higher still in people with more severe conditions.

Smoking increases the risk of a wide range of health conditions, including heart disease, stroke, cancer, COPD, and miscarriages amongst adults. Children exposed to second hand smoke have an increased risk of developing asthma, ear infections, behavioural problems and meningitis.

In July 2017, a National Tobacco Control Plan was published where the Government set out its aims around tobacco control measures called *Towards a smoke-free generation A Tobacco control plan for England*.

The national plan is to achieve the specific objectives by the end of 2022. The plan sets out how the tobacco policy fits with the localism agenda and how, together with local partners, the Government will:

- Reduce the number of 15 year olds who regularly smoke from 8% to 3% or less
- Reduce smoking among adults in England from 15.5% to 12% or less
- Reduce the inequality gap in smoking prevalence, between those in routine and manual occupations and the general population
- Reduce the prevalence of smoking in pregnancy from 10.5% to 6% or less

The North East London Sustainable Transformation Plan has a Tobacco Control plan that links well with the current local Tobacco Control Strategy. This supports the STP in its intentions to target pregnant women, use channel shift projects as an alternative to face to face programmes, the embedding of very brief intervention practice within all relevant professional groups.

# Barking and Dagenham Picture

The prevalence of smoking in Barking and Dagenham remains one of the highest in London and further action is required to decrease smoking rates across the borough. We currently have the 5<sup>th</sup> Highest prevalence of smoking in London, although it has improved in recent years from being the highest in London, there is still much work to be carried out.

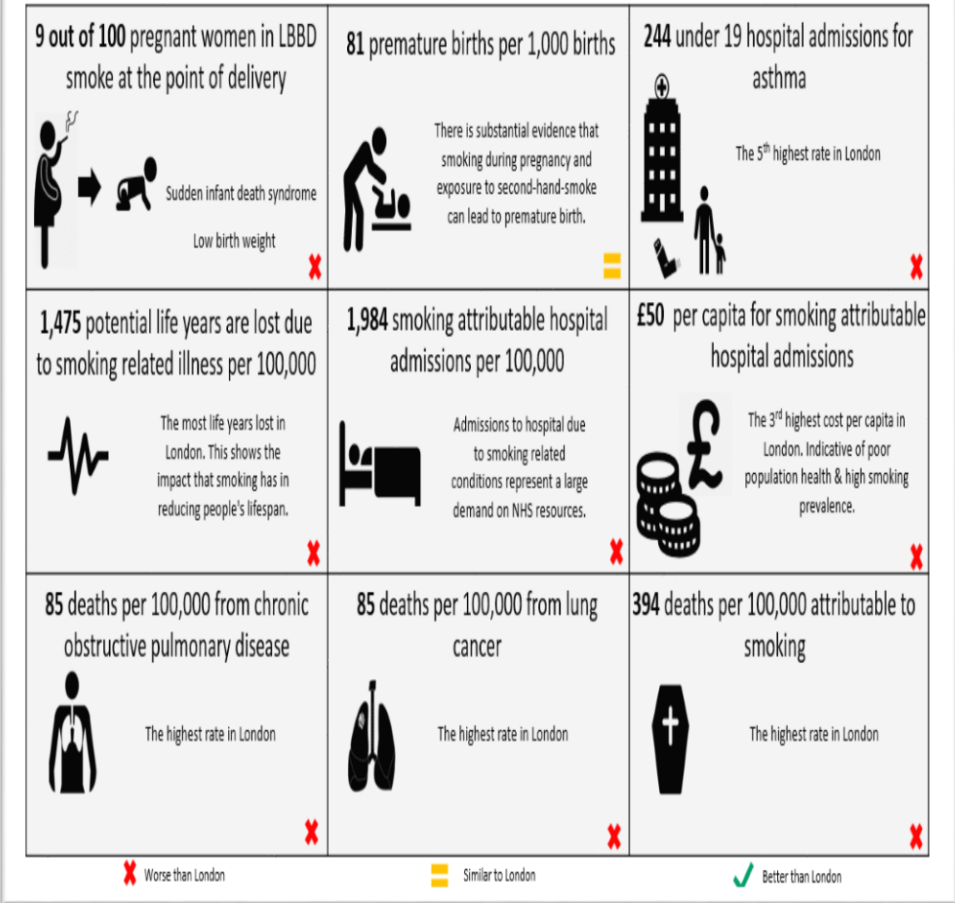
Smoking in the borough, is a major contributor to the high premature mortality and decreased life expectancy in Barking and Dagenham. Mortality in Barking and Dagenham from smoking in people aged over 35 years is the highest in London and above the national average. In the borough, mortality rates from smoking in people aged over 35 years is 394.9 per 100,000 people, compared to 260.4 in London and 283.5 in England<sup>ii</sup>.

While the number of people aged less than 75 years who die from cancer is falling in Barking and Dagenham, the mortality rate per is 85.1 per 100,000 from lung cancer in the borough. This is still above the national average.

Smoking is also responsible for approximately 17% of deaths from heart disease, and 80% of the deaths from chronic lung diseases such as bronchitis and emphysema.

Smoking is also linked to a greater risk of birth defects<sup>iii</sup>, male impotence and sperm abnormalities, early menopause, asthma, and babies who are exposed to second hand smoke have an increased risk of cot death<sup>iv</sup>.

## Smoking causes poor health outcomes for LBBD residents, from premature birth, U19 asthma from passive smoking to adult death from lung cancer



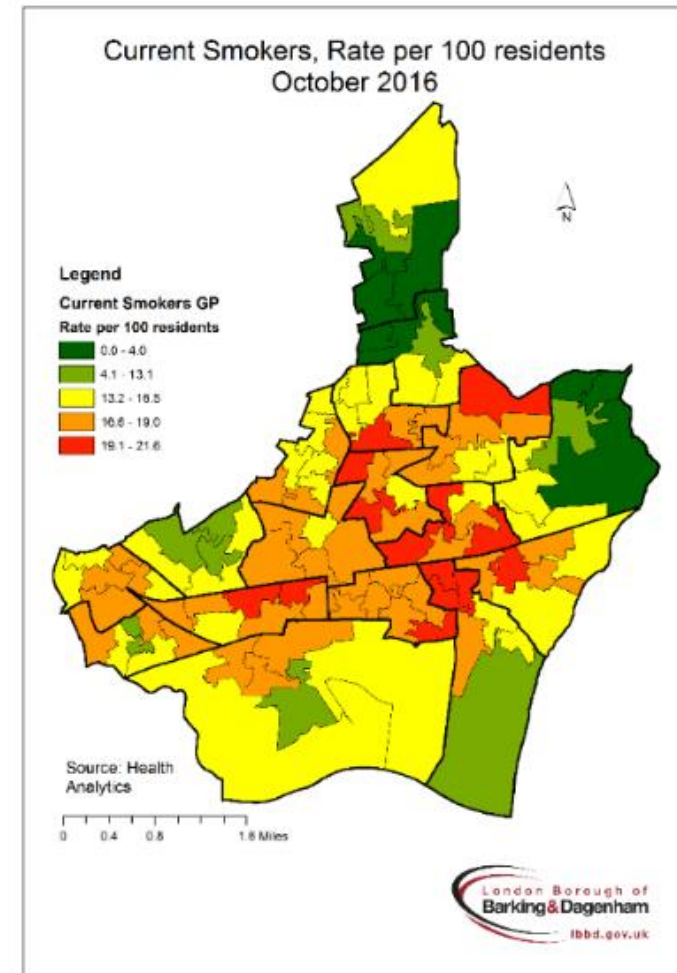
## Who is smoking?

Smoking prevalence is measured using national surveys or through GP data reported by QOF (Quality and Outcomes Framework) QOF figures for 2015/16 suggest that Barking and Dagenham has the fifth highest prevalence in London, higher than national.

There are approximately 20,757 households in Barking and Dagenham with at least one smoker. Most smokers reside within the poorest communities and when net income and smoking expenditure is considered; 18% of households with a smoker fall below the poverty line in Barking and Dagenham. The highest smoking prevalence falls in the areas where levels of deprivation are also highest<sup>v</sup>.

The areas where the smoking prevalence is highest in the borough are Chadwell Heath (North), Mayesbrook, Alibon, Eastbury, Goresbrook and the North of Heath.

Men are more likely to smoke than women, and although female smoking prevalence is lower than male prevalence in Barking and Dagenham, the proportion of women that smoke is higher than the average for England or London. Women are more likely to access Stop Smoking services than men in London<sup>vi</sup>.



Nationally several groups have been identified as being at a greater risk of smoking and thus at greater risk of dying from a smoking related illness. Prevalence is higher in these groups, and it is also suggested they find it more difficult to quit, even with support. These include some BME communities such as Bangladeshi men, and people in poorer socio-economic groups such as those who are 'routine and manual' workers. With a diverse population across LBBDD it is evident that attitudes towards smoking differ between ethnic groups and these are reflective of national smoking patterns (Figure 5).

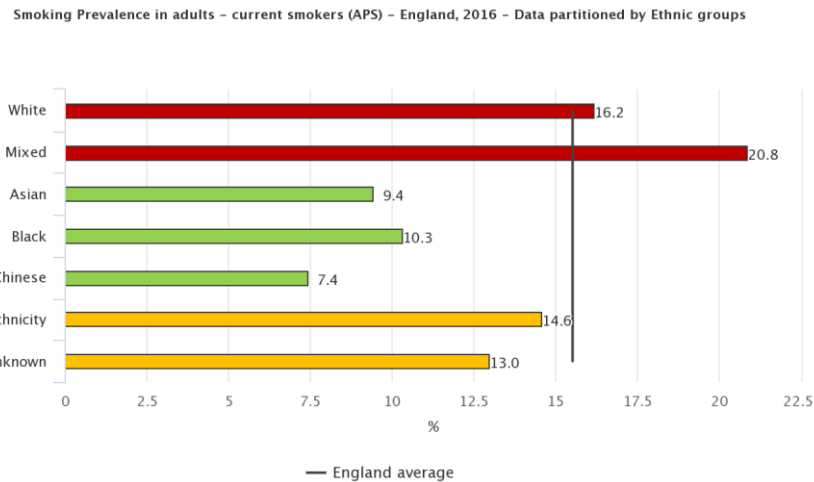


Figure 5: Smoking prevalence amongst ethnic groups

Smoking is a habit developed in early age with two-thirds of smokers starting before the age of 18 and 40% of smokers starting regular smoking before the age of 16.

The long-term trend has seen a decrease in the number of people taking up tobacco smoking across the UK<sup>vii</sup>.

It is also noted that young people from the most deprived areas progress to regular smoking more rapidly than those in the least deprived areas.

Local research on the health of young people indicates that youth cigarette smoking prevalence is relatively low; with a current estimated prevalence of 5.6% in 15 year olds. However, the use of Shisha (19.3%) and vaping (10.8%) are notably higher. In Barking and Dagenham, the prevalence of smoking is highest amongst young people aged between 20 years and 30 years old.

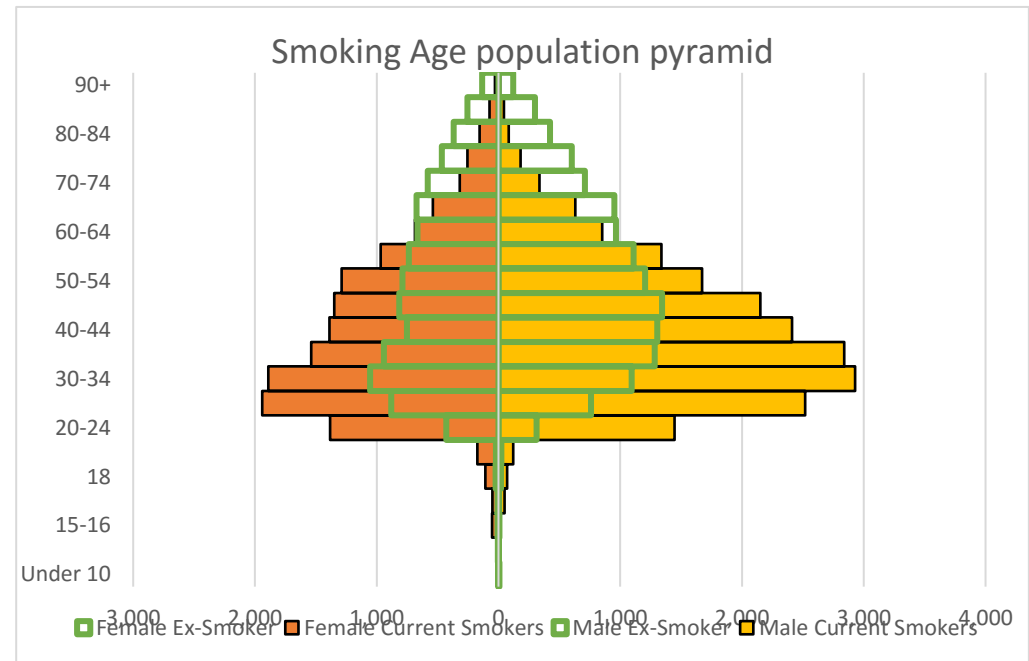


Figure 6: Smoking prevalence by age group

## Smoking in Pregnancy

All women from Barking and Dagenham who give birth should be asked whether they are smokers at the time of delivering. 8.6% of local women who had a baby in 2015/16 were smokers<sup>viii</sup>.

In recent years, a significant improvement has been seen in Barking and Dagenham, an improvement of more than four percent

**Smoking in pregnancy**

Smoking during pregnancy causes up to **2,200** premature births, **5,000** miscarriages and **300** perinatal deaths every year in the UK

It also increases the risk of complications in pregnancy and of the child developing a number of conditions later on in life such as:

- premature birth
- low birth weight
- problems of the ear, nose and throat
- respiratory conditions
- obesity
- diabetes

## Smoking & Teenage Pregnancy

Another important group demonstrating concerning rates of smoking are young pregnant women. The Health and Social Care Information Centre (HSCIC) conducted a survey in 2010 which found that younger mothers, women in disadvantaged circumstances and those who have never worked tended to be more likely to smoke throughout their pregnancy. It also found that mothers under the age of 20 were almost four times as likely to smoke before or during pregnancy, compared to mothers aged 35 or over (57 per cent compared with 15 per cent).

## Exposure to Second hand smoke

Every year nearly 10,000 children nationally are admitted to hospitals as a direct result of inhaling second-hand smoke<sup>x</sup>.

Many children still experience significant exposure to environmental tobacco smoke in the home, which is harmful to their health and wellbeing. In Barking and Dagenham there are approximately 52,637 children under the age of 15<sup>x</sup>. 34 percent of young people under the age of 15 years old live in a house with at least one smoker.

Children born into households where adults or siblings smoke may face years of exposure to second-hand smoke.

Early exposure to second-hand smoke contributes to many adverse health outcomes including lower respiratory tract infections, asthma, wheezing, middle ear infections and invasive meningococcal disease<sup>xi</sup>.

There is also evidence linking exposure to second-hand smoke with impaired mental health and with increased school absenteeism.

Additionally, smoking at home is a risk for hyperactivity/inattention problems in children. There is evidence that children from smoking households display difficult behaviour in schools, especially during the afternoons, as a direct result of nicotine deprivation<sup>xii</sup>.

One of the major contributors to a young person smoking is whether their parents smoke – a child from a smoking household is 4 times more likely to begin smoking themselves than a child whose parents do not smoke<sup>xiii</sup>. Evidence suggests that the younger an individual starts to smoke particularly during adolescence, increases the likelihood of being a life-long smoker the heavier they are likely to smoke during adulthood and the more likely they are to fall ill and die early because of smoking<sup>xiv</sup>.

## Smoking & Mental Health

While smoking rates amongst the general population have fallen dramatically in the past few decades they have remained markedly high amongst people with mental health conditions.

Smoking rates amongst people with a mental health condition are significantly higher than in the general population and there is a strong association between smoking and mental health conditions<sup>xv</sup>. This association becomes stronger relative to the severity of the mental condition with the highest levels of smoking found in psychiatric in-patients. In Barking and Dagenham the current smoking prevalence of smoking people who suffer from severe mental illness is 40.2% which is double the amount of the general population.

Seventy percent of those discharged from a psychiatric hospital are smokers. The result is lives cut short and in their final years lives blighted by heart and lung diseases, stroke and cancer. A third of tobacco now smoked in England is by someone with a mental health condition<sup>xvi</sup>. Yet the desire to quit is just as strong as for the average smoker. These smokers do not lack motivation to quit but are more likely to be highly addicted and heavily dependent on tobacco, and therefore need specialist support

## Smoking & Substance misuse

There is a strong link between smoking and alcohol addiction. An estimated 80% of alcohol-dependent people smoke tobacco and alcohol-dependent clients are more likely to die of tobacco related illness than alcohol-related harm. A much higher proportion of smokers than non-smokers are alcohol dependent and co-dependency has significant effect on health risks.

Additionally, studies of methadone, cannabis, cocaine and ecstasy users have shown 90% or more are smokers. A meta-analysis of 18 studies has shown that addressing tobacco use in clients can improve their alcohol and drug outcomes by an average of 25%.<sup>xvii</sup>


# The Economic Burden of Smoking for Barking and Dagenham

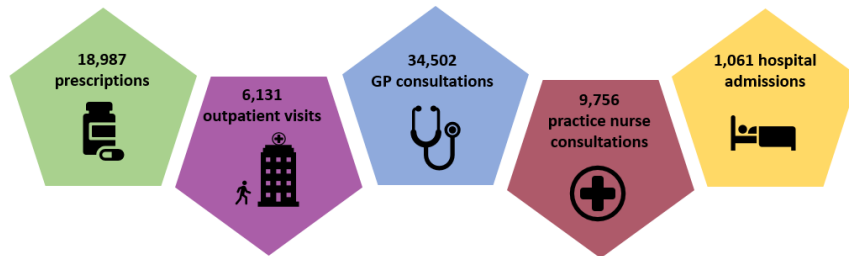
The economic impact of smoking is significant for the smoker, their family and society. Each year in Barking and Dagenham it is estimated that the societal cost is £52.8m, which equates to £1,753 per smoker per year.

There are significant costs associated with social care for people with smoking-related illnesses, workplace absenteeism, dealing with smoking-related house fires, clearing of cigarette butt litter and crime associated with illicit and counterfeit tobacco.

Treating smoking-related illnesses is estimated to have cost the NHS £6.9 million annually in LBBB, here £6.4 Million are directly from treating smoking related conditions and £437.719 is spent on treating the effects of passive smoking in non-smokers.

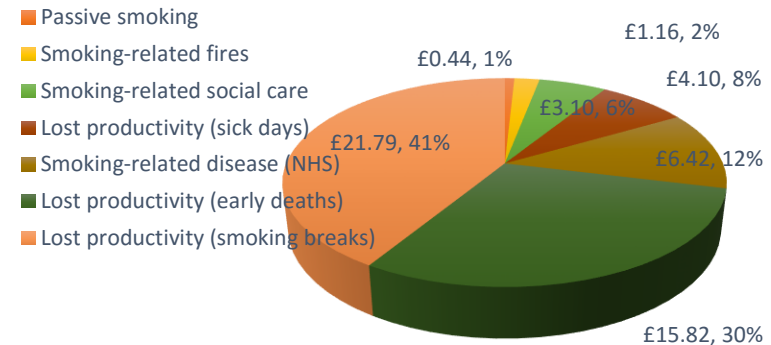
Aside from poor health outcomes smoking has considerable impacts both on the local economy and demand for local healthcare services

 **42,693** working days were lost in the past year as a result of smoking-related sickness.



Tobacco costs the local economy approximately twice as much as the duty paid to the Exchequer resulting in a short fall of £23 million. Seventeen smoking related fires are caused a year in Barking and Dagenham; with a total cost of approximately £1 million a year.

Most cigarette filters are non-biodegradable and must be disposed of in landfill sites. In Barking and Dagenham around 124 million filtered cigarettes are smoked each year, resulting in approximately 22 tonnes of waste. Of this, more than 21 tonnes of cigarette waste are discarded as street litter that must be collected by the council street cleaning services.



Motivating and supporting adults to quit, and prevent the uptake of smoking amongst young people will ensure more children can grow up in a safer, smoke free environment. In addition, less spending on tobacco products will result in a household having more disposable income.

# Key strategies that support the Barking and Dagenham Tobacco Control Strategy

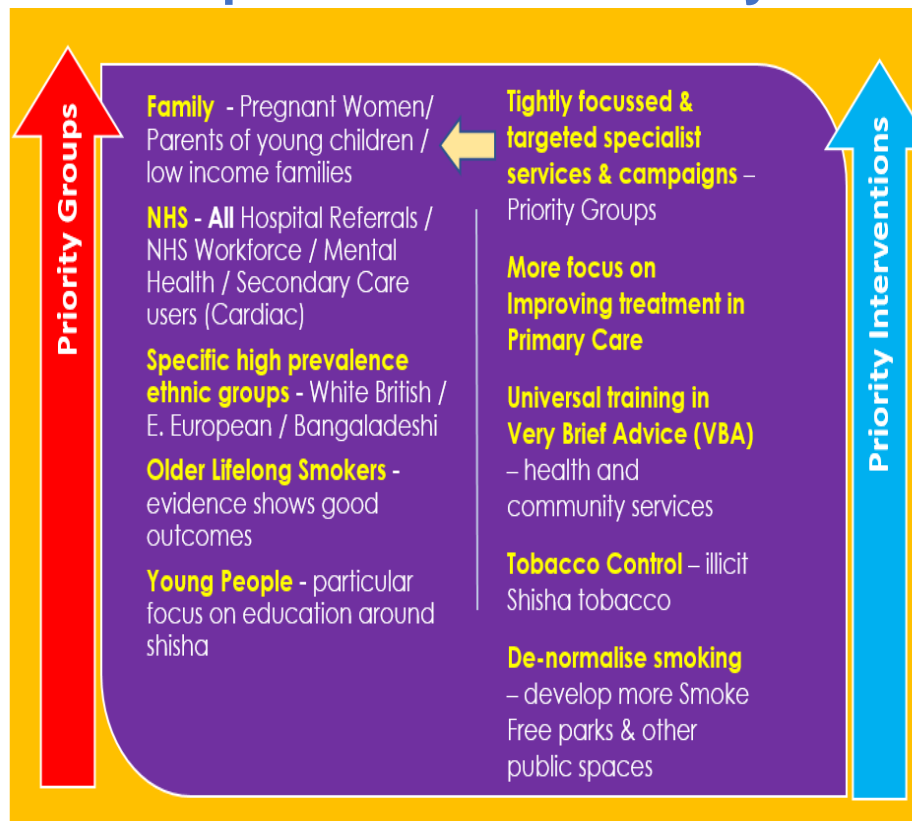
This Strategy has been developed around several Local and National Strategies

Level	Key Strategies, Plans and Guidance	
National Policy and Strategy Documents	<ul style="list-style-type: none"> <li>• Towards a smoke-free generation: A tobacco control plan for England (2017)</li> <li>• Burning Injustice. Reducing the tobacco-driven harm and inequality. APPG on Smoking (2017)</li> <li>• The Stolen Years ASH report (2016)</li> <li>• Public Health Outcomes Framework (updated 2016)</li> <li>• Smoking Still Kills: Protecting children, reducing inequalities (2015)</li> <li>• Health Matters: Smoking &amp; Quitting in England (2015)</li> <li>• Tackling illicit tobacco: from leaf to light (2015)</li> </ul>	<ul style="list-style-type: none"> <li>• NICE public health guidance PH45 Tobacco harm reduction approaches to smoking (2013)</li> <li>• NICE public health guidance PH48 Smoking cessation in secondary care: acute, maternity and mental health services (2013)</li> <li>• Creating a tobacco-free future; A Tobacco Control Plan for Scotland (2013)</li> <li>• Healthy Lives, Healthy People: A tobacco control plan for England (2012)</li> <li>• The Smoking toolkit study: A national smoking and smoking cessation study in England (2011)</li> <li>• A Smoke Free Future (2010)</li> <li>• Choosing Health White paper (2004)</li> </ul>
Regional Policies, Strategies and Plans	<ul style="list-style-type: none"> <li>• East London Health Care Partnership: Sustainability and Transformation Plan (2016)</li> <li>• Better Health for London – The report of the London Health Commission 2014</li> </ul>	
Local Policies, Strategies and Practices	<ul style="list-style-type: none"> <li>• Health and Well Being Strategy - Barking and Dagenham Health and Wellbeing Board. (2015)</li> <li>• Joint Strategic Needs Assessment (2016)</li> <li>• LBBB Mental Health Strategy (2016)</li> <li>• Five Ways to Wellbeing</li> </ul>	




To guide the Tobacco Control Work in Barking and Dagenham a multi-agency workshop was held in June 2017 to agree local priorities, prioritise the most effective use of resources and ensure delivery against these priorities in a context of limited resources and new structures. The recently published Burning Injustice report was used as a focus for the workshop.

## Workshop outcomes summary

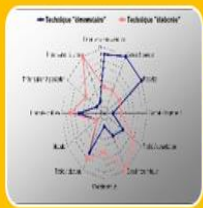


## Other Key Messages:




### Engagement

- Need to work **within** communities in a much more immersive way
- Clearer education / use of language is key / consistent messages / service join-up
- Innovative community SSS promotion e.g. in betting shops, Primark etc.



### Evaluation

- Need to receive and use good data to drive interventions
- More Shared Learning
- Beware unintended consequences - properly assess impact before making changes / stopping services
- Use NICE ROI & other tools to assess cost effectiveness



### Longer term

- Legislation - Smokefree law / Shisha
- More research is also required around shisha
- Work on deficit areas identified through the LBBB stocktake against the *Burning Injustice* recommendations

# Local approaches for a Tobacco-free future

The actions set out in this strategy consider the impact on those at risk of unequal health outcomes via six priority areas and approaches which have been defined by the World Health Organisation’s (WHO) Framework Convention for Tobacco Control (FCTC). They are informed by national and local strategies, the work of the local tobacco alliance and the workshop in 2017. Each Priority strand of the FCTC falls under the overarching category of Prevention, Protection and Treatment.

Page 64



## a) Aims for Prevention

*To prevent young people from becoming smokers & creating an environment where young people choose not to smoke*

1. To reduce the percentage of 11-15yrs who smoke to 1% by 2022
2. To reduce the percentage of 16-17yrs who smoke to 3% by 2022
3. To reduce the number of illegal tobacco sales to young people by 10% by the end of 2022

## b) Aims for Protection

*To protect families and communities from tobacco related harms*

1. To make it more difficult to purchase and sell illicit and counterfeit tobacco products in the borough
2. To reduce the number of homes with parents who smoke indoors
3. For half of the homes where parents smoke to be entirely Smokefree by 2022
4. To encourage Smokefree outdoor environments and spaces

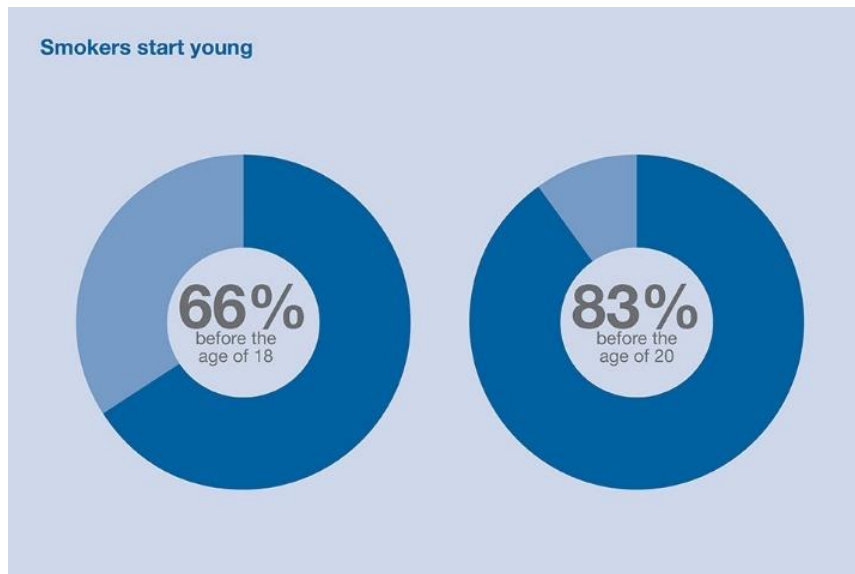
## c) Aims for Treatment

*To motivate and encourage every smoker to stop smoking*

1. To reduce adult smoking prevalence rates to 15% by 2022
2. To halve the amount of routine and manual smokers by 2022
3. To reduce the number of pregnant women who smoke by 3% by 2022
4. To halve the number of smokers with mental health conditions by 2022.

# 1.Prevention

## 1.1 Reduce the numbers of people taking up smoking, in particular young people



Page 65

Smoking is usually a habit developed in early age, with two-thirds of smokers starting before the age of 18 and 40% of smokers starting regular smoking before the age of 16<sup>xviii</sup>. The long-term trend has seen a decrease in the number of people taking up tobacco smoking across the UK.

To create an environment that supports young people to choose not to smoke we aim to create initiatives to ensure that young people are aware of the health harms of tobacco use, provide cessation support and continue efforts to reduce the availability, attractiveness and affordability of tobacco.

Improved health due to a reduction in smoking amongst young people, and reductions to exposure to second-hand smoke should result in fewer absences in schools and colleges.

### Approaches for engaging with Young People

#### Engaging with young people in school

- Continue to de-normalise the smoking culture of Barking and Dagenham throughout the life course through education
- Target young people at different stages; using a phased model; tailoring the prevention messages at Primary schools, Secondary schools and Further Education settings and through innovative practice
- Prioritise specific wards where high prevalence is a concern
- Dispel myths around smoking tobacco, illicit tobacco supplies and smokeless tobacco products.
- Monitor NICE harm reduction guidance and research, and implement accordingly

## Engaging with young people in the community

While schools are central to dissemination of information about tobacco to young people, it is essential to recognise that learning does not only take place within the school environment.

Youth groups and young people's services are effective; not only in reinforcing the messages delivered through traditional education, but in also meeting the needs of vulnerable young people.

- Collaborate with council, community, and voluntary service youth initiatives to deliver key messages around prevention of smoking & cessation services.
- Engage with young people to devise a campaign that is relevant to them.
- Develop accessible services and branding for young people to ensure that is relevant to them.
- Pilot smoking cessation services for young people in Secondary schools and Colleges.
- Encourage young people to train as Young Health Champions to enable them to act as advocates for Tobacco Control and healthy lifestyles.

## Develop an exemplary communications approach to engage young people and the wider community

- Deliver a tailored marketing and communications approach aimed at young people, faith groups, BME communities "routine and manual" workers, people experiencing mental health conditions and pregnant women.
- Support and publicise national campaigns.
- Develop systems to monitor and assess the work we do and influence the future work.
- Promote and publicise important smoking issues such as smoke-free homes and cars, and illicit and counterfeit tobacco, e cigarettes and Shisha.

## 1.2 Creating an environment where people choose not to smoke

Effective local tobacco control strategies require engagement from a wide range of partners. Reducing the number of people who take up smoking is key to reducing overall prevalence rates and, as such, is a priority of all tobacco alliance members.

If we are to change attitudes to smoking new approaches are required for targeting priority groups.

There is a need to develop the knowledge and skills to support positive mental and physical health behaviours which will be sustained into long term lifestyle changes. To have reach across the community, this approach requires the support of all services working with adults, families, children and young people.

Further work is required for providing appropriate prevention and cessation services for hard to reach groups such as those with mental health problems. It is important that the focus on smoking in Primary and Secondary care is strengthened, with additional support from community and voluntary sector organisations.

### Approach to strengthen Community, Primary & Secondary care provision

- Provide very brief advice (VBA) smoking cessation training to all front-line workers to utilise at every opportunity.
- To address smoking as a treatment option as opposed to an additional service
- To further develop channel shift for stop smoking services such as telephone and digital options
- Work with the CCG to develop primary care networks
- To embed Tobacco Control in the North East London Sustainability & Transformation Plans
- Ensure all partner organisation are up to date with current services, training and issues relating to tobacco control
- Work in partnership to address issues around tobacco control

## 2. Protection

### 2.1 Reduce exposure to second-hand smoke

The creation of smoke free environments will contribute to cleaner and safer neighbourhoods where citizens understand and support actions to take smoking out of sight of children, and change the norms of smoking. Limitations on areas where people can smoke will also reduce exposure to second-hand smoke and reduce the risk of fires.

The exclusion of smoking in enclosed public spaces has had positive impact and has underlined much of the work undertaken to promote healthy living environments. Additionally, the restriction of smoking in cars with children and young people present will have an impact on reducing the harms caused by second smoke. Nationally, there has been a high level of public support and compliance to the legislation. It is important to continue this work through our partnerships and ensure that compliance monitoring is supported and maintained.

#### Approach

- Educate parents on the impact of smoking
- Encourage communities to identify and implement initiatives to reduce children's exposure to second-hand smoke
- Explore further opportunities for implementing 'voluntary' smoke free spaces; such as children's play areas and other outdoor places where children are present.
- Support local partners to explore voluntary Smoke-free conditions for children and family areas
- Work with early intervention teams to provide health advice around smoking and create robust referral pathways to local cessation services across the borough.
- Work with the fire brigade to promote smoke-free homes & environments

### 2.2 Make our communities safer

Although great progress has been made to reduce levels of smoking across the country, the efforts to bring about better health by driving down the numbers of smokers are being undermined by cheap, smuggled and counterfeit tobacco. Counterfeit and illicit tobacco undermines price-based efforts to reduce smoking and there are links between illicit tobacco and organised crime<sup>xix</sup>. Raising awareness of the harms of counterfeit products will also reduce the supply and demand of such products and deter criminals from operating in the borough

#### Tackling Illicit Tobacco:

We will aim to target, identify, and punish those involved in the illicit tobacco market and focus on creating a hostile global environment for tobacco fraud through intelligence-sharing, undermining the profitability of the fraud, getting tougher on those involved through sanctions, changing public perceptions, and reducing tolerance of the fraud.

#### Approach

- Develop and strengthen the intelligence about illicit and counterfeit tobacco
- Continue to tackle the demand for local illicit and counterfeit tobacco
- Raise awareness about the effects of illicit and counterfeit tobacco
- Participate in Pan London and Sub region illicit tobacco group activity to combat cross borough challenges
- Tackle the demand for local illicit and counterfeit tobacco through joint work with Her Majesty's Revenue & Customs and the police

## 2.3 Smokeless tobacco and Shisha regulation

### Smokeless Tobacco

Smokeless tobacco is any product containing tobacco that is placed in the mouth or nose and not burned. Types of smokeless tobacco products most used in the UK often contain a mix of ingredients including slaked lime, areca nut and spices, flavourings and sweeteners<sup>xx</sup> (for example, Paan, Gutka and snus).

Smokeless tobacco products are readily available in shops in South Asian neighbourhoods across England. Around 85% of the different product types, are sold without any regulatory health warning. At present, there is little local data available to show how much these products are being used. However, it has been noted that these are predominately used within the South Asian communities accessing the specialist stop smoking service to give up smoking and smokeless tobacco.

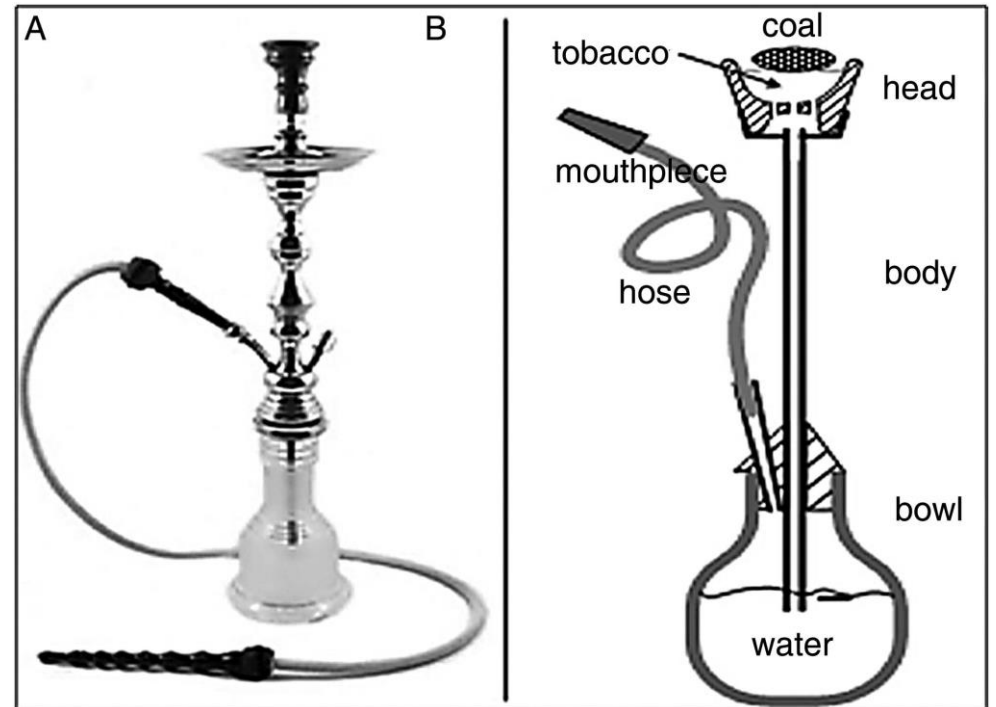
### Shisha

Page 68 Shisha, also known as water-pipe, hookah, narghile has traditionally been used in the Middle East and parts of Africa and Asia. Shisha is growing in popularity in western countries and in the UK and appears to be more popular among young people across the United Kingdom<sup>xxi</sup>.

There is a common belief that shisha smoking is less harmful and less addictive than cigarette smoking. The water does not filter out harmful substances in the smoke and although not as extensively researched as cigarette smoking, preliminary research suggests that shisha smoking is associated with similar risks to cigarette smoking<sup>xxii</sup>. Many users believe that herbal shisha products are less hazardous than tobacco products. However, herbal shisha involves burning charcoal, which contains toxic chemicals making herbals and tobacco shisha smoking as hazardous to health as cigarette use<sup>xxiii</sup>. The risk of carbon monoxide poisoning is also increased with the use of shisha.

In addition, second hand smoke from shisha smoking poses a risk to non-smokers from the mixture of exhaled smoke and charcoal used to heat the pipe<sup>xxiv</sup>.

Shisha is liable for excise duty, whether it contains tobacco or not. An All Party Parliamentary Group on Smoking and Health held an inquiry into the illicit trade in tobacco products in 2013, and recognised that a significant proportion of Shisha in the UK appears to be illicit, imported illegally with no duties paid<sup>xxv</sup>.



(A) Waterpipe device, (B) with illustration of its main parts

## Approaches to reducing the harms caused by Smokeless tobacco & Shisha

Under the revised European Union Tobacco Product Directive (EU TPD2) smokeless tobacco manufacturing and sale is to be monitored by regulatory services. Additionally, there is an age of sale restriction on the sale of e cigarettes.

- Increase awareness of the harms caused by smokeless/niche tobacco products, targeting specific communities utilising health awareness campaigns
- Develop and implement a cessation program and care pathways for smokeless tobacco users, and find sustainable mechanisms to embed these pathways in targeted communities, (e.g. Faith groups via religious establishments)
- Ensure the traders of these products are informed of, and are compliant with the legislation in relation to EU TPD2
- Develop guidance to facilitate the implementation on regulations regarding standardised packaging and ensure that local advice is provided to small, medium and large-scale sellers of tobacco products.
- Monitor the emerging number of 'Shisha' premises in the borough
- Limit activity around these Businesses Provide localised guidance and regulations around operating shisha lounges within the borough

- Highlight the relevant laws around the sale of tobacco products, e cigarettes, shisha and smokeless tobacco such as chewing tobacco.
- Investigate the trade of smokeless tobacco & monitor and enforce new regulations from the EU TPD2
- Develop a licencing procedure for the opening of shisha premises in the Borough

## Fire safety in the community

Fires caused by smoking materials - including cigarettes, roll-ups, cigars and pipe tobacco - result in more deaths than any other type of fire. Fires that are caused by smoking in Barking and Dagenham can total costs of approximately £1 million a year.

London Fire Brigade visit both domestic and commercial properties as part of their routine work to advise and enforce the fire regulations. The fire officers, in addition to dealing with fire provisions, provide brief advice on the adverse effects of smoking and raise awareness of the dangers of second hand smoke.

## Approach for Fire services

- Contribute to reducing the number of smoking related fires
- Raise awareness of the dangers of second hand smoke
- Promote the Smokefree Homes & Cars initiative
- Raise awareness of localised guidance and regulations around fire safety in the home and businesses in the Borough

## 3. Treatment

### 3.1 Pathways to Quit in Priority groups

The uptake and maintenance of a tobacco habit is influenced by personal, physiological, social, psychological and cultural factors. These factors all contribute in influencing the individual's perception towards the tobacco habit. Therefore, targeting those smokers who are most likely to smoke is essential.

#### 3.1 a. Pregnant women

Reducing the numbers of women smoking in pregnancy is key in impacting positively on the lives of both mother and baby. The journey beyond a baby's birth is just as important with continued postnatal smoking cessation contributing to the early years' agenda by reducing the baby's exposure to second-hand smoke and the associated health risks. A mother's desire to do the best for her child means that pregnancy offers a powerful opportunity for services to support women to quit smoking.

The BabyClear© initiative has been implemented in Barking and Dagenham since 2015 providing smoking cessation training and service delivery recommendations across the community and secondary care settings.

Since then a significant improvement has been seen in Barking and Dagenham. At present the smoking prevalence is 8.6% of women smoking at the time of delivery (2015/16), Although this is higher than the London average; it is significantly lower than the national average.

### Approaches for a Smoke-free pregnancy

#### BabyClear©

Barking and Dagenham are working in partnership with local stakeholders, to implement the Babyclear© within Barking, Havering, and Redbridge University Hospitals NHS Trust.

BabyClear© is an evidenced-based programme that aims to reduce the prevalence of smoking in pregnancy, and increase smoking cessation referrals. BabyClear© aims to reduce smoking in pregnancy through a systematic approach that identifies pregnant smokers, and supports the process of smoking cessation referrals. All pregnant women are offered a carbon monoxide (CO) screening, and specialist training is provided to both clinical and non-clinical staff that engage with pregnant smokers, across maternity and stop smoking services.

Further action is required needed to reduce smoking among pregnant women and among children and young people.

Our aim is to reduce smoking among pregnant women to 5% by 2022 and 3% by 2025. Some areas for improvement are:

- The monitoring of prevalence of smoking in pregnancy is currently too dependent on self-report and is inappropriately focused on time of delivery.
- A more robust approach including the use of bio-markers is needed.
- Smoking cessation needs to be raised as a treatment rather than an additional service in pregnancy.



- Raise awareness of the dangers of smoking in pregnancy at every contact of pregnancy
- Increase the number of pregnant women and their partners who use stop smoking services
- Implement further services in house by midwives to undertake in wards/ hospitals/ community services

### 3.1 b: Routine & Manual smokers

#### Workplaces in Barking and Dagenham

It is estimated that smoking breaks cost businesses in the borough £21.8m annually. Reducing consumption will result in a healthier workforce, a reduction in absenteeism and improved productivity. At present the smoking prevalence of smokers who work in routine and manual occupations is 26.9%.

An innovation in educating people about tobacco is required to increase the awareness of ill health and its associated economic issues

#### Approaches for engaging with Routine & Manual smokers

- Increase awareness of the harms caused by smoking to the individual and to workplaces
- Strengthen the enforcement of a Smokefree policy for **all** NHS and Local Authority buildings and grounds
- Design quitting campaigns targeting people in routine and manual occupations
- Cessation services will be adapted to specifically support the biggest employers of the borough such as the council, transportation services and major retail stores
- Utilising channel shifting method such as telephone or online support
- Encourage all workplaces in the borough to adopt a health workplace policy to include support around smoking cessation
- Initiate Smokefree grounds in all buildings owned by NHS & Council

### 3.1 c Approaches for engaging with Mental Health

#### Mental Health & Smoking cessation services

Supporting people with mental health problems to quit smoking is the single largest, most effective intervention to reduce physical ill health and premature death. Quitting smoking also has a positive impact on mental wellbeing and can make a big difference to an individual's financial welfare, lifting many out of poverty.

People with a mental health condition are just as likely to want to stop smoking as other smokers but they face more barriers to quitting and are more likely to be dependant and therefore need more support. There is an urgent need for action to tackle this growing health inequality.

- Mental health settings should identify service user 'stop smoking champions' to work with staff and service users to support more people to move away from smoking.
- All smokers with a mental health condition should be provided with clear, evidence based information about different options to quit or reduce the harm from smoking by primary care, social care, IAPT, specialist stop smoking services, secondary care services and pharmacists in a coordinated way.
- Carers, friends and family members should be provided with advice and information about how best to support those with a mental health condition to address, reduce and stop their smoking.
- Service users are included in the development of services designed to support people to quit or reduce the harm from smoking.
- Staff working in all mental health settings see reducing smoking among service users as part of their core role.
- People with a mental health condition should be supported to develop alternative options to smoking, to help establish new healthier routines.

### 3.1 d Approaches for Smoking & Substance misuse

The high prevalence of smoking and often greater dependence on nicotine within groups of substance misusers puts them at greater risk of smoking related disease. This is further complicated by a higher incidence of mental ill-health amongst both smokers and substance misusers when compared with the non-smoking population<sup>xxvi</sup>.

Studies suggest that important mental and physical health benefits follow quitting smoking and that alcohol, cannabis and other drug users undergoing treatment for their substance misuse can be more successful in maintaining abstinence when their smoking is also tackled<sup>xxvii</sup>.

To ensure a positive attitude and proactive approach to tackling smoking and substance misuse support in health care settings we need to:

- Raise awareness of the physical and mental health burden of smoking; along with other substance use needs to be raised within the healthcare community at every stage of client interaction
- The benefits to health and to successful treatment of alcohol and drug addiction when combined with smoking cessation, need to be communicated effectively.
- Local smoking cessation and addictions services should coordinate to ease referral between services and improve provision of support for substance misusers.
- Staff from both services should be provided with regular training that equips them to provide brief advice and referral to the other service. Support is required within health care settings to support cannabis cessation.
- Smoking cessation services should be supported to provide a more holistic approach to treatment that enables issues such as substance misuse and mental health to be considered when support is provided.
- There needs to be support and encouragement given to the services and pilots currently in place.
- to help them evaluate their work, identifying lessons learned on engagement, referral, changes in behaviour and well-being, harm reduction and successful quit attempts.

### 3.2 Harm reduction

In the interest of Public Health and harm reduction approaches it is important to promote the use of E-cigarettes and Nicotine Replacement Therapy as a substitute to smoking tobacco products.

#### E- cigarettes

In 2015 Public Health England published a comprehensive review of the latest evidence on e-cigarettes and a document highlighting the implications of this evidence for policy and practice. While the evidence base on e-cigarettes is growing, there are a limited number of good quality and reliable studies, especially about cessation which is the main driver for public health interventions<sup>xxviii</sup>.

E-cigarettes meet many of the criteria for an ideal tobacco harm-reduction product. Although nicotine delivery from e-cigarettes depends on several factors, including level of user experience and device characteristics, they can in principle deliver a high dose of nicotine, in the absence of the vast majority of the harmful constituents of tobacco smoke<sup>xxix</sup>.

It has been established that e-cigarettes are considerably safer than smoking cigarettes, they are popular with current smokers and that they have a role to play in reducing smoking rates in the UK.

Where people are still accessing stop smoking services, and the current popularity of e-cigarettes as an aid to quitting, there is an opportunity to improve success rates by combining the use of e-cigarettes with the most effective method of quitting (behavioural support from services). The Barking and Dagenham Specialist Stop smoking service is an e-cigarette friendly service.

#### Approaches for Harm reduction

- Monitor the usage of E cigarettes in the borough along with quit attempts
- Ensure E cigarette sales and safety are in line with TPD2 regulations
- Ensure under age sales of e cigarettes are monitored & tested

## Commissioning intentions

These will be refreshed each year and will include a specialist stop smoking service to deliver targeted work focused on the priority groups. Barking and Dagenham will also continue to strengthen community based stop smoking services within pharmacies and GP practices as these have a greater reach across the borough. They will be developed with partners to align with the Sustainability and Transformation Plan and aim to link prevention work with other developments.

### Commissioning intentions Specialist Stop Smoking Service

A specialist stop smoking service has been commissioned to deliver targeted work focused on the priority groups as referenced above. Commissioners will work with Community Solutions who will manage the healthy lifestyle team, including the specialist stop smoking service, to refine the required outcomes from April 2018. Commissioners will also look to align, where possible, the prevention work with other developments such as the retendering of the young person's substance misuse service (known as Subwise) in late 2017.

### Commissioning intentions: Primary Care and Community services

Commissioning intentions: primary care and community services: Barking and Dagenham will continue to provide community based stop smoking services within pharmacies and GP practices. These services are widely dispersed across the borough and therefore are close and convenient to where people live. Pharmacies are also often open in the evening and at weekends. Public Health will work with the CCG and practice networks to improve services and activity will be monitored via a performance dashboard.

## Implementation of the Tobacco Control Strategy & Action plan

To reduce the smoking prevalence and to tackle the health inequalities across the borough, we need to help existing smokers give up and reduce the numbers of young people taking up smoking. It is vital to keep the tobacco control agenda in key focus<sup>xxx</sup>.

It is particularly evident that the Tobacco Control Strategy will require support to implement and to make a notable difference reducing the smoking prevalence. This will be guided and monitored by the local Tobacco Control Alliance. Tasks, activities, and projects will be delegated to the relevant leads to action under time frames agreed at the alliance meetings.

### Monitoring & assessing progress

Adopting a universal and consistent approach to the tobacco control strategy will ensure an effective delivery of the strategy. The Tobacco Control Alliance will be responsible for overseeing the implementation of the actions in the strategy action plan, additionally for advising on any changes required to the plan if necessary.

### Tobacco Control Action Plan

The Action Plan is a live document. Responsible leads will be required to report quarterly on activity and outcomes at the alliance meetings. Updates will be forwarded to the Tobacco Control Co-ordinator, collated, and shared at alliance meetings. Six monthly updates will be available for the Health and Wellbeing Board.

**Annual Review**

An annual review should be carried out to ensure the work that is being carried out is achieving projected outcomes. Making the best use of existing and emerging research, both national and international, will be vital to ensuring the success of this strategy.

**Refresh of the Tobacco Control Alliance**

A review of the alliance is required to invite new members from fields where there is little or no representatives. This will develop the work of the tobacco alliance and help to guide future work

---

---

**REFERENCES**

- <sup>i</sup> Towards a Smokefree generation: A Tobacco Control plan for England (2017)
- <sup>ii</sup> ASH Ready Reckoner tool: Tobacco control profiles (2017)
- <sup>ii</sup> Barking & Dagenham JSNA: Our health our Borough (2016)
- <sup>iv</sup> Tiesler, C, Chieh-Mei, C, Sausenthaler, S et al. Passive smoking and behavioural problems in children: Results from the LISA plus prospective birth cohort study. *Environmental Research*, 111(8):1173-1179, (2011)
- <sup>v</sup> Office for National Statistics, Adult smoking habits in Great Britain, (2015)
- <sup>vi</sup> Statistics on smoking: England, 2016 Health and Social Care Information Centre, (2016)
- <sup>vii</sup> New issues and old challenges; a review of young people's relationship with tobacco (2017)
- <sup>iv</sup> Statistics on Women's Smoking Status at Time of Delivery, Health and Social Care Information Centre, (2016)  
<http://digital.nhs.uk/datacollections/ssatod>
- <sup>ix</sup> Smoking, Drinking and drug use among young people in England in 2014. Health & Social Care Information Centre (HSCIC) 2015,  
<http://www.hscic.gov.uk/catalogue/pub17879/smok-drin-drug-youn-peop-eng-2014-rep.pdf>
- <sup>x</sup> <http://www.rcpch.ac.uk/state-of-child-health/report-in-a-glance> (accessed January 2017)
- <sup>xi</sup> Smoking Still kills; Protecting children, reducing inequalities (2015)
- <sup>xiii</sup> Hopkinson, NS., Lester-George, A., Ormiston-Smith, N., Cox, A. & Arnott, D. Child uptake of smoking by area across the UK. *Thorax* (2013)
- <sup>xiv</sup> Royal College of Physicians, Passive smoking and children. A report of the Tobacco Advisory Group of the Royal College of Physicians. (2010)  
<http://www.rcplondon.ac.uk/sites/default/files/documents/passive-smoking-and-children.pdf> (Page 117)
- <sup>xv</sup> *ASH Fact Sheet on Smoking and Mental Health* (2013)
- <sup>xvi</sup> The Stolen years; The Mental Health and Smoking Action *ASH Report* (2016)
- <sup>xvii</sup> <http://www.ashscotland.org.uk/media/4655/Tobacco%20and%20Substances%20Conference%20Report.pdf>
- <sup>xviii</sup> New issues and old challenges; a review of young people's relationship with tobacco (2017)
- <sup>xix</sup> Tackling Illicit Tobacco: From leaf to light (2015)
- <sup>xx</sup> NICE Public Health Guidance 39. Smokeless Tobacco Cessation: South Asian Communities
- <sup>xxi</sup> Public Health Implications of Shisha Smoking in London Dr Mohammed Jawad Department of Primary Care and Public Health, Imperial College London, (2013)
- <sup>xxii</sup> Briefing 13: Waterpipe Tobacco Smoking (2013) published by National Centre for Smoking
- <sup>xxiii</sup> [http://www.ash.org.uk/files/documents/ASH\\_134.pdf](http://www.ash.org.uk/files/documents/ASH_134.pdf) Waterpipes (Shisha) Factsheet. (2014)
- <sup>xxiv</sup> Waterpipe tobacco smoking: The critical need for cessation treatment *Kenneth D. Ward, Kamran Siddiqi, Jasjit S. Ahluwalia, Adam C. Alexander Taghrid Asfar. Drug and Alcohol Dependence* 153 (2015) 14–21
- <sup>xxv</sup> Reducing the harm of shisha; Towards a strategy for Westminster. (2015)

---

<sup>xxvi</sup> Addictions services working together to support the needs of people with a history of substance misuse ASH Scotland (2012)

<sup>xxvii</sup> Closing the gap: priorities for essential change in mental health (2014)

<sup>xxviii</sup> E-cigarettes: an evidence update: A report commissioned by Public Health England (2015)

<sup>xxix</sup> Nicotine without smoke Tobacco harm reduction; A report by the Tobacco Advisory Group of the Royal College of Physicians (2016)

<sup>xxx</sup> Burning Injustice. Reducing the tobacco-driven harm and inequality. APPG on Smoking and Health, (2017)

APPENDIX A

# Integration of **Health & Social Care** in Barking & Dagenham

**Our Journey So Far;  
our current position**

***A short narrative history and some notes  
on current and future plans, developed to  
aid thinking on health and social care  
integration in Barking & Dagenham.***

**DRAFT VERSION 1**

## Introduction

It is too easy to see 'integration' as the new, fashionable answer to the sustainability problems of the health and social care system. As anyone working in health and social care will readily certify, it has been a long-standing policy theme. The immediacy of the current financial pressures is shining an uncompromising spotlight on the level of complexity involved in further integration of health and social care, particularly across changing geographies. To give a useful context to some of that complexity it is essential that we understand the history of integration, and can build on the achievements of colleagues past and present.

For a number of years, Barking & Dagenham has pursued various integration options for health and social care, both for adults and for children. There have been varying degrees of success and longevity across these different activities, but the approaches taken clearly evidence a willingness to share responsibility for outcomes, to share control over resources, and to consider new structural and managerial opportunities. This short paper gives an overview of the journey so far, and at the end will consider the implications for the way forward into 2017/18 and beyond.



# Part 1

## Looking back

## Early steps

In November 2000, Barking & Dagenham Council and the local NHS took a very substantial step towards integrating service management and delivery. The decision was taken by the then-Council Executive to have the Director of Social Services appointed to the post of Chief Executive of the Primary Care Trust, thereby initiating the management of both social care and health functions under a common structure<sup>1</sup>. This was to have taken effect, more or less, from the inception of the Primary Care Trust on 1 April 2001, which had been created in the third wave of PCTs to emerge nationally under the NHS Plan 2000<sup>2</sup>, out of the 481 Primary Care Groups that had previously existed.

A report to Cabinet in September 2003 ended this arrangement<sup>3</sup>, the minutes noting that *“joint management arrangements between the Primary Care Trust and Social Services [have] been terminated”*, with the Director of Social Services returned to her substantive Council post. The termination of the arrangements, which had been described by the Guardian<sup>4</sup> as *“pioneering”*, came as a surprise nationally. The then-President of ADASS observed that it served as *“a powerful reminder of the need for organisations to attend to the core need of meeting the needs of local people above structural reform”*.

In a theme that will recur through the narrative of integration attempts in Barking & Dagenham, causes cited included pressure on resources (the PCT was significantly below target capitation at the time) and changing relationships with more central NHS bodies, in this case the new North East London Strategic Health Authority.

## Bloodied but not beaten

Bruising as it was to have dissolved the integrated PCT management arrangements so publicly, it is crucial to maintain a wider view of the joint work that continued in health and social care. The report that re-established Council management arrangements following the ending of formal integration set out in the first lines to reaffirm the Council’s commitment to continue integration of services for the public benefit<sup>5</sup>. The report observed

---

<sup>1</sup> <http://modgov/documents/s656/Main%20Report.pdf>

<sup>2</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC32310/> and [http://www.nhsconfed.org/~media/Confederation/Files/Publications/Documents/The\\_legacy\\_of\\_PCTs.pdf](http://www.nhsconfed.org/~media/Confederation/Files/Publications/Documents/The_legacy_of_PCTs.pdf)

<sup>3</sup> <http://modgov/ieListDocuments.aspx?Cid=180&MID=1547#AI6101>

<sup>4</sup> <https://www.theguardian.com/society/2003/sep/03/guardiansocietysupplement.politics3>

<sup>5</sup> <http://modgov/documents/s4327/Health%20and%20Social%20Care%20Management%20Arrangements.pdf>

that it was not expected that there would be any services “*where existing integrated working arrangements will discontinue*”. Once again, a theme for the future is indicated: that the pragmatic approach to establishing joint delivery takes precedence over grander, high-level integrated management arrangements.

Amongst these arrangements, in January 2002, the Council had agreed<sup>6</sup> to proceed with integrated personal, social and healthcare services for people with a learning disability, under a Partnership Arrangement with pooled budgets. In December 2003, the Council proceeded with building Grays Court<sup>7</sup> for the provision of intermediate care for speeding up hospital discharge, the facility to be rented by the PCT for these purposes.

Whilst various of these specific shared arrangements continued, the next significant milestone came in 2008 with the completion of a report by consultancy *ChangeFX*, received by the Cabinet in late 2008<sup>8</sup>, on integration and joint working. The report, firmly anchored in the context of the Comprehensive Area Assessment being introduced by the Audit Commission, drew on learning from the 2001-2003 experience. It summarised that learning as being about:

- *Excessive pace in the face of significant complexity;*
- *Lack of a clearly agreed common purpose, rooted in community outcomes;*
- *Lack of genuinely shared sense of ownership (since the new PCT had not had time to form properly);*
- *Lack of common culture, and the clashes that resulted in the face of a lack of clarity about what was a joint activity and what was any one agency’s.*

These are the sorts of conclusions that will resonate with any setting where integration is pursued. Nonetheless, the next steps recommended for Barking & Dagenham were rooted in the challenges to be delivered jointly under the Local Area Agreement. It was observed that the commissioning of services across the four Outer North East London PCTs needed strengthening as they disaggregated commissioning from direct provision under national directives. Moves were made to form a steering group, appoint a joint Programme Director, and established a shared vision.

Following acceptance of the ChangeFX recommendations, the borough began work on a new Health & Wellbeing Strategy which was eventually agreed to run from 2010 to 2012/13. In the months following this refresh of the

---

<sup>6</sup> <http://modgov/documents/s599/Learning%20Disabilities%20report.pdf>

<sup>77</sup> <http://modgov/ieListDocuments.aspx?Cid=180&MID=1755#A17109>

<sup>8</sup> <http://modgov/documents/s20220/Anne%20BristowExecutive%20Report%20-%20improving%20partnership%20working.pdf>

direction, national policy developments began to build towards the Health & Social Care Act 2012, which would establish Health & Wellbeing Boards in the form that they currently exist. However, under the Local Strategic Partnership a fledgling Health & Wellbeing forum was introduced in 2008/09, such that it was ready to take on 'Shadow Health & Wellbeing Board' status, and begin to test out the new national proposals, from its 23 November 2010 meeting<sup>9</sup>. The borough partnership was therefore already well set-up for the introduction of the Act and its new governance requirements from 1 April 2013.

## Service integration continues

In the meantime, the partners continued to operate integrated arrangements for the delivery of learning disability services and support for people with mental health problems. By 2005 NELFT and the Council were operating joint learning disability services<sup>10</sup>. It was not until 2011 that formal agreements under Section 75 of the NHS Act 2006 covered the operation of integrated mental health services<sup>11</sup>, though they had been operating jointly for some time. The operational director for NELFT attended the Council's Adult & Community Services Departmental Management Team as a joint appointment, and by this means the effective integrated oversight was maintained.

## Integration from the bottom up

In 2008, the Unique Care pilot was introduced, with the PCT and Council bringing together resources for primary and social care services to pilot joint working to improve hospital discharge and prevention of admissions. Relatively quickly, this pilot was recognised as having significant potential to improve services and, from 2011, the model was rolled out as an operational mechanism for health and social care. The six resulting 'clusters' of primary, community and social care services were established as the fundamental basis for integrated health and social care delivery. There is relatively little formal discussion of the model in the Council governance, and for reasons which, with hindsight, are positive: the development was achieved with relatively little fanfare, and with the emphasis on practical, ground-up moves to integrate. Space was created to support co-location, the regular multi-disciplinary case management discussions were established, and together

---

<sup>9</sup> <http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=477&MID=5306#A134857>

<sup>10</sup> <http://moderngov.barking-dagenham.gov.uk/documents/s11232/Action%20Plan%20to%20Achieve%20Full%20Compliance.pdf>

<sup>11</sup> <http://moderngov.barking-dagenham.gov.uk/documents/s37378/Mental%20Health%20Section%2075%20report.pdf>

with the use of Health Analytics to bring a data-driven 'integrated overview' of the service users at greatest risk of hospitalisation, the model was largely formed. Greater governance began to be set in place over time, including ensuring that the model became the core of the Better Care Fund plan when first introduced.

In 2012, the partnership was able to take the model for Integrated Care Clusters to the National Children & Adults' Social Care Conference<sup>12</sup> and present it as pioneering practice, answering a topical debating point about how to achieve integration. A packed audience for the policy session received the presentation well, and left with a suite of supporting documents and information. Key to the presentation and the interest that it generated was that integration could be a pragmatic, staff-led activity, rather than part of a high-level top-down strategic plan.

### Joint Assessment & Discharge Team

The next major operational development is the integration of hospital discharge services with neighbouring London Borough of Havering and the CCGs and health trusts for Barking & Dagenham, Havering and Redbridge. The Health & Wellbeing Board agreed the proposal in June 2013, and Barking & Dagenham would become the initial host organisation for the service. It has since been widely credited with being responsible for such strong performance on delayed transfers of care, and has set a strong direction for joint work on the hospital discharge pathways.

## Adapting to the new NHS

With the implementation of the Health & Social Care Act 2012, the relative roles of both the NHS and local government changed radically. Public Health transferring to the Council, the establishment of the Health & Wellbeing Board, and commissioning of Healthwatch were the Council's major new responsibilities. As significantly for the integration journey, perhaps, was the creation of the Clinical Commissioning Group in place of the Primary Care Trust. Central government imposed severe resourcing limits on CCGs and their support costs, and new shared arrangements were developed in order to defray the costs. For some time, the PCTs or Outer North East London had increasingly merged their day-to-day activities, and this had had an impact on strategic relationships in Barking & Dagenham. Now, with the creation of Commissioning Support Units and small teams at borough level to support the CCG clinical directors, there were strong local relationships with long-standing trusted partners, but an increasing difficulty in accessing information

---

<sup>12</sup> <http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=477&MID=6315#AI41718>

and a frustration from the Council's perspective that the operational power of the Commissioning Support Unit (for north east London) was driving the strategy rather than the locally accountable CCG Governing Body.

Nonetheless, the Council had been an early adopter of the Health & Wellbeing Board, with its pre-existing shadow Board standing it in good stead. Membership was wide and inclusive, and the borough was at the forefront of advocating for providers to be part of the core Board membership so that it had a genuine system leadership role, rather than a more restricted commissioning focus.

On 1 April 2013, the Health & Wellbeing Board formally took on its statutory role as the borough-based system leadership forum, promoting integration and being the checkpoint for consistency of decision-making with the Health & Wellbeing Strategy and the Joint Strategic Needs Assessment. This built on the steady development of good relationships over the preceding 18 months.

### **Campaigning: Health for North East London**

All of these developments came at a time of some strong campaigning from local people and councillors across the three boroughs of Barking & Dagenham, Havering and Redbridge, related to proposals to downgrade the A&E department at King George Hospital and centre activity on the A&E at Queen's Hospital<sup>13</sup>. Local members were vocal in opposition to the proposals, centring around poor consideration of access to Queen's Hospital for residents of Barking & Dagenham, and the poor performance of the over-stretched A&E at Queen's. Referral to the Secretary of State, including by Barking & Dagenham Council, led to intervention by the Independent Review Panel in 2011, and ultimately the Secretary of State accepted the proposals, but with caveats around improvements in performance at Queen's Hospital before services could be considered to be safe to transfer. The discussions on these matters coincided with the issuing of a poor inspection judgment by the Care Quality Commission on the emergency department at Queen's Hospital, which ultimately contributed to the 'special measures' rating for Barking, Havering & Redbridge University Hospitals NHS Trust. The move remains to be fully enacted, though there have been gradual and partial shifts of 'blue light' activity from King George to Queen's Hospital. Through its positive engagement in the work of the Integrated Care Coalition, the Council has shifted its policy position to broadly accept the clinical case for relocation of services, but continues to raise concern about the readiness of Queen's Hospital, and further questions the changing demographics of the area that raises the need for more emergency care options.

---

<sup>13</sup> [http://webarchive.nationalarchives.gov.uk/tna\\_la\\_nhs/20120831162929/http://www.health4nel.nhs.uk/](http://webarchive.nationalarchives.gov.uk/tna_la_nhs/20120831162929/http://www.health4nel.nhs.uk/)

Throughout, however, integrated work continued with Barking & Dagenham an active participant. The scrutiny call-ins and heated discussions in partnership forums may have been tough and uncompromising, but they did not fundamentally challenge the position that Barking & Dagenham Council wanted to collaborate for better health and care for the residents of the borough. Disagreement was real and strongly felt, but it was not a disagreement about the basic outcome of better and more accessible health and care services, it was a disagreement on one important aspect of ‘how’.

## Better Care Fund

From its first announcement as the Integration & Transformation Fund, Barking & Dagenham’s position was to use this national process to support our local priorities to the greatest extent possible. It was received proactively, and an agreed plan was quickly developed<sup>14</sup>. The funding that was included in what came to be known as the Better Care Fund was existing funding, and came with commitments already made. Barking & Dagenham Council readily agreed to pool more than the minimum amount, including substantial preventive elements of the Public Health Grant. The plan was signed off in September 2014, with a total Barking & Dagenham pooled fund was £21.6m in 2015/16.

Progress from then onwards has been mixed. The experience of operating a risk share arrangement, as required in the guidance, was not a positive one. The target which formed the basis of the risk share – emergency admissions – was volatile and continued to rise over the year, whilst performance remained good on hospital discharge. Major schemes in the BCF – integrated care cluster arrangements, intermediate care, and the Joint Assessment & Discharge Service – continued to perform well. Developmental strands suffered for two reasons: a need for greater flexibility in redistributing resources beyond the small allocations initially made, and the commissioning and leadership resources to see change through, to scope the benefits and to sustain the implementation. All flexible monies were in the local authority funds in the pool, with CCG money tied up in NELFT contract and therefore inflexible. Reflecting on the Better Care Fund, it has not really deepened the partnership relationships since its first agreement, and the administration process has become more of a distraction than a help, given the otherwise strong context of partnership working in Barking & Dagenham.

## Emerging cross-borough working

Part of the difficulty for the Better Care Fund was that, broadly in parallel, financial constraints on the management costs of the new CCGs required that

---

<sup>14</sup> <http://modgov/documents/s74173/Integration%20Transformation%20Fund%20201516.pdf>

they pool some of their activity. Thus, a relatively small borough-based team supported the CCG Governing Body, with the bulk of the support resource being provided through the Commissioning Support Unit, which grew to support 13 north east London boroughs, as mentioned above. The joint arrangement of Outer North East London PCTs had already seen relationships more strained between Barking & Dagenham Council and commissioning health partners. In November 2010, Cabinet received<sup>15</sup> a report on the White Paper *Equity & Excellence: Liberating the NHS* which detailed a number of steps being taken to prepare for the proposed health reforms and a new role for the Council. As well as establishing the 'shadow' Health & Wellbeing Board, the paper sought approval to enter into an agreement under Section 75 of the NHS Act 2006 to ensure that a range of existing integrated services "are not destabilised by debates about the terms of the agreements during the forthcoming period of transition".

In January 2012, Chief Executives and senior leaders from commissioning and provider organisations across the health and social care sectors in Barking & Dagenham, Havering and Redbridge met to explore their vision and ambitions for collaborative working to deliver more effective integrated care for people in North East London<sup>16</sup>. As a result, a new guiding partnership was established to focus on system integration and to oversee the development of a joint Integrated Care Strategy, to be called the Integrated Care Coalition. This would be a strong focus for integrated planning between health and social care in Barking & Dagenham, Havering and Redbridge (BHR). It is under this banner that the Joint Assessment & Discharge Service would be developed, and the principles of Barking & Dagenham's integrated care cluster arrangements would be shared with partners in other boroughs who were thinking along similar lines. Eventually, the Integrated Care Coalition would be the vehicle for the major project to shape devolution of health and social care to BHR and London.

### **Transforming Care for people with learning disabilities and behaviours that challenge services**

Following the Winterbourne View scandal there were attempts nationally to deliver community-based placements for NHS patients that had been in long-term care in Assessment & Treatment Units. When concerns were raised at the pace of delivery of this work, NHS England launched Transforming Care<sup>17</sup>, to drive 'system-wide change' in services for this cohort of people. Barking & Dagenham has engaged in this programme proactively, notwithstanding the potential of the required work to skew activity towards this small cohort and away from the wider needs of the community of people with a learning

---

<sup>15</sup> <http://modgov/documents/s27237/NHS%20White%20Paper%20Report.pdf>

<sup>16</sup> <http://modgov/documents/s60766/20120619%20Integrated%20Care%20Report.pdf>

<sup>17</sup> <https://www.england.nhs.uk/learning-disabilities/care/>



disability. The presence of a joint commissioner post has been helpful in focusing this work but, for example, the rates of people with learning disability receiving an annual healthcheck has continued to be a concern, and the activity needed to drive improvement is lost to the need to deliver the NHS England targets on TCP.

### **Integrated Care Partnership**

The common theme from the three pieces of work described above (Transforming Care, the BCF and the cross-borough CCG structures) has been to disrupt shared expectations around the outcomes desired for local residents, and the relationships in place through which they can be delivered. Barking & Dagenham has generally been vocal in advocating for a strong focus on the needs of the borough's population, with some scepticism about top-down imposition of programme and commissioning arrangements, whether from NHS England or from a multi-borough NHS commissioner arrangement. Where outcomes have been compromised by the lack of local commissioning focus or proactive NHS leadership, such as healthchecks which are commissioned from GPs by the local authority, this debate has resurfaced.

More positively, however, in September 2015 there was an agreement to pursue an ambitious proposal to develop a business case which would scope a potential future Accountable Care Organisation. The ambition at the outset was one that had a strong political backing Barking & Dagenham, with a single organisation to take responsibility for health and social care, under joint political and clinical leadership. The subsequent failure to secure a vision as ambitious as this was in part related to failing to marry up the strategic ambition with the priorities at a more operational level, particularly amongst wider primary care. Therefore, unlike B&D's earlier cluster integration work, those at the frontline had not been convinced of the potential for transforming their working practices and environment, and the case for such major transformation was therefore harder to make.

# What has past integration activity taught us?

Learning from the history of integration can be summarised as the following key points, and they are worth keeping in mind whilst considering the current position with respect to integration activity:

## 1 The win-win

It is vital that any integration is approached as a win-win, serving both parties well. This should be reflected in balanced and mutually agreed outcomes, and an equal sense of ownership.

## 2 Resources

Integration needs to be resourced appropriately, with clarity about what resources each partner are contributing for what outcomes. Equally, it needs to have the investment in co-ordination and leadership if it is to work effectively.

## 3 Aligning strategy and operations

To succeed, any integration approach needs to inspire commitment in both spheres of operations and high-level strategy. This takes time to develop.

## 4 Continuous leadership

Integration needs on-going management oversight – it isn't something that just 'coasts along', but requires continuous input and direction.

## 5 Willingness to rethink

Partners to integration work need to be brave enough to change it when it's not working – and to see the longer horizon, so that a big decision to stop or change something isn't a fundamental rejection of working together, it just recognises that another way needs to be found.

## 6 A focus on Barking & Dagenham

Finally, it is of vital importance that the reasons for integrating services are absolutely grounded in delivering for the needs of

Barking & Dagenham residents. To command local engagement and political leadership, any multi-borough arrangements need to be carefully nuanced to ensure their required tailoring for individual borough needs.

## Part 2

# Current activity

## The Integrated Care Partnership for Barking & Dagenham, Havering and Redbridge

Despite not achieving the level of ambition originally intended, the Council remains committed to the development of greater integrated arrangements across Barking & Dagenham, Havering and Redbridge for the delivery of health and social care. Not only does this bring a sustainable health and social care system, but it will deliver a better service to residents. The commitment to a leading role is exemplified by Councillor Maureen Worby taking on the chairing of the Integrated Care Partnership Board.

As part of that programme, the work on localities is being taken forward by Barking & Dagenham, and the six clusters have been relatively quickly reorganised into three localities. This is felt to be a good move, and aligns with the new Target Operating Model for adults care and support, children's care and support, and the Disability Services. However, Barking & Dagenham continues to push the case that this is only one small part of the picture of transformed integrated services for BHR. There is widespread agreement on this point, but there are also differing views about the pace, scope and complexity. With the Joint Commissioning Board recently established, there needs to be some impact quite quickly from both this new forum and the provider collaboration arrangements led through the System Performance & Delivery Board.

In particular, joint commissioning must have real teeth, and involve a handover of real control of budgets and outcomes from constituent and partner agencies. This can initially be in relatively defined areas of spend and outcomes, such as learning disability, or a pathway such as hospital discharge, but there should be a real plan to expand and develop the remit, keeping in view the need to ensure that all partners can see benefit. In particular, the local authorities all have financial challenges and, notwithstanding the additional cash investment from central Government, they remain under severe pressure on adults' and children's social care. It is important that the integration arrangements deliver financial efficiencies and benefits for the local government sector as well as the NHS. In time, if this is starting to become a reality, Barking & Dagenham has expressed an interest in scoping an arrangement whereby the Integrated Care Partnership would become a new, joint Health & Wellbeing Board for the BHR area, cementing shared statutory responsibilities at that level.

The System Performance & Delivery Board has initially focused on the need to ensure that the financial gap in the NHS is planned for closure as required by NHS England. However, Barking & Dagenham is quite keen that the group quickly refocuses its activity to the original scope set out in the business case for the ACO, where the finances of local government were built into the

modelling. For this, it is essential that across the partnership the equivalence between clinical (“health”) and professional (“social care”) leadership are recognised, as well as the role of social care being wider than the propping up of the hospital system. Barking & Dagenham’s degree of proactivity in its commitment to the partnership overall is to an extent dependent on maintaining all partners’ financial and delivery requirements firmly in view.

## Devolution

Currently still awaited, the final devolution settlement for London will hold some interest for Barking & Dagenham, the health elements having been significantly shaped by the BHR partnership work. The extent to which any devolution measures (such as retention of NHS capital receipts for local investment) is yet to be seen, with both the London and North East London Sustainability & Transformation Plan ‘levels’ playing a significant role which is yet to be fully clarified. The BHR partnership has, however, been clear that most of what was asked for can, in practical terms, already be done within existing legal frameworks. The devolution settlement should, however, provide a framework within which to ‘push back’ on excessive regulatory control, if BHR can ensure that the right arrangements are in place to manage the programme well, and deliver the outcomes for residents.

## Sustainability and Transformation Plan

In October 2016, a plan for health service transformation in North East London was submitted to NHS England for review. It had been developed over a very short timescale, and was a first draft. The Sustainability & Transformation Plan is one of 44 such plans nationally. Subsequently refined, the plan and its partnership arrangements are increasingly the main focus for all health service planning activity and, crucially, for the discussion on devolution. North East London STP takes in three health ‘systems’: the BHR system (based loosely around Queen’s Hospital); Waltham Forest and East London (WEL, based around Barts Health NHS Trust sites); and City & Hackney (with the Homerton Hospital as its focus).

Bearing in mind the work that had been undertaken to build a strong, democratically led partnership for the transformation of health and care services in Barking & Dagenham, Havering and Redbridge, the top-down imposition of this planning framework was not welcomed, in Barking & Dagenham or across any other local authority. In principle, the actual ambitions and transformation proposals for the STP were as contained in the BHR devolution business case, with common themes around care closer to home, localities, and transformation of key pathways in planned and urgent and emergency care. What the STP still omits, which is more strongly threaded through the BHR work is the inclusion of social care in the

transformation planning. Certainly, in terms of financial gap, the STP is focused entirely on NHS finances, whilst the BHR proposals started from the outside on the principle of including local government and NHS financials.

The principle of subsidiarity was pushed strongly by all local government partners, which was similarly agreed through the BHR work as well so that only things that were genuinely more valuable to be done at BHR level were planned at that level. However, the tenor of discussions since then has been to establish a cross-STP governance, including forums for Members, voluntary sector and officer groups such as DASS/DCS/DPH. There has been a significant level of discussion about how the 'top-level' STP Board is composed, whether with representatives from every sector and every borough (i.e. a councillor from each borough, or a couple of councillors to represent the sector). BHR favoured a focus on the systems putting forward their representatives, with the BHR Integrated Care Partnership providing their mandate and the forum for them to bring back issues and establish policy positions. This remains to be fully resolved and a Memorandum of Understanding was in development to shape the governance and focus agreement of partners. This approach has also led to a number of discussions about what can be usefully done at STP level, which seems to push against subsidiarity by seeking to abstract issues up to STP level rather than waiting for such issues to emerge where they cannot be 'cracked' at system (i.e. BHR) level.

Having raised a number of these issues through the appropriate discussions, sharing them with BHR partners, Barking & Dagenham's position is to contribute to the STP as far as it is possible to resource such contributions, but to focus most energies on the BHR collaboration and in-borough transformation activity. The Council continues to observe the development of the STP and monitor its impact on the programmes which have been agreed through BHR and partners. To this end, we have not yet agreed to sign the Memorandum of Understanding that has been proposed to bind the partnership together in the STP; we are not alone across local authorities in north east London.

## **Prevention**

The theme of prevention of ill-health features strongly in both the STP and the BHR programmes. Barking & Dagenham has taken a robust approach with the transfer of public health responsibilities to the Council, and in the deployment of the Public Health Grant. It currently funds a wide-ranging programme, including early years health improvement provision, Active Age interventions, healthchecks, general population health improvement and services to address domestic violence and substance misuse.

The theme of the coming years is to rationalise and focus this investment so as to achieve maximum value and impact. Reviews are underway of all programmes, with the Council's wider transformation and the health and social care partnership arrangements in mind.

With the Public Health responsibilities comes a requirement to commission healthchecks for the population, as well as screening for cancers. Performance on this has been variable to date, being heavily dependent on the primary care sector to offer them to the eligible population and manage take-up (for which they are remunerated). This is an area where the Council will be seeking to exert greater influence in future to give reality to the prevention ambitions that the partnership has set itself. It is a critical element of the prevention programme and the low rates of uptake mean that the basic opportunities to address behaviours and provide earlier intervention are being missed. The Cabinet Member and Deputy Chief Executive have met with the Chair and Accountable Officer of the CCG to put their concerns about the poor performance of the primary care sector in this area.

## Children's services

Since its inception, there has been a subgroup of the Health & Wellbeing Board, with joint reporting to the Children's Trust, to co-ordinate between commissioners and providers of health and care services for children and young people. A newly formed Children's Partnership will now bring greater weight and breadth to this collaboration, to strengthen our partnership oversight of the children's agenda under the Health & Wellbeing Board. Barking and Dagenham's Health and Wellbeing Strategy, Joint Area Needs Assessment, Corporate Parenting Strategy, Education Strategy and Early Help Strategy provide an overarching summary of the borough's vision for its community, with NHS and Council influence over, and sign-up to, the strategic objectives, partnership working and accountability structure. This solid collaboration was well-evidenced in the recent joint inspection of the local area's arrangements for meeting the needs of children and young people with special educational needs and disabilities. Formalisation of joint commissioning arrangements was highlighted as an area that would benefit from further development. Working together with schools, the Council has been lobbying for some time for investment in therapy services for children, which the Clinical Commissioning Group has now been able to factor into its commissioning intentions for the coming year.

One area that will be seeing significant development over the coming year is in the redesign of a more comprehensive 0-19 offer. The Council's new responsibilities for commissioning health visiting services has been the starting point for this development, but linking the offer more broadly into



the new Community Solutions, Children's Care & Support and other preventive interventions is seen as a high priority.

## Mental Health

After a number of years of operating integrated arrangements for delivery of mental health social care services, Barking & Dagenham Council commissioned a review of its Mental Health Social Care Services. This followed correspondence from the Chief Social Worker for Adults, Lyn Romeo, seeking assurances from statutory Directors of Adult Social Services that the appropriate statutory duties around adult mental health services were being satisfactorily discharged. The review report was completed in February 2017 and was received by the Deputy Chief Executive in March 2017.

The Report recognised a number of areas of good practice in place in Barking and Dagenham's mental health services. However, alongside this, it raised some immediate concerns around compliance with safeguarding procedures, the stability of the workforce (the Approved Mental Health Professional Service in particular), and some limitations with the Care Act compliance of the service. In overall summary, it was indicated that the distinctive value of social work did not have the opportunity to have the impact that it might within the current integrated arrangements for delivery of mental health services overall. This becomes particularly relevant, considering the changing ways in which the NHS and local authority deliver and commission mental health and related support.

It was also recognised that the way in which the Council and its health partners approached integrated services had changed, with a more comprehensive locality-based approach is being developed under the BHR Integrated Care Partnership. Alongside this, the Council has initiated its new Community Solutions service for initial access to social care services alongside welfare, employment and housing advice. Finally, work is underway to rethink the future of employment and vocational support for this service user group. It was recognised that this was an opportunity to re-evaluate the place of mental health social care services in this new landscape.

In her role as statutory Director of Adult Social Services, therefore, the Deputy Chief Executive took the decision to reinstate a direct management relationship with Mental Health Social Care Services. A temporary six month extension to the Section 75 arrangement with NELFT is being negotiated to maintain the service for the delivery of the integrated service. With a date effective from 1 October 2017, a refocussed Mental Health Social Care Service will be in place, continuing to deliver under Council management, and within a strong partnership with NELFT.

Currently, there are no clear plans for integrated commissioning arrangements for mental health, although a BHR programme on mental health service transformation, and the emergence of the BHR joint commissioning board, may bring opportunities to revisit this issue.

## Learning Disability

Learning disability continues to be managed (by the Council) as an integrated service. With the new Disability Service about to launch, integration across age as well as across service structures and organisations will be an emerging theme. It will be important to maintain the shared focus on service user experience through these changes, with expected improvements in transition planning, but also as continued pressure is exerted on budgets (especially high cost placements) and support planning is reviewed.

Alongside work more broadly on learning disability services, the Transforming Care Programme continues to be a major centrally-mandated focus for partnership work with health. Barking & Dagenham commits significant resource to this, above and beyond the one-day-per-week of joint commissioner time that the NHS currently pays for. However, the demands for reporting and for case managing a small number of high-need individuals continues to outstrip available resources. In addition, the “dowry” system promised for those patients who had been in Assessment & Treatment Units the longest continues to fall short of the resourcing needed for the health and social care packages in the community. This represents a significant resource challenge for the Council, and whilst it is an important principle not to hold up care placement on the basis of funding disagreements, such decisions are exercised with due caution to ensure that funding responsibility is clear and proportionate.

There has been some greater progress in joint commissioning for learning disability than for mental health services. A joint commissioner post has been established for some time, with CCG contributing one day per week and the Council bearing the remainder of the cost. This was a pragmatic decision to enable the proposal to create the post to go ahead when the CCG was under significant scrutiny for its management overhead. In the new BHR joint commissioning arrangements, it is likely this will be revisited to get a more robust set of resources in place to support this work. The Council, as lead commissioner for learning disability services, continues to express concern that a disproportionate focus of the Clinical Commissioning Group is on responding to NHS England’s pressure on delivering the Transforming Care Programme, and not the improvement of services and wellbeing for the wider cohort of people with a learning disability.

## Continuing Healthcare and Section 117 Aftercare

Joint funding decisions on significant spend for individual packages tend to focus around Continuing Healthcare and Section 117 Aftercare. The former is the regime under which those with severe and long-term healthcare needs can have their needs met by the NHS rather than the social care system, which is, of course, means-tested rather than provided free at point of use. Section 117 of the Mental Health Act prescribes that those leaving a stay in detention under the Act must be provided with no-cost aftercare support for a period of rehabilitation, which can be joint health and social care funded, or down to either partner solely.

As part of attempts to manage spend, the CCGs for BHR announced a programme of proactive review of CHC, which at various points has had savings targets attached of the region of £1m per borough. The implication is to shift the cost to the local authority social care budget where eligibility is reviewed and CHC is withdrawn. The Council continues to engage in establishing the a workable, compliant, policy framework for this, and ensuring that dispute procedures are in place and are used proactively. There are forums established for taking forward discussions about difficult-to-resolve cases, including where we have identified a case that might now be eligible for CHC or for other joint NHS funding. This remains an area where there will be dispute over due process.

## Integrated Care

The direction of travel on integrated care more generally, albeit with an initial focus around frailty and long-term conditions, is set out above. Barking & Dagenham has moved from its six clusters to three localities for the collaboration between community health, primary care and adult social care. With the addition of children's social care, and with the introduction of the Disability Service and Community Solutions, the Council's transformation programme will add greater strength and depth to the locality model in Barking & Dagenham. NELFT and the CCG are also working on the final stages of moving to the model, and this will be the bedrock of health and social care delivery not only in Barking & Dagenham, but also in neighbouring Havering and Redbridge. It will therefore be the expectation that any activity by the new joint commissioning board will be firmly rooted in supporting delivery as far as possible at this locality level.

In this vein, the Council continues to take a proactive position on minimising hospital discharge, yielding a performance on acute hospital discharge that is one of the best in the country. Minimal delays are caused by social care, though there is a level of shared and NHS-only discharge delays that continue to merit partnership scrutiny. This has not come without cost, and we have had to take steps to contain pressures in the crisis intervention budget. We

are in discussions with neighbouring boroughs about the future of the interventions that support this positive success, including the Joint Assessment and Discharge Service, which will be included in the Better Care Fund plan once again and will therefore, in time, potentially be a more formally jointly commissioned intervention. Further requirements of the Better Care Fund that seek to minimise hospital delays, such as Discharge to Assess (where the patient is discharged to a community setting or back home before being assessed for longer term care), would need careful scrutiny to ensure that costs are appropriately met by the system, rather than the Council incurring significant additional cost to the benefit of the hospital.

### The 'improved' Better Care Fund

Over the coming three years, the Council is expecting to receive enhancements to the Better Care Fund pool of around £1m, £5m and £8m respectively. These allocations have been announced for some time, responding to the national growing pressure on the adult social care system. The aims of the BCF remain broadly the same, as outlined in the recently-issued guidance, namely to avoid hospital or care home admission and to improve hospital discharge. It is therefore largely focused on older, frail people or those with long-term conditions. One condition strengthened in the new BCF is the protection/stabilisation of adult social care, and the Council will engage with partners on this basis, noting the increasing pressure in the market and the budget gap that the Council is currently still forecasting.

There have also been moves to seek to improve the flexibility of the CCG allocations into the BCF pool, by opening up more information to commissioners on the NELFT contract and its service-level cost breakdown. This is welcomed by the Council, and the one-sided approach to freeing up re-investment opportunities only in Council resources should be improved if this can be achieved. To that end, in addition, the Council is proposing to reduce its investment in the BCF pool, from the enhanced allocations it has made in the past down to the prescribed minimum. This is to remove some Public Health and General Fund spend and to maximise the flexibility the Council has to reallocate in order to manage the pressures ahead.

Discussions are well advanced about placing the BCF into the context of the three-borough arrangements so that the Joint Commissioning Board may be able achieve greater efficiencies by fostering collaboration with neighbouring boroughs on schemes such as, for example, reablement and Discharge to Assess. This is to be a staged process, and currently boroughs are working on aligning the BCF plans, with a view to setting out the intention of a single plan for the second year (18/19) for areas where this makes shared sense.

Guidance has been issued late in the year, delayed by the General Election, and the two-year plan will be submitted in mid-September.

### **Financial pressures: NHS and adult social care**

Both sectors are currently under significant financial pressure. Barking & Dagenham CCG has to save £15m from its ca. £400m budget, part of a plan across BHR that needs to remove £55m of cost from the system, which the System Performance and Delivery Board has been tasked with co-ordinating. A number of savings proposals are now emerging for consultation, some of which are likely to be controversial (reduction in IVF cycles, cosmetic procedures) and some which have the potential to cut across partnership priorities (cessation of funding for children's Portage services).

For the Council, there is still a significant budget gap, some of which will have to be met by further savings in adult social care. The new investment of resources falls into four main headings: the social care precept, the original adult social grant from the Autumn Statement, the expected Better Care Fund investments, and now the recent further investment from the Spring Budget. These funds will need to stabilise local social care markets, support further transformation in future years (including some digital options, for example), meet escalating costs, and simply contain existing budgets. The new additional investment comes through the Better Care Fund and will need to be signed off as a joint plan with the CCG, albeit that there is clarity in the guidance of the focus on stabilising adult social care. The Council therefore will need to enter these negotiations with a clear emphasis on the need to support social care spend before any further joint investments can be considered.

## **Part 3**

# Policy positions

Based on the history outlined above, and the overview of current work and priorities, the policy positions that follow are proposed as both a statement of the Council's intent, but one which partners should be able to agree to in principle through the Health & Wellbeing Board.

## **1 Our focus is on Barking & Dagenham**

Joint arrangements both within the partners of the Health & Wellbeing Board, and our neighbouring boroughs, must deliver outcomes for the residents of Barking and Dagenham.

## **2 We are shaping our own destiny**

Our mission is to deliver its shared vision, articulated through the Borough Manifesto, and the Health and Wellbeing Strategy. All other activity must be otherwise resourced.

## **3 BHR is our major focus for cross-borough work**

We look to the BHR Integrated Care Partnership to be the main focus for its collaboration across boundaries in health and social care. It will support the STP where it can, but it will always critically evaluate proposals from the STP to ensure that there is not a more local level at which they can be more effectively led, shaped and delivered.

## **4 Everything should strengthen localities, where feasible**

We are strongly committed to locality work, and will influence all partners to consider the opportunities for strengthening the local partnership delivery around a common locality structure.

## **5 We are committed to integrated delivery**

For specific care groups (children with special educational needs and disabilities, learning disabled adults, those with mental health conditions), We understand the potential of integrated commissioning, both within Barking and Dagenham and with partners from neighbouring boroughs. However, all partners will continue to receive assurance that statutory duties are being discharged effectively.

## **6 Partnership can and should encompass robust challenge**

We believe that the key to successful partnership is the ability to robustly challenge one another. We will encourage all partners to do so where decisions do not appear to be in the interest of local residents, or which are in contradiction with shared priorities.

## **7** We want to strengthen democratic leadership of health

Real democratic accountability – not just consultative forums – should be a part of all integrated governance arrangements, ensuring the leadership of all integrated arrangements are truly accountable to the residents they serve.

## **8** We work at our own pace

While the crisis facing the health and social care sectors is severe, effective integration takes time to devise and implement. We will not rush into arrangements without first properly considering the consequences; we will value quality over speed.

## **9** We will work sustainably

Our population is growing and changing. To be able to continue to offer residents the excellent health and care services they need and deserve, sustainability must be a critical consideration in all future work and arrangements.

## **10** Innovation is key

Lastly, we will endeavour to make Barking and Dagenham a centre for health and social care innovation, and the test-bed in which our current challenges are met. We will do this because we owe it not only to partners across the country who face similar pressures, but also – more importantly – we owe it to our residents.



**APPENDIX A**

East London Health and Care Partnership:  
Consultation on payment development and drivers for change

Published 11 July 2017

Updated on 13 July 2017 to reflect extended deadline for consultation responses

Author Katie Brennan

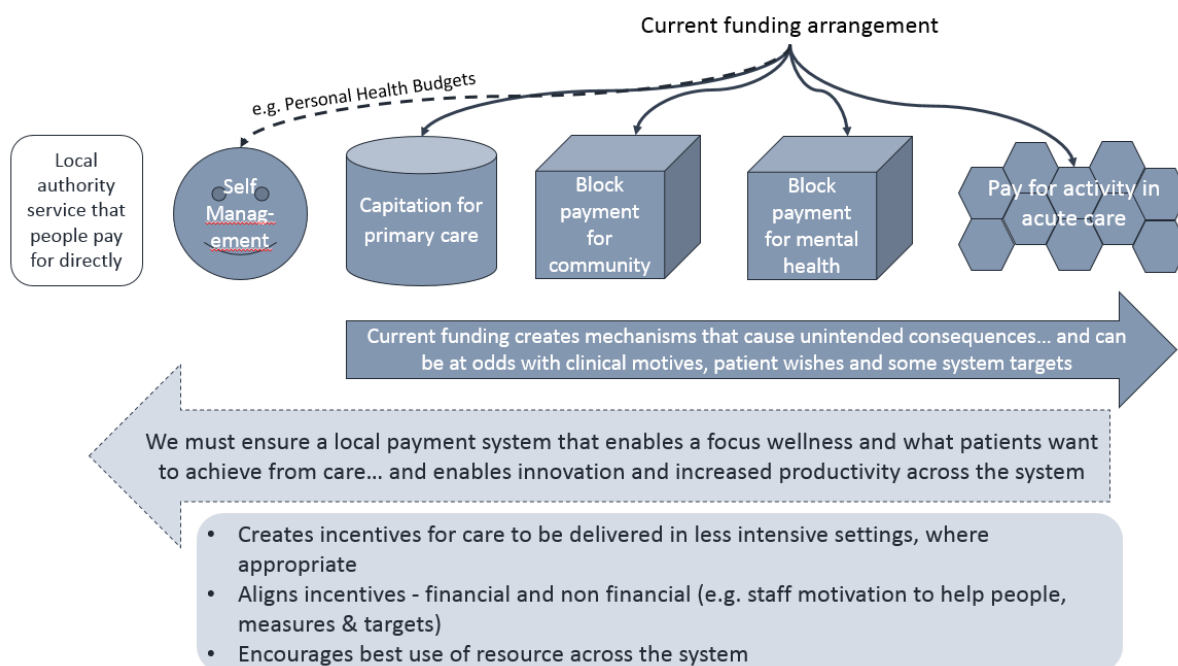
## Summary

East London Health and Care Partnership (ELHCP) is working towards a new approach to managing health and care across East London, working together in a more integrated way and taking shared accountability for delivering improved outcomes for local populations. As part of this, the three sub-systems within ELHCP (i. City and Hackney; ii. Waltham Forest, Newham and Tower Hamlets; and iii. Barking and Dagenham, Havering and Redbridge) are developing Accountable Care Systems (ACSs) and are keen to use a consistent approach. To support this, it is important to examine current payment mechanisms and consider where changes to payment can support system development in East London.

There is a need to reduce variations in the quality of care and develop care packages that provide a patient-centred and coordinated approach. Alongside this, by the 2020/21 financial year the overall funding gap in East London is projected to be £578 million. We will not be able to rely on external funding to solve these issues. Improvements to services will need to be made and the funding gap will need to be closed using a combination of service redesign and improved productivity. The way the system currently pays for services and works together as organisations make it harder to successfully meet these challenges.

Service design and ways of working will be the primary route to meet system challenges. There are a number of payment options and combinations of payment approaches that may enable incentives within the system to operate in a more coherent way, and more effectively enable the delivery of system objectives. At present in East London there are a variety of contractual payment mechanisms running concurrently depending on the type of organisation.

The diagram below gives an illustration of challenges:



As a system we must consider what configuration of payment will most effectively support system objectives. Examples and evidence from other areas, including NHS vanguards, can be drawn on to inform our thinking.

We recognise that, on its own, changing payment will not solve all the system issues. Payment systems can support strategy, but should not drive it. Therefore, new governance arrangements are also needed to ensure ELHCP can deliver genuinely accountable, coordinated care. These arrangements need to be underpinned by improved data collection and use of analytics for strategic commissioning as well as continual improvement to care. New contracting frameworks and payment mechanisms can feed into this and support clinical improvement.

The ELHCP is clear that work to develop payments should not be used (or perceived) as a programme to cut costs. The aims of this work are to ensure the system is maximising use of the resources available to it and to support ELHCP discussions about improving service delivery and prioritising care in a transparent and evidence-based way.

## Table of Contents

<b>1. Structure and timelines</b> .....	5
<b>2. Context and view of the current payment system</b> .....	7
Background and context .....	7
Specific challenges within East London .....	9
Setting objectives and agreeing priorities .....	10
<b>3. Payment options and considerations</b> .....	13
Overview of payment forms (this list is not exhaustive) .....	13
Payment approaches widely used within East London Health and Care Partnership .....	15
Examples of local payment solutions .....	17
Considerations for local payment development .....	19
<b>4. Service model, system organisation and pace of change</b> .....	22
Options for organisational form .....	22
Considerations for pace of change .....	24
<b>5. What else is needed to support system objectives?</b> .....	25
Lessons from other health and care systems .....	25
Getting the infrastructure right, whatever option is chosen for payment .....	26
<b>Annex: ELHCP Payment Development Consultation - questions</b> .....	28

To help readers navigate this document the following diagram is located at the front of each section of this document. It will highlight:

- What section the reader is on
- Content and themes covered in that section
- Consultation questions asked in that section

Summary

1. Structure and timelines

2. Context and view of the current payment system

3. Payment options and considerations

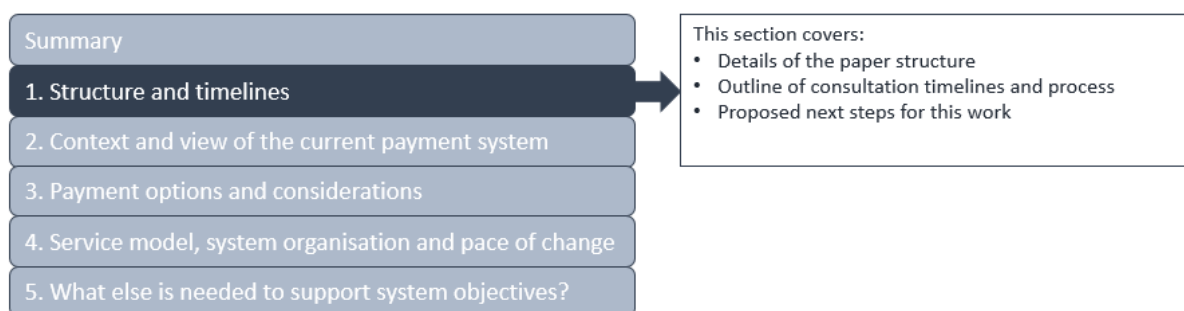
4. Service model, system organisation and pace of change

5. What else is needed to support system objectives?

This box will....

- Offer a summary of key points in each section
- Show consultation questions asked in that section

## 1. Structure and timelines



1.1. This paper considers the strategic objectives for ELHCP and asks: how appropriate are existing payment systems to deliver shared Sustainability and Transformation Plan (STP) objectives? It is broken into five sections.

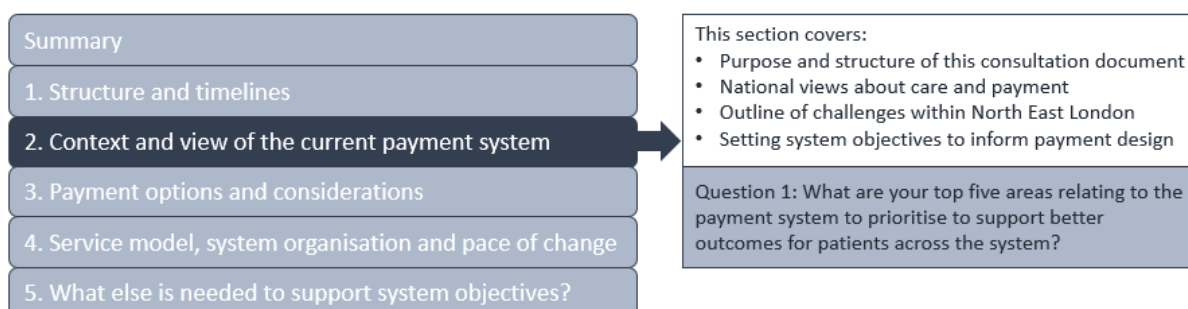
- Section one provides an **overview** of the paper structure and content as well as the consultation process
- Section two sets out the **challenges faced by health and social care** over the coming years, nationally and within East London.
- Section three outlines **payment options in use across East London** and seeks to describe the benefits and issues with these approaches. It also considers alternative payment options and looks at examples of local health and care payment approaches developed elsewhere.
- Section four considers options for **contractual form and scope and scale of service models** that payment may cover. It also outlines possible timelines for transitioning to a new payment approach that may be developed.
- Section five notes **other workstreams** that are needed at an STP level to complement development work around payment design. Without these other components any change in payment will not drive the desired change in the system.

1.2. Throughout this document are thirteen questions. They are clearly labelled at the end of each section and are intended to generate a base understanding of each organisation's views. An eleven week engagement period will start on Tuesday 11 July 2017. The consultation will take account of both written and verbal feedback. Verbal feedback will be captured through workshops – which will include engagement with providers, commissioners, voluntary sector, front line staff, patients, residents and carers.

1.3. Further to this, each organisation is asked to draft a written response. The eleven-week engagement period has been set to give organisations the opportunity to engage their Board and other leaders in their response. Therefore, feedback should reflect organisational consensus.

- 1.4. Written and verbal feedback will be consolidated to generate an understanding of areas of consensus and points of difference, and inform next steps. **Written responses should be sent to [enquiries@eastlondonhcp.nhs.uk](mailto:enquiries@eastlondonhcp.nhs.uk) by 18:00 on Friday 29 September 2017.** This is an extension from the original deadline of 4 September. If you have general questions about this document or the consultation process please send them to the email address above or [Katie.brennan1@nhs.net](mailto:Katie.brennan1@nhs.net).
- 1.5. For ease of reference, the list of thirteen questions is available in the annex to this document. This is a simple template that can be copied into another document to allow for free text responses.
- 1.6. Next steps: pending feedback, a working group will be established to develop recommendations.

## 2. Context and view of the current payment system



### Background and context

2.1. Across East London providers and commissioners must meet increased financial pressures and a need to provide more person-centred care. There are practical challenges and barriers that prevent us from achieving this:

- The practicalities of working across team and organisational boundaries are often a major challenge, running contrary to existing cultural and structural characteristics.
- In all sectors, financial pressures and increased workload can have an impact on the ability to innovate and transition to change.
- Some providers face substantial fixed costs, commitments that cannot be shifted within short or medium term time horizons.
- East London faces a total financial gap of £578m in the ‘do nothing’ scenario to reach a break even position by the 2020/21 financial year. Achieving a 1% surplus target for commissioners increases the gap by another £30m to around £610m.

2.2. East London Healthcare Partnership (ELHCP) is comprised of providers, commissioners and local government representatives covering the eight local government footprints. Across the ELHCP, health and care partners have an ambition to develop more effective and coordinated approaches to delivering care across the local health systems. To meet these challenges ELHCP organisations will need to confirm common objectives, agree ways of working, develop governance arrangements and consider service model design. These will be central drivers of change. Payment development and the availability of good quality data and analytics both have an important role to play to support that work and align incentives across the system.

2.3. Historically, the majority of NHS healthcare has been paid for on an activity basis. This was introduced to encourage activity and investment in the system when funding was increasing and waiting times needed to be reduced. The payment approach was initially effective at driving investment and reducing waiting times. However, it has had the unintended consequence of drawing health and care resources towards operational capacity for measurable units of treatment, with insufficient focus on improving the

outcomes and wellbeing patients experience. It also limits the opportunity for targeting investment in a more flexible and effective way.

- 2.4. Today, our health and care systems face new challenges. The system must deliver improved quality, a more patient-centred approach to care, better support for population health and more effective use of resources.
- 2.5. The challenges our partnership faces are consistent with the issues described in the Five Year Forward View<sup>1</sup>, published in October 2014, and the accompanying 'Next Steps'<sup>2</sup> document, published in March 2017. They set out objectives for care that is patient-centred, focused on recovery, prevention and early intervention. They also set out the need for a health and care system that makes best use of resource and treats people in the lowest intensity setting - providing care 'closer to home' where ever possible. This need is primarily driven by what people say they want and need from health and care services.
- 2.6. Messages from national bodies have been increasingly consistent when it comes to possible solutions. They are encouraging local health and care systems to adopt a more coordinated approach to find solutions to the challenges they face. Those in prominent national roles have advocated implementation of a capitated payment linked to outcomes as the best way to support needed change. In any case, there is a clear move in national policy to encourage payments linked to person-centred outcome measures. This has been signalled as a desirable direction of travel from NHS England and been enshrined in the tariff. For example, as of April 2017 NHS England and NHS Improvement require mental health providers and commissioners to adopt transparent payment approaches based on capitation or episodic payment, which must be linked to achievement of agreed outcomes. In ELHCP, work is underway to comply with these requirements using existing data and information. Plans to develop improved patient level data for mental health will support this work further in future.
- 2.7. NHS England and NHS Improvement support development of local solutions that are co-developed and can demonstrate positive impacts on ways of working and system goals. This means local areas have an opportunity to drive their destiny, but they must take active steps to develop a local approach. If not a solution may be imposed by national bodies. Within ELHCP we need to consider and develop the best payment approach for our local system.

---

<sup>1</sup> The Five Year Forward View, NHS England (23 Oct 2014) <https://www.england.nhs.uk/ourwork/futurenhs/>

<sup>2</sup> Next Steps on the NHS Five Year Forward View (31 March 2017)

<https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/>



## Specific challenges within East London

2.8. Often, payment development is perceived to be about transferring risk from one part of the system to another, or from one organisation to another. However, to be successful, payment development must be about enabling new ways of working. This means:

- ensure those in the health and care system with the power to change how care is delivered have the right incentives to do so – and that incentives within the system are aligned with one another;
- remove barriers to organisations and staff working in a more coordinated way;
- a cultural change, so the system works together towards collective, local objectives and system partners are empowered to take a more patient-focused approach to service design; and
- ensure risk is shared across the partnership in the safest way.

2.9. Within London there is a recognition that care needs to change and a desire to innovate. Below are two examples that illustrate issues that are more difficult to address in the context of the current payment structure.

- Outpatient care:
  - There is a desire to move to new ways of working for delivery of outpatient care. The way current payment levels are set across the system and payment mechanisms interact can provide a disincentive to coordinate care and develop person-centred service models. For example it makes it more difficult to:
    - increase advice and guidance provided to people and patients to prevent issues arising and allow them to manage their wellbeing;
    - move towards more non-face to face consultations, where appropriate; and
    - make better use of scarce hospital capacity and enable patients to have access to specialist consultation without the inconvenience of an often unnecessary hospital visit.
  - Other issues include:
    - The variation between payments received for non-face to face versus face to face is too large;
    - There are no mechanisms for income to reflect fixed costs and stepped costs that may become ‘stranded’; and
    - There is no national tariff guidance or advice about how to address issues identified within ‘pay for activity’ frameworks.
- End of life care:
  - Current service provision within the STP footprint is poor overall and only a small proportion of patients currently die at home or at the place of their choosing. Sufficient payment levers are not currently in place across both the health and care system to be able to realign this.
  - There is no incentive for providers from different sectors to work together and provide joined up care.

- Existing financial mechanisms are skewed by payment for activity, which has a tendency to incentivise care to take place within a hospital even if that is not in line with the patient's preference.

2.10. It is clear that the system must adapt to address these pressing challenges.

- Evidence from work in the NHS as well as international examples<sup>3</sup> suggests providers and commissioners need to work more collaboratively and take a system/population view of care and resource use.
- A number of structural and cultural changes are needed to support this:
  - payment development;
  - improved use of data and analytics; and
  - governance arrangements that enable organisations and front line staff to work in a more coordinated way.

2.11. There are a range of ways health and care systems have delivered this type of change in England and abroad (examples include Oxfordshire Mental Health<sup>4</sup>, and see footnote 3 above for international examples). Improved accessibility and use of linked data sets and payment reform have featured as a key part of achieving these goals. An agreed set of objectives and clear vision for the system is also important, the vision for the payment system should be fully in line with the vision for the wider health and care sector. The ELHCP now needs to decide what the right approach is for our populations and health and care economies. Can this be achieved via tweaks to the existing payment system, or is more comprehensive payment development needed?

Setting objectives and agreeing priorities

2.12. Lessons from other health and care systems within the NHS demonstrate the need for a clear vision and set of priorities to mobilise thinking and focus efforts toward common goals<sup>5</sup>. All parties within the health and care sector that want to implement new ways of working need to be clear about what the system is trying to achieve. When setting these objectives it is important to put patient and population needs at their centre. This promotes a patient-centred approach to solutions and aligns system objectives with those of front line staff and the population. It is also important to be

---

<sup>3</sup> International examples include:

<http://www.pwc.co.uk/government-public-sector/healthcare/assets/lessons-from-spain-the-alzira-model.pdf>  
Struijs JN & Baan CA (2011). Integrating Care through Bundled Payments – Lessons from the Netherlands. N Engl J Med, 364:990-991. March 17, 2011.

<http://ccn.health.nz/Resources/OutcomesFramework.aspx>

<https://www.kingsfund.org.uk/publications/population-health-systems/kaiser-permanente-united-states>

<sup>4</sup> [https://improvement.nhs.uk/documents/234/MH\\_outcome\\_based\\_commissioning\\_update\\_note\\_v2.pdf](https://improvement.nhs.uk/documents/234/MH_outcome_based_commissioning_update_note_v2.pdf)

<sup>5</sup> <http://www.pwc.co.uk/industries/government-public-sector/healthcare/insights/shifting-to-accountable-care-characteristics-and-capabilities.html>:

'Experience from accountable care organisations operating across the world shows that the successful delivery of accountable care requires capability in eight key areas: 1. Strategy & vision: There is a compelling vision and clear strategy for managing and delivering clinical, patient and service user outcomes. This is shared by all organisations involved in the delivery of health and care.'

open about local opportunities, and challenges that need to be addressed. It is important for payment to be developed and configured in a way that supports agreed system objectives.

2.13. From a patient perspective, the ELHCP<sup>6</sup> sets out areas for improvement:

- Apart from City and Hackney all East London areas are below the national average for success in getting a GP appointment and ‘ease of getting through to someone at a GP surgery on the phone’ (based on patient surveys).
- Address inconsistent patient experience for A&E, inpatients, maternity, and outpatients and for mental health providers (based on Friends and Family Test).
- Many patients do not die in their preferred place (as few as 22-29% in some areas. See example above on end of life care).
- One year survival rate for all cancers is lower across all seven CCGs than survival rates across England.

2.14. In most cases what local people want from their interactions with the health and care service is consistent across geographies – and the list is likely to resonate with each of us as service users. The patient representative group National Voices has set out what service-users say they want and findings from Barking and Dagenham, Havering and Redbridge (BHR) and Tower Hamlets echo these national themes:

- the ability to plan my care with people who work together to understand me and my carer(s);
- allow me control; and
- bring together services to achieve the outcomes important to me<sup>7</sup>.

2.15. To deliver better outcomes for patients and address the strategic system challenges, providers and commissioners across ELHCP will need to focus on the following:

- incentivising early intervention and prevention for whole populations;
- encouraging all providers collectively operate within costs constraints of the system; and
- removing the barriers that currently block care coordination.

---

<sup>6</sup> ELHCP October 2016, apart from the first bullet, which represents updated data (as of 7 July 2017) from the NHSE’s GP Patient Survey <https://gp-patient.co.uk/>

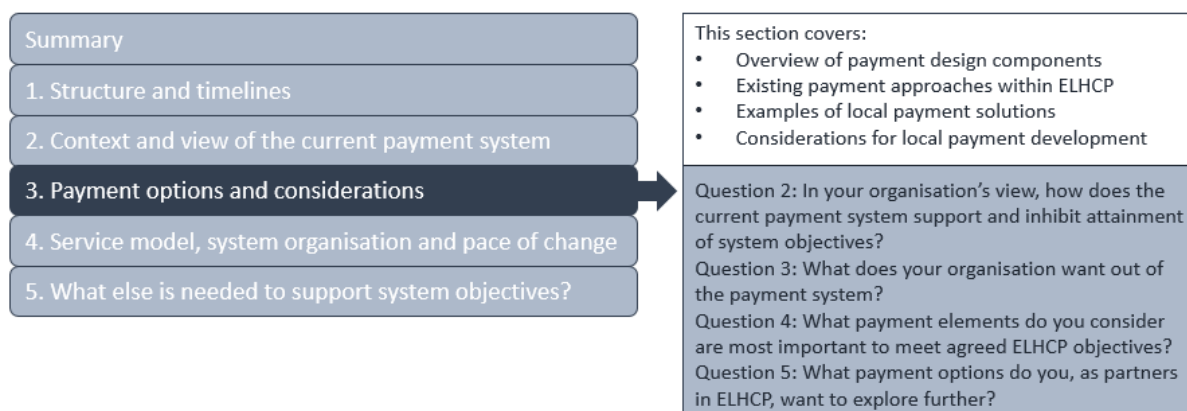
<sup>7</sup> <http://www.nationalvoices.org.uk/sites/default/files/public/publications/narrative-for-person-centred-coordinated-care.pdf>

2.16. Change will not happen overnight. Improvement processes can be overstretched and become unfocused unless they have clear priorities. It is important that system leaders agree clear system-wide objectives and, given that, decide which areas of work to prioritise. Possible areas to prioritise include:

- i. Incentivise better outcomes rather than increased volume of interventions.
- ii. Reward delivery of care that enables patients to control decisions regarding their own health and care.
- iii. Manage financial risk between organisations.
- iv. Manage transformation and the process of transition.
- v. Design a contractual framework that aligns providers and commissioners objectives to deliver collective outcomes.
- vi. Improve quality-linked patient-level data across the whole system.

**Question 1: What are your top five priority areas relating to the payment system to support better outcomes for patients across the system?**

### 3. Payment options and considerations



3.1. Across health and care systems a range of payment approaches are generated using adaptations of a standard set of payment tools: fee for activity, block payment, capitated payment, payment for outcomes, cost and volume arrangements and so on. Drawing on these tools, and using them in combination, there are an infinite number of payment options that may be developed and implemented locally. This section considers system goals that payment needs to support, outlines common payment approaches used in East London, examines a range of payment approaches available and offers real world examples of different local payment approaches.

Overview of payment forms (this list is not exhaustive)

3.2. Payment cannot drive transformation, but it has an important role to play in supporting system change. This section provides an overview of a range of payment forms that can be drawn on when developing local payment approaches. All have benefits and drawbacks. The important thing when designing a payment approach is to ensure that incentives across the system are appropriately aligned to support desired outcomes and reduce the risk of unintended consequences.

3.3. *Block payments* offer a fixed amount of funding to a provider to deliver care to an agreed population over a fixed period of time. This provides a stable source of funding to enable investment and delivery of quality care. It is calculated based on historical expenditure and can be adjusted to reflect expected efficiency gains, trends in patient needs (demographic growth and changes in case mix) and cost uplifts. Non-acute providers using block contracts have a clear awareness of their cost envelope and can organise their service availability to match it. However, since they then have limited capability to flex their staffing they have little incentive to attract additional work. To manage demand they may extend waiting times, take a measured approach to acute discharge and actively move patients on to alternative care settings.

3.4. *Primary care per capita* is payment for core GP services allocated on a per capita basis, using an average payment per patient based on the GP patient list. In principle, this arrangement incentivises GPs to take on new patients. In addition to core services, commissioners provide specific additional payments for items of locally prioritised

activity, for example locally-enhanced services linked to clinical outcomes for specific long term conditions. The bulk of primary care funding and costs, therefore, are relatively predictable, enabling them to remain financially sustainable as providers. GPs provide direct treatment, but they also have a significant role diagnosing and referring patients to alternative care settings. The increasing constraints on GP time and the increase in the number of appointments/contacts they are required to make potentially creates a perverse incentive to avoid risk and refer patients for tests or acute diagnoses rather than undertake measures available out of hospital that might be viable alternatives. The limitation on their resource can also limit their capacity to provide preventative care in the most effective way.

- 3.5. *Fee for service* means a care provider is paid separately for each component of an interaction with a patient. This means there is a specific price for each individual resource used (ice pack, splint, serum, etc.) and for each care action taken (scan interpretation, drawing blood, physical examination, etc.). Some private insurers in the United States use this approach for payment. Provided fees are set at or above efficient cost levels, it offers remuneration for all activity and resources used to treat a patient, but does not create incentives for early intervention, preventative care or coordination between care providers.
- 3.6. *Payment by activity* (as per the current national tariff). This is payment by event or episode. It was developed over a decade ago, at a time when the NHS had a specific set of priorities to reduce waiting times and increase acute activity<sup>8</sup>. However, it can limit incentives for coordinated care or care focused on early intervention and recovery. Further limitations of this approach are explored in para 3.10.
- 3.7. *Cost and Volume payment* is a variant of payment for activity, and often incorporates caps and collars. This payment mechanism helps to manage volume risk. It involves a block element for the core service, allowing for variable costs and/or case adjustment between a threshold and a ceiling. This works particularly well for services that have to be provided come what may, where it is clear what the core service costs for example, A&E services have to be provided 24 hours a day seven days a week. The contract can be set assuming a certain level of patient attendances and acuity, with additional payments up to a ceiling that are flexed if more people attend than expected. This type of approach can be useful to address a specific volume risk in one service, but on its own does not support reduced demand risk or integrated approaches to care.
- 3.8. *Outcomes based payment* is where organisations link a portion of payment to attainment of agreed objectives. Evidence suggests that outcomes based payment is most effective at supporting transformation when focused on a small set of measures that are aligned to patient and population outcomes rather than more specific and lengthy list of clinical outcomes. It is also more effective when framed as a payment rather than a penalty, and supports innovation best when it accounts for a relatively

---

<sup>8</sup> <https://www.kingsfund.org.uk/press/press-releases/current-payment-systems-not-suited-current-challenges-facing-nhs-new-report>

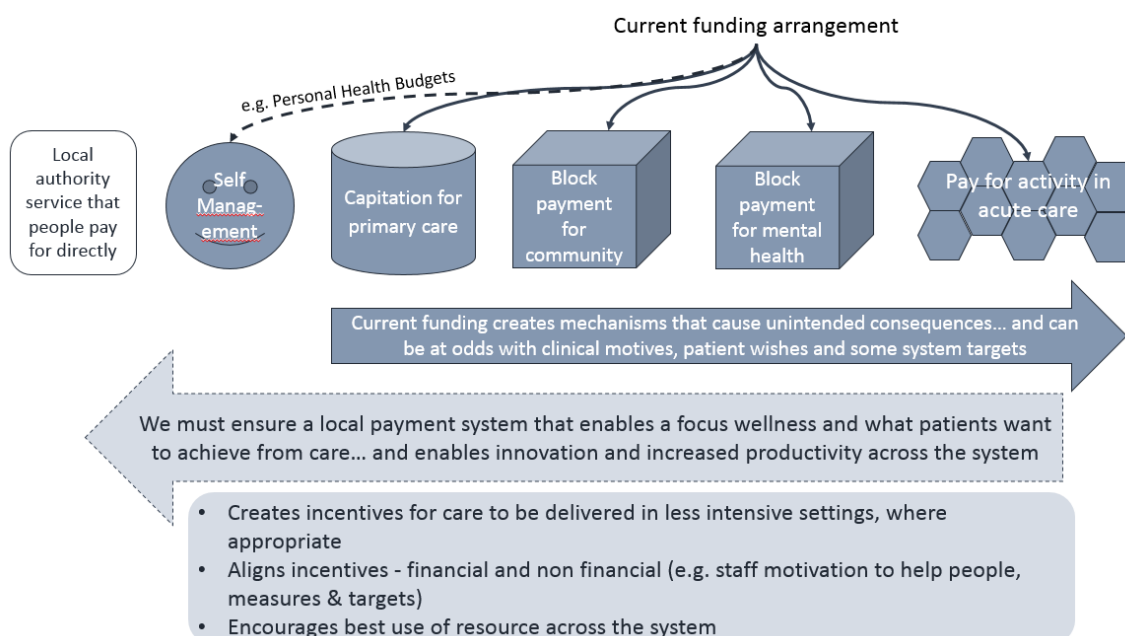
small share of total payment. If the size of the outcomes-based payment as a share of the total payment is set too high, the agreed metrics are likely to focus on clinical outcomes that can be easily achieved rather than more ambitious person-centred outcomes. Successful outcomes based payments require co-development of appropriate metrics and the existence (or development) of supporting data systems allow agreed outcomes to be measured in a direct way, limiting proxy indicators wherever possible.

3.9. *Gain and loss share arrangements* can give providers an opportunity to have a stake in the success of the system. It can allow them to retain a share of savings they are able to generate for the system or have to absorb a share of losses incurred. They can also be deployed to mitigate financial risk to individual organisations that are due to switching to a new integrated care model, by redistributing changes in revenue from one part of the system to another. In financially constrained health and care systems the ability for gain and loss share arrangements to operate effectively is more limited, as any funds in the pot will need to be held back from funds that may be needed to provide care. In this case it may be more appropriate to have an agreed risk pool across providers and commissioners that is ring-fenced to manage unanticipated changes in demand.

Payment approaches widely used within East London Health and Care Partnership

3.10. This section looks at payment forms used within ELHCP and considers the incentives they place on the system. There are a number of smaller scale commissioning arrangements that are experimenting with different payment forms in order to improve incentives within the system. However, at present, the majority commissioning arrangements within ELHCP combine:

- Fee for activity – or Payment by Results in the acute sector; with
- Block payments for community and MH services; and
- Primary care per capita core payments and outcomes payments.



3.11. The structure of the current payment system as outlined in the diagram above supports some objectives desired by the system, but also presents real barriers to realising the changes required.

- Benefits include:
  - It encourages providers to clear RTT backlogs in acute care, ensuring payment for units of care provided, enabling activity and reducing backlogs.
  - It allows quality of care per intervention to remain to standard in acute settings, through nationally prescribed reimbursement for each unit of care delivered.
  - It encourages quality coding of data for acute care as payment is linked to it.
  - It enables providers to manage, and be remunerated for, unanticipated surges in demand.
  - It stimulates providers to be internally efficient.
  
- Issues include:
  - It is not designed to promote or support larger scale shifts in care from settings where the prevailing contract form is activity driven, to other settings where care is paid for under a block contract.
  - It is not well suited to promote coordination of a more patient-centred way of delivering care.
  - It provides almost insufficient direct incentive for health promotion and disease prevention at the provider level, locking the vast majority of NHS funding into treating the effects of poor health rather than preventing their occurrence.
  - It does little to support targeted investment of funds to areas that will deliver more effective care, or better efficiency, productivity or innovation across the wider system. I.e. it does not always support allocative efficiency of care across the system.
  - It provides insufficient direct financial incentive for providers to engage in patient flow and demand management programmes across the system. For example, demand pressures may continue to result in activity and referral rates in the acute sector that are above plan. In this case, performance targets may be breached and the cost to the system of acute activity becomes unsustainable.
  - Tariff-based payment rewards delivery of prescribed interventions on a volume basis, which may not always lead to better outcomes for the patient and the system.
  - It can be perceived as complex to understand. This acts as a barrier to engaging staff (in particular clinical staff) to understand the impact the payment system has on care delivery within the local system – this effects the quality of discussions on root cause analysis and solutions when looking to support change.



- Where Trusts are under financial pressure, it can create a tension between (i) the draw to meet local needs and coordinate with local partners and (ii) pressure from regulators to maximise funding streams to shore up financial position.

3.12. Clearly the payment system can act to create pressure and impact adversely on both commissioner and provider organisations. Currently, the tools to address issues in the system are not in the hands of those who have the capability to impact change on the ground.

**Question 2: In your organisation’s view, how does the current payment system support and inhibit attainment of system objectives?**

Examples of local payment solutions

3.13. There is a growing consensus within the English NHS and internationally that having both *payment by activity* arrangements and *block* contracts in place does not create the most effective mechanisms to support co-ordinated, patient-centred, prevention-focused and sustainable care. For example, under this payment system funding must flow to acute providers as their activity increases. In a financially constrained system this means funding may need to be found from other areas of the system (e.g. primary and community care), where the system may otherwise wish to invest. Most health systems working toward transformation and increased accountability for patient outcomes have developed their own local payment system to better align incentives.

### Examples of systems starting to form accountable care arrangements in UK

Type (from most to least formal)	Scope	Scale	Risk	Further details
<b>Northumbria ACO:</b> prime provider with full risk share	Health and social care inc. providers (acute, GPs, MH, LAs, ambulances)	320,000 people Rural population	Full transfer of risk and responsibilities from commissioners to new provider org Function of CCG reduced	Region has historically strong integrated platform Model will focus on urgent and emergency care
<b>Torbay and South Devon NHS FT:</b> fully merged with some risk share	Acute, community and social care services	675,000 people Budget of £331 million 8,000 staff across 2 sites	Partners each share both underspending and overspending in according to different proportions	Result of merger between several health and social care orgs.
<b>Symphony in South Somerset:</b> corporate JV with some risk share (Outcomes 2.5%)	Secondary, community and primary care	Initially 1,500 people with multiple LTCs Will be expanded to full population of approx. 540,000	Proposed at least 2.5% (aligned with CQUINs) at risk for delivery outcomes increasing over time Further risk share plans to be agreed	JV has a single budget for the population and can delivery care across settings South Somerset is a PACS vanguard
<b>Mid-Nottinghamshire Better Together:</b> memo of understanding without risk share	Services in Primary, secondary, community and social care	310,000 people Budget of £340 million	Combined CQUIN to incentivise a joint outcomes framework	Signed MoU to work together through a strategic partner board and test a shadow capitated, outcomes-based contract
<b>Working Together in South Yorkshire, Mid Yorkshire and North Derbyshire:</b> loose partnership, no risk share	Acute care only	2.3 million and 7 providers 15 hospital sites Approximately 45,000 staff	Pooled budgets in limited functions such as procurement	Seven trusts in North Yorkshire that pools funds for procurement and is driven through central programme executive

Source: built on work from McKinsey & Company, October 2016, but updated to reflect ongoing developments. Many of these schemes are currently being developed and we will track their progress, and reflect lessons learned as ELHCP payment development work progresses.

3.14. Within East London, contracts that have developed alternative payment arrangements to support transformation include:

- Tower Hamlets Community Health Services alliance contract, which brings together care across a number of locations, including hospital, community and GP care. Key developments include a new single point of access that is available 24 hours a day, seven days a week; better integration of adult and children services and a single patient record.
- Newham CCG is working closely with the provider based MSK Collaborative to establish a ring fenced contract for MSK activities. The providers will decide how resources are distributed between them. The new contract will provide for incentive payments, risk pools and efficiency savings. Providers have indicated that internal Collaborative transactions will operate on a mixed economy basis - i.e. some components will still comply with National Tariff rules whilst others will be forms that include the potential for block and tolerance<sup>9</sup> type agreement. Providers have the opportunity to minimise risks such as stranded costs via control of a risk pool that will be operated by the Collaborative. There is also an opportunity to link outcomes to this payment arrangement.

3.15. With both NHS and international examples of care transformation, most systems include the following elements as part of their payment systems:

- i. Capitated payments<sup>10</sup>: Most NHS vanguard sites are planning to use capitated contracts with incentives or penalties linked to delivery of outcomes. In addition to the table above, NHS examples include Salford, Dudley, Stockport, Kent and Coastal, Sandwell & West Birmingham CCGs and others. Internationally, systems delivering patient-centred, coordinated care have generally used capitation, whether they be risk adjusted to mirror commissioner allocations or not<sup>11</sup>.
- ii. Outcomes or Incentive based payments:
  - Payments linked to patient and population outcomes are a core component of successful systems because they more directly incentivise delivery of desired objectives. This can form a small but important proportion of the overall contract value. Although some areas have developed outcome frameworks, the scope of measures that will be linked to mature contracts has not yet been published by any vanguard area. Some (e.g. Mid-Nottinghamshire Better Together) base contract outcomes on process

---

<sup>9</sup> The tolerance element relates to elements of growth exceeding expected levels that are driven by higher than expected GP referrals. Further details are TBC as contract negotiations are ongoing.

<sup>10</sup> Capitated payment, or capitation, means paying a provider or group of providers to cover the care provided to a specified population across different care settings. The regular payments are calculated as a lump sum per patient. <https://www.gov.uk/guidance/capitation>

<sup>11</sup> <https://www.kingsfund.org.uk/projects/supporting-new-nhs-care-models/key-choices-designing-new-systems>; Struijs JN & Baan CA (2011). Integrating Care through Bundled Payments – Lessons from the Netherlands. N Engl J Med, 364:990-991. March 17, 2011.

measures in the short- term, but will move to patient and population outcomes in time.

- Clinical outcomes, for example the Quality and Outcomes Framework are useful to drive an initial change in behaviour, but can be unsustainable as providers rely on payments to continue that behaviour. Depending on outcomes measured, they can be complex to administer for little long-term gain.
  - iii. Risk-gain share: This can be used as a component of capitated budgets to manage uncertainty in volumes or flows of patients, or to drive specific changes in provider activity.
  - iv. Pooled budget arrangements between health and social care (e.g. Section 75<sup>12</sup>): These are a useful tool, already in place in most localities. On their own they are not sufficient to align incentives to promote whole population care. However, as part of addressing the wider determinates of health and wellbeing, it is important consider how payment for relevant care can support improved coordination between staff and improve outcomes for people and patients.
- 3.16. Any development of the payment system that designs incentives needs to take an objective approach to ensure those incentives are placed in the hands of those most capable of making a difference, rather than where it is most expedient. Such work will also need to consider how any payment flows between organisations may be managed appropriately. Alongside payment development evidence shows it is important ensure the relevant governance, reporting and data sharing arrangements are in place.

#### Considerations for local payment development

- 3.17. There is no perfect payment system. In practice local systems need to work together to design payment options that work best for their area. Different types of payment are useful to support different system objectives. The table below illustrate the strengths and weaknesses of different approaches explored above.

---

<sup>12</sup> Section 75 of the NHS Act 2006 gave PCTs and local authorities legal powers to enter into integrated and lead commissioner arrangements. Where lead commissioning arrangements are in place, commissioning duties are delegated between organisations, and one organisation leads on behalf of the other(s) to achieve a jointly agreed set of aims. The lead commissioner is responsible for commissioning the agreed scope of services, within the relevant budget, and for entering into contracts with providers. Governance of integrated or lead commissioning arrangements are typically set out in a section 75 agreement (along with arrangements for pooled budgets).

[https://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/Options-integrated-commissioning-Kings-Fund-June-2015\\_0.pdf](https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Options-integrated-commissioning-Kings-Fund-June-2015_0.pdf)

Impact on...	Mechanisms			
	Fixed period of time	Population	Activity	
	Block funding	Capitation	Episode of care	Fee for service
Increase activity	✗	–	✓	✓
Cost control	✓	✓	✓	–
Primary prevention	–	✓	✗	✗
Secondary prevention	–	✓	✓	–
Care pathway coordination	✗	✓	✓	✗
Person Centred Care	–	✓	✗	✗

Source: based on work from McKinsey & Company

3.18. Payment for outcomes can apply to any of the above payment types.

3.19. It is possible to meet system objectives using the current payment system through local variations to tariff for given services. Local providers and commissioners have already developed a range of ‘work around’ payment and service solutions for specific types of care. However, without a strategic and coordinated approach to payment across a local health and care system there is a risk that special contract agreements and a proliferation of modifications to service models will lead to increasingly fragmented and incoherent incentives across the system as a whole.

3.20. Any payment development work will need to consider how to support patient choice as part of its objectives. Contract forms for such arrangements can include (i) the commissioner carving out an amount for patient choice from the whole population budget, which is then used to pay out of area providers; or (ii) the identified amount being managed through a prime provider, sub-contractor arrangement – although the latter would require transparent arrangements to address the potential financial conflict of interest. With either arrangement, the amount would be based on an estimated volume of patients. Overspend could be addressed through a risk pool arrangement, however there would be an incentive for providers to maintain and improve quality to encourage patients to choose their service. Analysis based on Service Level Agreement Monitoring (SLAM) data for 2015/16 shows that 87% of total spend on acute tariff-based services within ELHCP is commissioned from providers within the ELHCP footprint.

3.21. Evidence suggests that payment mechanisms that are less complex in structure are easier for all people in the system to understand and react appropriately to. Decisive steps should be taken to minimise complexity, both to enable greater transparency and reduce the bureaucracy associated with a burdensome set of rules and processes.

3.22. Given the challenges the NHS now faces, and the experience of other areas that have implemented reform, there is a strong case to review payment mechanisms to support greater coordination and a patient-centred approach to care.

**Question 3: What does your organisation want out of the payment system?**

**Question 4: What payment elements do you consider are most important to meet agreed ELHC objectives?**

**Question 5: What payment options do you, as partners in ELHCP, want to explore further?**

## 4. Service model, system organisation and pace of change

Summary	<p>This section covers:</p> <ul style="list-style-type: none"> <li>Options for contracting and organisational form</li> <li>Scope and scale of service design and payment</li> <li>Exploration of the possible 'pace of change'</li> </ul> <p>Question 6: Is it best for payment to cover populations based on a person-centred approach or disease/condition specific approach?</p> <p>Question 7: What geographic footprint is appropriate for payment: CCG level; City &amp; Hackney/Waltham Forest, Newham and Tower Hamlets/Barking and Dagenham, Havering and Redbridge; or across the ELHCP footprint?</p> <p>Question 8: What services would be included in a new payment approach?</p> <p>Question 9: What steps are needed to secure this type of buy-in and practical engagement among all ELHCP member organisations?</p>
1. Structure and timelines	
2. Context and view of the current payment system	
3. Payment options and considerations	
4. Service model, system organisation and pace of change	
5. What else is needed to support system objectives?	

### Options for organisational form

4.1. This consultation is not about organisational form. However, there is an intrinsic link between organisational form and development of a contract form to support it.

4.2. Successful coordinated systems can operate using a range of contractual forms. An 'accountable care system' can operate under one single organisation or, alternatively, governance structures can enable different organisations to operate in a coordinated way. Local partners should consider the local provider landscape and relationships when determining which option is best for their area. Below is a spectrum of options.

	Options	Type	Description
Formal	Accountable Care Organisation	Single legal entity	<ul style="list-style-type: none"> <li>One person (CEO) in charge, with one board, and single accountability</li> <li>Pooled 'capitated' budgets</li> <li>Complete risk transfer</li> </ul>
	Accountable Care Partnership or System	Partnership	<ul style="list-style-type: none"> <li>Joint accountability via partner board (or lead provider) alongside organisational governance structures</li> <li>Some / shadow pooling of budgets</li> <li>No risk transfer or shared risk</li> </ul>
Informal	Collaborative network	Collaboration	<ul style="list-style-type: none"> <li>Boards and CEOs for separate organisations, individual accountability to commissioner</li> <li>No pooled budgets</li> <li>No shared risk</li> </ul>

4.3. When considering contract arrangements it will be important to agree the scope and scale of services, as well as what units payment is linked to and what provider(s) payment covers.

4.4. *Scope of payment:* There are two elements to consider

- Setting a ‘whole population’ scope for payment supports a person-centred approach to care, in which no specific condition or disease is singled out. The rationale for this is that it enables a focus on specific segments of the population, not disease pathways, in order to reinforce and encourage integrated working. This offers less complication about when people transition in and out of a pathway and encourages early intervention and management of conditions. Categories could include: Adults with complex needs, children with complex needs, mostly well adults, mostly well children, older adults, under-5 children, etc.
- Setting a condition based approach, for example MSK services or diabetes care can encourage joint working of providers along a limited care pathway. It may not support integrated care for people with multiple conditions.

4.5. *Scale of payment:* A key consideration for payment development is around geographic scale. Scale could be set in a way that is coterminous with local authorities, i.e. at a CCG level, this would support integration with social care. If the focus is to enable better integration between acute and community services, a wider scale footprint may be more appropriate, for example across i) Waltham Forest, Newham and Tower Hamlets; ii) Barking Havering and Redbridge, and iii) City and Hackney. For some care needs it may be appropriate to consider a single payment approach for the whole ELHCP footprint. This can enable discussions about service configurations across geographies to make the most of resources and capabilities across provider organisations.

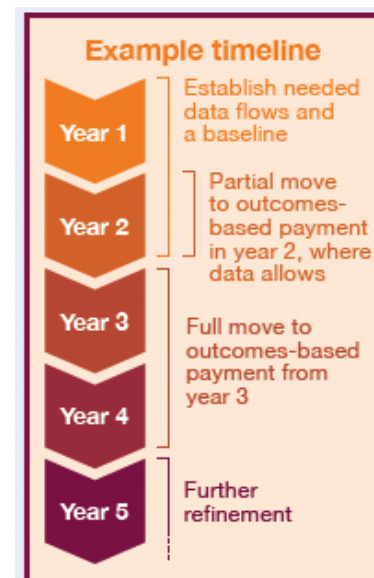
**Question 6: Is it best for payment to cover populations based on a person-centred approach or disease/condition specific approach?**

**Question 7: What geographic footprint is appropriate for payment: CCG level; City and Hackney/Waltham Forest, Newham and Tower Hamlets/Barking and Dagenham, Havering and Redbridge; or across the ELHCP footprint?**

**Question 8: What services would be included in a new payment approach?**

## Considerations for pace of change

- 4.6. The move to a new way of paying for care does not need to happen via a 'big bang'. Most areas that have introduced changes to payment system have done so via an incremental approach, and taken an evidenced based approach to selecting and testing options. A key first stage will be to get data and information in place – outline what type of data is needed (both the minimum needed to support our objectives, and ideally what data we would like to have).
- 4.7. System partners work together to understand and improve baseline data, and consider evidence about (i) opportunities for service development and/or improve use of resource within existing services; and (ii) implications on the system of different payment methodologies.
- 4.8. Experience from other areas shows that this initial stage is a vital step toward achieving transformation. This also shows that the relationships and ways of working established when organisations are committed to the process can be as important a lever for change in local systems as the payment, contracting and governance mechanisms that are developed out of that work. However, that development stage requires real commitment and leadership from all partners as well as continual active cooperation in the development process.

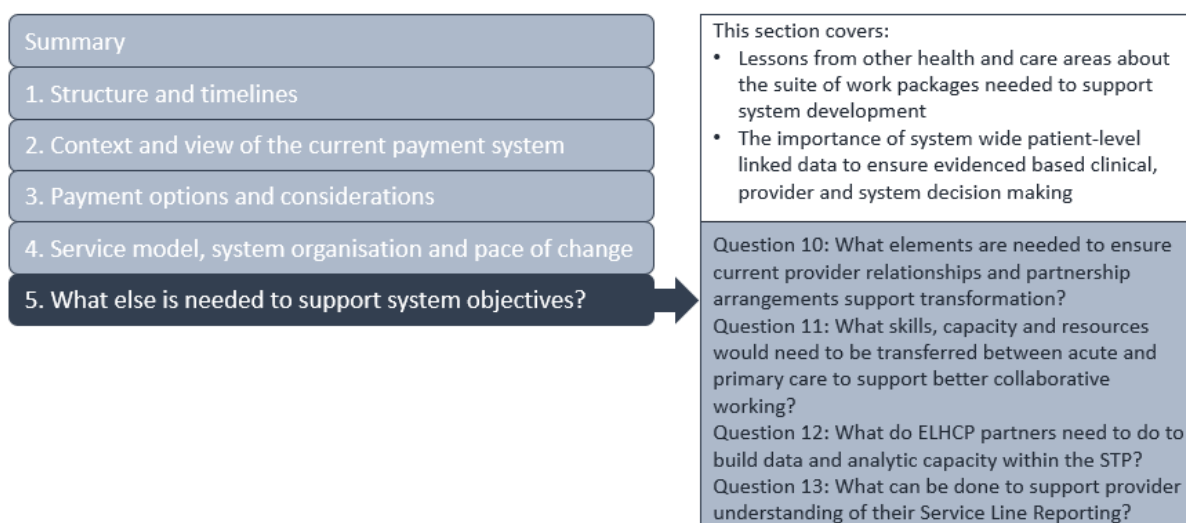


Source: NHSI overview based on Oxfordshire & Cheshire & Wirral

**Question 9: What steps are needed to secure this type of buy-in and practical engagement among all ELHCP member organisations?**



## 5. What else is needed to support system objectives?



### Lessons from other health and care systems

- 5.1. A number of components are needed to support and enable change within the health and care system. A common vision, good quality data and information (one version of the truth) and structures that allow people in the system to work together to solve collective problems are all essential.
- 5.2. Experience from other health and care systems show the following elements are needed:
  - *An understanding of patient and population needs.* For example, in Somerset the Symphony project Accountable Care Organisation acts as the ‘engine room’, providing data analytics to inform population segmentation, carry out risk stratification (in terms of need and cost), and inform service redesign.
  - *Good quality data and information* to inform system-wide decision-making as well as provider actions and the activity of front line staff. Practical examples of where this has worked include Northumberland Tyne and Wear NHS Foundation Trust and Group Health, who operate a closed insurer and provider system in the USA. In both cases, they invested in developing data over time and used this to inform services and care, understand their impact on patients and support continuous improvement using data in an active dialogue led by clinicians.
  - *Patient and public feeding into goal-setting and decision-making.* For example, commissioners and providers in Oxfordshire developed an outcomes based commissioning model for adult mental health, which was co-developed with experts-by-experience and third party sector partners. The framework is based on a capitated payment approach linked to outcome measures.

- *Governance assurance tools for cross-boundary working* for safe, high quality care. These give public and providers assurance that safety and quality will not be compromised, and could include:
  - monitoring progress of system goals;
  - monitoring performance of organisations within the accountable care system;
  - infrastructure and planning to raise issues early to deliver services more effectively;
  - aligning assurance across health and social care; and
  - links with others outside the local system (e.g. London Borough Councils, voluntary sector, housing authorities and the education sector if they are not formally part of the accountable care system).
  
- *Professional working arrangements* across organisational boundaries. This includes setting out routes to develop innovations in care pathways using new technology, skill mix and care delivery.
  
- *Escalation and dispute resolution routes*. Lessons from Hudson Headwaters Health Network in the US suggest it is important to acknowledge that partnership working is challenging. This includes identifying issues that may arise in a partnership environment, and having mechanisms set up in advance to manage quality issues and disputes.
  
- *Funding flows that reduce barriers* to front line staff being able to deliver efficient care in a person-centred way. This needs to be supported by complementary organisational structures. It means avoiding overcomplicated management and payment forms. Supporting teams and giving permission to be more innovative and have a greater degree of ownership and using mechanisms that reduce patterns of behaviour that add limited value.

**Question 10: What elements are needed to ensure current provider relationships and partnership arrangements support transformation?**

**Question 11: What skills, capacity and resources would need to be transferred between acute and primary care to support better collaborative working?**

Getting the infrastructure right, whatever option is chosen for payment

5.3. Based on the evidence above, it is clear that further investment and development is needed to support a system-wide data and analytic function in ELHCP. The aim of this function is to:

- a. *Support clinical decision making* - enable continual improvement and best use of resource from front line staff (e.g. adoption of a learning system approach)

- b. *Support providers* to manage and monitor performance and resource-use as well as identify (and act on) opportunities to improve care. To do this, providers need to understand outcomes for people in their care, their activity and costs at a granular level and how these relate to resource utilisation.
- c. *Enable system management* and improved strategic commissioning to support health and wellbeing across health and care systems - including constructive, evidenced-based discussions on care and quality improvement

5.4. Learning from successful transformation work shows these elements are needed to support analytics and system intelligence:

- *Patient level data* is key to supporting sophisticated system intelligence and clinical decision making. It enables us to track people through care pathways and understand the impact of their interactions with the health and care system.
- *One version of the truth*, where all organisations have access to consistent data and analytic outputs and have the same understanding of where issues and opportunities lie.
- *Use of advanced statistics and analytics* help us understand patterns and correlations. Retail and other sectors have used this for years and it is time for health organisations to make better use of the information we have. NHS England has kicked off a tender process for common specifications and procurement of business intelligence and analytics across London. Data and analytics is a critical part of the work to develop payments and support system development. Therefore, comments on analytic needs are sought as part of this engagement process, which will help inform ELHCP analytic development as well as any London-wide efforts.
- *Patient and population engagement at scale*. As commissioners and providers, we need to complement the data and information within the health and care system with patient and population voices via the appropriate forums and representative groups. This will add depth and understanding to data outputs and offer input to shape analysis undertaken.
- *Patients and carers able to readily access and enter their own details*, to support public engagement and people's ownership of their care. People are used to this with other services and will increasingly demand this from health and care, it also provides valuable information to inform diagnosis and care<sup>13</sup>.

**Question 12: What do ELHCP partners need to do to build data and analytic capacity within the STP?**

**Question 13: What can be done to support provider understanding of their Service Line Reporting?**

<sup>13</sup> Example: Salford, where partners are working on a new integrated care model with personal health data. <http://www.cbrgovernment.com/healthcare/salford-nhs-trust-improve-services-data-analytics-control-centre/>

## Annex: ELHCP Payment Development Consultation - questions

Below are the thirteen questions asked in this consultation document. This list allows easy access to all questions in a single place and can be copied into another document to help frame your organisation's written response to this consultation. **The deadline for written responses is 18:00 Friday 29 September 2017.** This has been extended from the original deadline of 4 September.

### Consultation questions

1. What are your top five priority areas relating to the payment system to support better outcomes for patients across the system?
2. In your organisation's view, how does the current payment system support and inhibit attainment of system objectives?
3. What does your organisation want out of the payment system?
4. What payment elements do you consider are most important to meet agreed ELHCP objectives?
5. What payment options do you, as partners in ELHCP, want to explore further?
6. Is it best for payment to cover populations based on a person-centred approach or disease/condition specific approach?
7. What geographic footprint is appropriate for payment: CCG level; City and Hackney/Waltham Forest, Newham and Tower Hamlets/Barking and Dagenham, Havering and Redbridge; or across the ELHCP footprint?
8. What services would be included in a new payment approach?
9. What steps are needed to secure this type of buy-in and practical engagement among all ELHCP member organisations?
10. What elements are needed to ensure current provider relationships and partnership arrangements support transformation?
11. What skills, capacity and resources would need to be transferred between acute and primary care to support better collaborative working?
12. What do ELHCP partners need to do to build data and analytic capacity within the STP?
13. What can be done to support provider understanding of their Service Line Reporting?

## Appendix 1: General update September 2017

### Index

1. Background and context (our public narrative) .....	2
2. STP in detail.....	5
2.1 Vision and priorities .....	6
2.2 Governance.....	7
3. Engagement with local authorities.....	9
4. Involving local people and communications/engagement generally .....	9

## **1. Background and context (our public narrative)**

As more and more people choose to live and work in east London, the demand on health and social care services is at an all-time high. Our doctors, nurses, paramedics and other health and care professionals are looking after record numbers of people every day as our population grows faster than in any other part of the country.

Despite immense pressures, local hospitals are continuing to treat A&E patients as fast and effectively as any major western country. Our GP, mental health and community services are among the very best in the country, and local councils are providing vital care to the most vulnerable.

It's thanks to the dedication and hard work of the professionals involved, and the support of many thousands of voluntary carers, community and charity organisations across the area that we are getting the care we need.

But change must be allowed to happen, and things improved, if we are to protect the health and care services we value so much, not just for now but for future generations.

The NHS has constantly adapted and must continue to do so as our community and our health needs also change.

It is now able to treat people with new drugs and clinical care that weren't available in the past. With this comes an increase in life expectancy, but also a rise in the ailments of old age. More people now have conditions including heart disease, arthritis and Type 2 diabetes.

There are big opportunities to improve care by making common-sense changes to how the NHS has historically worked and bring it closer to the social care services run by local councils.

This has a chance to deliver improvements that matter:

- to make it easier to see a GP;
- to speed up cancer diagnosis;
- to offer better support in the community for people with mental health conditions;
- to provide care for people closer to their home.

If we do nothing and carry on providing services in the way we do now, without any changes, we will not only miss out on these improvements, we will fail to keep up with the growing demand and simply won't have enough money to keep services going.

In the east London area alone, there will be a £580m shortfall in funding within four years, by 2021. Services and facilities may have to close and standards of care will suffer if not addressed urgently.

Change is required, and fast, to help keep us healthy and well in the future and to receive care when we need it.

It's why neighbouring NHS hospitals, community and mental health trusts, family doctors, pharmacies, local councils and others have come together to plan for the future and redesign local health and care services to benefit us all – now and in the years ahead.

Working as the East London Health & Care Partnership, and backed by the leaders of all the organisations involved, they are combining their expertise and resources to develop ways of giving our nurses, doctors and care staff the best chance of success to look after us when we need them to.

With a shared goal to help people live healthy and independent lives, the Partnership's mission is to protect vital services and provide better treatment and care built around the needs of local people, safely and conveniently, closer to home.

A top priority is to reduce the pressures on our hospitals and accident and emergency departments. A&E is all too often used as the only door into health and care services, when ideally people should be supported by NHS 111 staff, GPs, community staff and resources in their own homes.

The Partnership also wants better outcomes for cancer patients, people with diagnosed with diabetes and improvements to mental health services, and to help people become independent with access to care at home.

Reshaping services to provide them in the right place, where people need them most and supported by the right team of staff from across health and social care, is a key and urgent requirement.

The response to the demand on services needs to offer better alternatives that help prevent people's health deteriorating. This isn't just to make the most efficient use of the resources and money available, but to provide a better quality of care and services in the community, where local people have told us they want them.

Attempting to improve the hundreds of health and care services for the two million people of east London – a population expected to grow by around 30,000 more people in 2017 alone – is a daunting and complex task, but many of the most beneficial changes can be made quite simply.

Significant improvements are already being made by joining services up and people are starting to feel the benefit. The area now has some of the best care provision and facilities in the country, but there's still much to do.

Although they operate safely, some our hospitals aren't fully equipped to meet the needs of modern healthcare. Waiting times for appointments and treatments must be reduced. And more has to be done to safeguard our most vulnerable people, such as the elderly, disabled and those with mental health difficulties.

### **'Barrier busters'**

The East London Health & Care Partnership isn't afraid to tackle these challenges. It will build on the successes achieved so far and bring health and social care providers even closer together, breaking down any barriers between them as necessary.

The good work already being done to meet more localised needs will continue. The Partnership is not there to undo what works, slash budgets or act secretly behind closed doors. Instead, it will drive forward wider benefits that can only be achieved by everyone working together, coming up with new ideas and better ways of working that can put a stop to duplication and unnecessary expense.

The Partnership's main priorities are:

- To help local people live healthy and independent lives
- To improve local health and care services and outcomes
- To have the right staff in the right place with the right resources to meet the community's needs
- To be a well-run, efficient and open Partnership

The Partnership's *NEL Sustainability and Transformation Plan (STP)* sets out how these priorities, and those of the wider health and care sector, will be turned into reality.

It describes how the Partnership will meet the health and wellbeing needs of east London by improving and maintaining the consistency and quality of care, and plugging the shortfall in funding of services.

The plan proposes improvements across the whole of east London, such as the availability and quality of specialist clinical treatments, how buildings and facilities could best be used, particularly those in need of renewal, and the introduction of digital technology to enhance services for local people.

The involvement of councils enables the vision for better health and care provision to be aligned with the development of housing, employment and education, all of which can have a big influence on people's health and wellbeing.

The Partnership is committed to being transparent and engaging fully with key stakeholders and the wider public in the development of its plans.

But the biggest single factor in the long term is to prevent ill health and the time pressure and financial pressure preventable conditions put on the NHS. This is something we can all play a part in – everyone living and working in east London. It's not just down to the authorities.

Public health information and advice will be strengthened. Information and support to help us live healthier lives will be made more widely available, online and through social media. It's up to us to enjoy life to the full by doing those little things each day that help us stay healthy and fit. We can watch what ourselves and our families eat and drink and all get more active.

Rather than immediately going to the doctor or calling for an ambulance when we don't need to, we can go to the pharmacist and get advice from telephone and online services first.

We can all do our bit and if we do this, and get behind the work of the East London Health & Care Partnership, the prize is being able to lead healthy and independent lives, and get the care we can trust and rely on when we need it

## **2. The STP in detail**

The *NEL Sustainability and Transformation Plan (STP)* sets out how local health and care services will transform and become sustainable over the next five years, building and strengthening local relationships and ultimately delivering the vision of the NHS Five Year Forward View.



Forty four such plans have been developed throughout England. They are geographically set around 'footprints' that have been locally defined, based on natural communities, existing working relationships, patient flows and taking into account the scale needed to deliver the services, transformation and public health programmes required.

Twenty organisations across eight local authorities have worked together to develop the local STP. They are:

#### **NHS**

CCGs: Barking & Dagenham; City & Hackney; Havering; Newham; Redbridge; Tower Hamlets; Waltham Forest

'Provider' Trusts: Barking, Havering and Redbridge University Hospitals Trust; Barts Health NHS Trust; The Homerton University Hospital NHS Foundation Trust; East London NHS Foundation Trust; North East London NHS Foundation Trust

#### **Councils**

Barking & Dagenham; City of London Corporation; Hackney; Havering; Newham; Redbridge; Tower Hamlets; Waltham Forest

The STP has been defined as one for north east London (NEL) by NHS England, because it has divided the capital into five 'footprints': north east; north west; south east; south west; and north central.

Originally drawn up in June 2016, and then redrafted following engagement with key stakeholders, the STP was submitted to NHS England and NHS Improvement on 21 October 2016.

The plan is currently only a 'draft'. It will continue to evolve as the organisations concerned develop it further, agree shared solutions, and as we receive feedback from stakeholders.

The STP describes how the organisations involved in the partnership will:

- Meet the health and wellbeing needs of its population
- Improve and maintain the consistency and quality of care for our population
- Close the financial gap.

All of the organisations involved in the STP face common challenges, including a growing population, a rapid increase in demand for services and scarce resources. By working together they will be best placed to drive change and make sure health and care services in north east London are sustainable by 2021.

The STP builds on existing local transformation programmes and supports their implementation including:

- Barking and Dagenham, Havering & Redbridge (BHR)
- City and Hackney
- Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme

- The improvement programmes of our local hospitals, which include supporting Barts Health NHS Trust out of special measures.
- Vanguard projects eg Tower Hamlets Together

The organisations behind the STP are actively seeking to collaborate where it makes sense to do so, sharing learning from the devolution pilots and transformation programmes.

## 2.1 STP vision and priorities

The vision of the NEL STP is to:

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

To achieve this vision, we have identified a number of key transformation priorities:

- The right services in the right place: Matching demand with appropriate capacity in east London
- 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 place-based care and clearly involves key partner agencies
- Using our infrastructure better

These priorities have now been categorised under four headings:

- Healthy and independent local people
- Improving services
- Right staff, right place, right tools
- A well-run partnership

More information on this is given in Appendix 2

To deliver the STP we are building on existing local programmes and setting up eight work streams to deliver the priorities.

The work streams are cross-cutting east London-wide programmes, where there are benefits and economies of scale in consolidating a number of system level changes into a single programme.

The work streams are:

- Promote prevention and personal and psychological wellbeing in all we do

- Promote independence and enable access to care close to home
- Ensure accessible quality acute services
- Productivity
- Infrastructure
- Specialised commissioning
- Workforce
- Digital enablement

Each delivery plan sets out the milestones and timeframes for implementation.

The full STP, and eight delivery plans, can be found on our website [www.eastlondonhcp.nhs.uk](http://www.eastlondonhcp.nhs.uk)

The delivery plans are currently being refreshed. Updated versions are due to published in the autumn.

A summary of what the Partnership is planning to do across services, such as urgent and emergency care, primary care and mental health, and what it means for local people, is given in Appendix 3.

## **2.2 Partnership governance**

The launch of the Sustainability and Transformation Plan (STP) process signalled the move towards working in larger geographical areas and the need to develop governance arrangements to support strategy development and change at a system level. To achieve this, 20 organisations in East London have been working together to develop the East London Health and Care Partnership (ELHCP).

The Partnership governance structure is attached as Appendix 4.

Progress has been made in bringing the governance groups together.

- ELHCP Community Group – A group of local people, voluntary sector, and other key stakeholders to promote system wide engagement and assurance.

A wide range of organisations and people (around 300 in total) from across east London have been invited to co-create the group.

An initial meeting was held on 4 July and attended by nearly 100 people and work to develop the group is ongoing. More information is given in section 4 on page 10 below.

- ELHCP Mayors and Leaders Advisory Group - To provide a forum for political engagement and advice to the ELHCP STP

Cabinet members (health) from the eight east London councils have held three meetings to date to discuss how this Group could develop. See section 3 on page 9 below.

- ELHCP Social Care & Public Health Group – Directors of Children’s and Adult Services and Directors of Public Health

The directors of adult services are setting up a working group to look at the current and future challenges relating to the social care workforce across east London, including recruitment and key worker accommodation

- ELHCP Assurance Group – An independent group of audit chairs and local authority scrutiny members to provide assurance and scrutiny

This Group is due to hold its first meeting soon. Borough scrutiny committees are being invited to nominate members to join the Group.

- ELHCP Finance Strategy Group -To provide oversight and assurance of the consolidated east London financial strategy and plans to ensure financial sustainability of the system.

This group is now meeting regularly. It includes council and NHS chief finance officers among its members.

The arrangements are underpinned by a Partnership Agreement (see Appendix 4) which, while not legally binding, intends to ensure a common understanding and commitment between the partner organisations of:

- The scope and objectives of the ELHCP STP governance arrangements
- The principles and processes that would underpin the ELHCP STP governance arrangements
- The governance framework / structure that would support the development and implementation of the ELHCP STP

The Partnership Agreement has now been circulated to the member organisations of the ELHCP for signature.

### **3. Engagement with Local Authorities**

The ELHCP is engaging widely with stakeholders to shape its governance arrangements. Engagement with local authorities has been paramount and is being achieved through various forums.

There are now three local authority representatives on the Partnership board:

- Tim Shields, LB Hackney (for City and Hackney)
- Kim Bromley-Derry, LB Newham (for Newham, Tower Hamlets and Waltham Forest)
- Andrew Blake-Herbert, LB Havering (for Barking & Dagenham, Havering and Redbridge)

Cabinet members (health) from the eight east London councils have held three meetings to date to discuss how the Mayors and Leaders Advisory Group could develop.

At the most recent meeting, on 23 June, the cabinet members expressed a strong desire to be more involved in the work of the Partnership, and the shaping of ideas, especially in the development of proposals around accountable care systems and a single accountable officer role. A similar request for more involvement has come from the various Health & Wellbeing boards and some scrutiny committees.

The Partnership chair, Rob Whiteman, and exec lead, Jane Milligan, are now exploring ways of doing this. This includes having political representation on the Partnership board and in the development of transformation programmes.

The cabinet members have also been asked to nominate fellow members to join the Community Group (referred to in 2.2 on page 7 above).

Scrutiny members are being asked to join the Assurance Group. The INEL and ONEL JHOSCs have been invited to nominate members from each to join this Group, but this may end up happening on an individual borough basis.

The Partnership is also actively encouraging local authority officers to be involved in the transformation work streams listed on page 7 above.

### **4. Involving local people and communications/engagement generally**

STPs have been widely criticised for being put together too hastily with little consultation.

The timescale set by NHS England to produce the initial plans was tight. As a consequence, there was only a limited time for engagement. Some key stakeholders felt disengaged from the process, as did patient representatives. Also, much of the detail behind the plans was initially kept under wraps giving rise to accusations of secrecy and the STPs being seen as no more than 'hit lists' and cuts to services.

NHS England acknowledges this criticism, but it caused significant reputational damage to what is a genuine and necessary attempt to deal with very real challenges.

The immediate priority of our communications and engagement strategy has therefore been to repair that damage.

Most, if not all, of our key stakeholders recognise and understand the challenge. We want to rebuild their trust and confidence and engage with them in a more positive way so they are involved in developing shared solutions.

A starting point has been to talk about a partnership rather than a plan. It is why we changed our name to the East London Health & Care Partnership.

The STP itself is still being referred to as such, but it is just one of many things the organisations involved can do together to protect and improve health and care services for the people of east London. Our plans to explore the link between health and housing, starting with a conference on 18 October, is one example

It was also felt east London was a more appropriate and familiar way of describing the area as a whole rather than north east London – the name used by the health service to denote the area.

Next is to communicate in an open and honest way; unravel the jargon, speak in plain and simple language and be accessible and transparent. Most importantly, we must listen to what people have to say.

Relevance is also important. Our communications will reflect a knowledge and understanding of the many different audiences we want to reach and be targeted to suit each group. What does it all mean for them? How are their interests being taken into account? What part can they play?

Local relevance and insight is particularly important. We will work closely with our communications and engagement colleagues in the partner organisations at borough level to make full use of their knowledge and networks.

An online Briefing Room has been set up as a central source of information and materials for members of the Partnership to adapt and use in local communications and engagement activities. This includes narratives around the STP (what it is and what it isn't); the various transformation plans and programmes (as they emerge); facts and figures; presentations (tailored for specific audience); information videos; and case studies.

At the heart of our stakeholder engagement will be the Community Group – a subgroup of the East London Health and Care Partnership.

Part of the Partnership's governance structure, the Community Group's principal purpose is to act as a reference group to support the development of the Partnership's strategies, plans and activities and recommend the most effective ways for it to communicate and engage with its many different audiences.

Nearly 100 representatives from the voluntary, business, education, health and care sectors attended an event on 4 July for stakeholders and partners that could form our Community Group.

It is in effect a 'group of groups', made up of a range of people from professional organisations, the education and business sector to voluntary organisations, local councillors, Healthwatch and other patient and public groups.

How such a wide and diverse group comes together and gets involved, and how the Community Group develops, is still 'work-in-progress'. A working group of some of those that attended the event on 4 July is helping plan the next steps.

In the meantime, some of the organisations and public and patient representatives are being invited to take part in the Partnership's activities, such as improvements to the signposting of services.

A determined effort is also being made to involve young people in the Community Group. This is currently being progressed through local councils, NHS organisations, colleges and universities.

Another key audience is, of course, frontline staff – not just those in the NHS, but in councils too. Their buy-in is key and we have started engaging with them to create understanding about what the Partnership, and the STP, means to them.

We very much want staff to be involved in shaping services and our internal communications will reflect this. They will recognise the contribution everyone has to make, encouraging and valuing people's achievements, opinions and ideas.

If we are to give staff the effective help and support they need it's vital we listen to what they have to say, and demonstrate what we do as a result.

While staff and the other key stakeholders in the Community Group are taking precedence in the immediate future, we eventually want to reach out and engage with as many people as possible, including the wider public.

The Partnership's website has been rebuilt, with an improved design. ([www.eastlondonhcp@nhs.uk](http://www.eastlondonhcp@nhs.uk))

An easy guide to what the Partnership plans to do and what it means for local people is to be published on the website in early August. Printed copies will be made available for people that don't have access to the internet, with extracts placed in local publications.

Social media and YouTube will also be used to raise awareness of the challenges to health and care in east London, promote service improvements and run prevention campaigns.

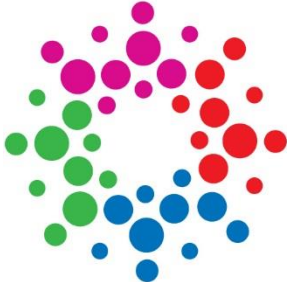
The Partnership is also planning to hold a series of public engagement events across east London during the autumn and winter.

Designed in collaboration with local councils and NHS organisations, with at least one major event in each borough, the events will be used to create awareness and understanding of what the Partnership is doing and what it means for local people. The larger events will feature a 'Question Time' session, and current and planned improvements to services will be showcased in a mini expo.

The Partnership communications and engagement team are working closely with their 300 plus colleagues in the member organisations to create shared opportunities to increase audience reach and give consistent messaging. They are also forging links with wider comms networks across London, including those in other boroughs, the Met Police, London Fire Brigade, TfL, professional organisations, eg Royal College of Nursing, and national charities. The Partnership's comms and engagement is seen as leading in the STP field.

This page is intentionally left blank





# Transformation Priorities

# Four big issues and four Priorities

1

Poor health, growing population & more demand

2

Variable access and quality of services

3

Lack of workforce, poor technology and buildings

4

Unaffordable health & social care system

Healthy & independent local people

- Preventing ill health and loss of independence
  - Tackling inequalities
- Good mental well-being

Improving services

- More services out of hospital and integrated in primary, mental, social & community care
- Improved priority services: maternity, mental health, cancer, urgent & emergency care
- Strong hospital & specialist services

Right team, right place, right resources

- Healthy work places
  - Skills & career development, recruitment & retention
  - Housing for key workers
- Digital & online services  
Better buildings

Well run partnership

- Partnerships
- Productivity – value for money
- Better organised - new organisations bringing together providers & commissioners
- Living within our means

# Our story

The transformation agenda for health and social care across East London is significant and exciting. We are challenging ourselves to be clear that more of the same isn't enough, or will provide fit for purpose health and care going forward. These are the four big challenges the ELHCP want to tackle:

## 1. Healthy and independent local people

- We have one of the largest and fastest **population** growth rates in the country - 18% over the next five to ten years
- This is both growth of a younger population and also the older population
- East London also has a transient population and areas of intense **health inequalities** and deprivation
- People want their **whole health and social care needs** considered as one and we too often treat and manage people in parts, in particular not making sure that people's mental as well as physical health are treated equally. We have also traditionally focused more on resourcing physical health needs than mental and well-being needs.

## 2. Improving services

- **Resources** (capacity) are not necessarily in the right part of the system, often still tied up in acute hospitals rather than in the **community**, where people tell us they want them.
- Access is too often through A&E, at a point of crisis. The front door to the system should be people's own front doors with care provided by multi-disciplinary teams across health and social care, supported by the voluntary sector and our strong local communities.
- The problem with accessing care in a crisis through A&E means our solutions tend to be too much about providing care around a few hundred hospital beds, rather than care around the one and half million beds in people's own homes.
- This support should be centred in the home, and using digital technology and more self-care support to prevent crisis and maintain independence.
- It's not only about demand and capacity not lining up, the **quality** of some of our services and the outcomes people get are variable –and we want the best standard for everyone across East London
- Access to primary care is **variable** and the Care Quality Commission has highlighted services, **quality** and **outcomes** across our providers that need to improve
- Some services are not as **resilient** as they could be, for example primary care and urgent and emergency care services
- We have a long history of innovation through working with patients and clinicians to co-design individual components of care, but this hasn't been easy to spread more widely.

# Our story

## 3. Right team, right place, right resources

- We have the opportunity to innovate training, roles and ways of working. It's about the right care, at the right time, in the right place and most importantly – the right team.
- Community-based working often gives more autonomy to staff and releases them to innovate and provide whole person care- and this is important, as not only is capacity not always in the right part of the system, but we need new types of roles, development opportunities and ways of working as finding and keeping the **workforce** these days is challenging, especially with the cost of living and housing in London.
- We also have serious challenges our estates and technology. We have some of the best buildings, but also others that are not fit for purpose, such as Whipps Cross Hospital. We also have estate with old hospital buildings that could be re-purposed used for new integrated health and social care facilities, creating health campuses
- People live their lives on their smart phones now and there is an urgent need for health and social care services to become more **digital friendly**

## 4. Well run partnership

- Ultimately all our challenges above mean that the **financial** as well as service and quality sustainability of our health and care system is impacted. There is scope to be more productive and if we do not seize the opportunity our financial challenges and sustainability will continue and service stability will be affected.
- In recent years the system has become **fragmented**: causing duplication, not always working to the best advantage for the patient or local people and putting artificial barriers between professionals and organisations across health and local government services. We need to make sure we are organised well and working in partnership.
- Individual institutions will not address the financial or quality goals we have, and in order to get the best of our collective resources we need to transform how we work together using a **partnership** approach, rather than working with an individual organisation focus.

## What are we doing?

- Providing better information to the public on where to get the most appropriate healthcare.
- Launching a new, improved NHS 111 Integrated Urgent Care (111 and Clinical Advice Service) and working towards improved links with other health services eg Mental Health, GPs, Pharmacists, Urgent Treatment Centres, ambulance services and community health professionals.
- Improving access to weekend and evening GP appointments as well as introducing the chance to be seen not just in person, but on the phone or online.
- Creating Local HealthCare Hubs bringing community nurses, GPs, mental health staff and other NHS specialists under one roof in community settings.
- Creating consistent Urgent Treatment Centres, so people understand what treatment can be given there
- Creating special areas in the hospital for specific emergency conditions so that people do not need to stay overnight in a hospital bed when there is no medical need for this.

## What does it mean local people?

- You will be able to understand the range of local healthcare services available and how to access them.
- By calling or contacting NHS 111 Integrated Urgent Care (111 and Clinical Advice Service) you will be able to access the most appropriate clinical advice on where your health needs will best be treated as close to your home as possible.
- You will be able to book GP appointments more easily and these will be also be available in person during evenings and the weekends as well as over the phone and online. You will be able to be seen by a range of healthcare professionals in your community in new Local HealthCare Hubs more quickly.
- Wherever you live in east London, you will be able to be seen at our Urgent Treatment Centres for the treatment of minor injuries, including broken bones and minor burns.
- You are likely to be satisfied with your experience as a patient because we will be reducing the time you need to spend in hospital.

## What are we doing?

- Improving access to weekend and evening GP appointments as well as introducing the chance to be seen not just in person, but on the phone or online.
- Creating Local HealthCare Hubs bringing community nurses, GPs, mental health staff and other NHS specialists under one roof in community settings.

### Quality improvement

- Helping practices improve the experience of their patients
- Helping practices improve services for people with long term conditions
- Helping practices become a better place to work and remove administrative headaches
- Training staff in proven improvement techniques
- Sharing solutions that work across east London
- Established an east London Primary Care Partnership for Quality improvement Board which will enable acceleration of quality improvement approaches, learning and case studies across the whole area.

### Provider development

- Helping GP federations develop to improve care, reduce overheads and give primary care a stronger future
- We are bringing GP federations and networks together to share learning and experience, and solve common challenges - we have recently set up an east London Primary Care Provider Forum.
- Establishing a range of online resources that GP federations and practices can use to take forwards quality improvement

### Workforce development

- Working out what mix and number of staff will be needed going forwards and how to find and train them
- Working together to retain current staff for longer, making east London an attractive place to work for new recruits

## What does it mean local people?

- More time with GPs to avoid rushed appointments and increased accurate diagnosis.
- Patients being able to book appointments quickly, within a reasonable timeframe and a pre-booked one if they wish.
- Patients being able to see a preferred clinician if they wish to wait longer for an appointment.
- Patient access to reliable information about the practice so that they can make their own decisions
- Patients not only being able to book appointments via telephone but by other means, such as through the internet website, emails, digital TV or by text.
- Increased access to a range of health professionals to provide care best suited to individual needs
- Better support and information to enable the public to take better control of their own health.
- A service that treats patients as people not numbers.



### **What are we doing?**

- Enabling GP appointments to be booked online.
- Allowing people to view their own health and care records.
- Putting more services, such as some GP consultations and mental health services, online.
- Improving information systems and sharing records to allow health and care professionals to work closer together.

### **What does it mean local people?**

- You will be able access health and care services more quickly and easily.
- You will be able to book GP appointments or talk to your GP online.
- Doctors and other care professionals will be better placed, with the right information, to help prevent illness and give you better care, should you need it.
- You will be able to get care closer to home, or in your home.
- You will have better information on how to stay healthy and well.

## What are we doing?

- Working with partners to address the wider determinants of mental health eg access to accommodation, education and employment.
- Supporting the roll out of digital self-management tools such as the London Digital Mental Wellbeing Service ([www.digitalwellbeing.london](http://www.digitalwellbeing.london)).
- Developing an east London-wide suicide prevention strategy.
- Supporting employers to improve staff mental health and emotional wellbeing via programmes such as Mental Health First Aid.
- Developing our talking therapies services so they are more appointments with reduced waiting times.
- Integrating mental health services into GP surgeries, A&E and General Hospitals.
- Developing perinatal mental health services for expectant mums and mums of new babies.
- Improving services for people experiencing a crisis by ensuring everyone in crisis can access mental crisis support 24/7.
- Delivering mental health treatment at home.
- Delivering specialist mental health services for children and young people closer to home.
- Developing a new Child and Adolescent Mental Health Psychiatric Intensive Care Unit here in East London.

## What does it mean local people?

- Improved access to and shorter waiting times for psychological therapies.
- A wider range of mental health services to be accessible via your GP
- Your mental and physical health and social care needs treated as one, wherever and whenever necessary.
- Enhanced support to access the right education, employment and accommodation opportunities for people with mental health issues.
- People in east London will have access to the same range of mental health services wherever they live.



## **What are we doing?**

- Ensuring that we are seeing all patients who need an urgent appointment within 2 weeks.
- Making sure that patients are receiving their tests and diagnostics on time to enhance early diagnosis and treatment and improve cancer survival.
- Educating GPs and other professionals to improve better communication with hospital consultants.
- Encouraging patients in east London to take up their screening.
- Improving IT and administrative processes to make sure the cancer referral pathway is effective and patients' care is integrated.
- Listening to patients and carers to ensure that we keep improving their care with all our partners.
- Working with Public Health services to improve prevention and lifestyle choices.

## **What does it mean local people?**

- If you are referred urgently by your GP or another health care professional you will get seen within two weeks.
- If you have a cancer diagnosis, you will receive treatment quickly in order to improve your chances of survival.
- A number of health and social care professionals will be involved in your care to ensure your care is integrated.
- Your experience of care will be positive because we are listening and making improvements.
- If you take up screening when you get an appointment, you are likely to receive early detection and treatment.
- If we in east London improve our lifestyle choices, fewer of us will develop cancer.

## **What are we doing?**

- Working with and listening to local women in East London to understand their needs and design care based on those needs.
- Working to ensure that unbiased information regarding choice of place of birth is available for women.
- Ensuring the workforce is sustainable in the next 5 - 10 years to cope with the level of births in East London.
- Ensuring safe and high quality care for all mothers and babies.
- Working together to ensure each woman receives continuity of care with the same staff members throughout her pregnancy and birth

## **What does it mean local people?**

- You will be able to see one or two midwives throughout your pregnancy to ensure continuity of care.
- If you have a long-term condition such as diabetes, or you are having twins or other multiples, you will be seen by your midwife and obstetrician regularly and may be referred to a specialist
- You will be able to use a website or app to give you more information about the places available to you to give birth in East London.
- The plan for care during your pregnancy will be developed and agreed between you and your midwife or obstetrician.
- Your overall experience of care during and after your pregnancy will be positive and of high quality.

## What are we doing?

- Following national recommendations from NHS England we will review the prescribing of certain medicines, where there is either limited evidence for their effectiveness or for which there are safer alternatives. This will ultimately save money for NHS reinvestment.
- Buying specific medicines (biosimilars such as anti-inflammatory medicines infliximab and etanercept) from alternative better value suppliers, which saves money for re-investment.
- Reducing medicines waste may involve the empowerment of patients, encouraging them to take charge of their overall health. This could lead to better outcomes e.g. medication reviews with pharmacists that identify medications that are no longer needed.
- Decreasing antibiotics resistance by reducing the amount and type prescribed and educating patients and prescribers on the importance of completing courses of anti-biotics in the instances where they are necessary.
- A review of the pharmacy workforce; analysing the benefits of increasing the presence of clinical pharmacists within GP practices and/ or clinics in order to help ensure the right medicines, at the right time for the right patients.

## What does it mean local people?

- You will be able to get professional medical advice for all minor ailments in all pharmacies, including out of hours pharmacies.
- Pharmacists will also give you consistent advice on the nature of medicines available to buy over the counter and available on prescription and point you in the correct direction for your symptoms.
- You will not be prescribed anti-biotics unless they are essential.
- You will be less likely to be kept in hospital waiting for medicines to be prescribed.
- The cost of prescribing medicines to you as a tax-payer will be less, meaning funds can be allocated to other parts of the health and care service.

## **What are we doing?**

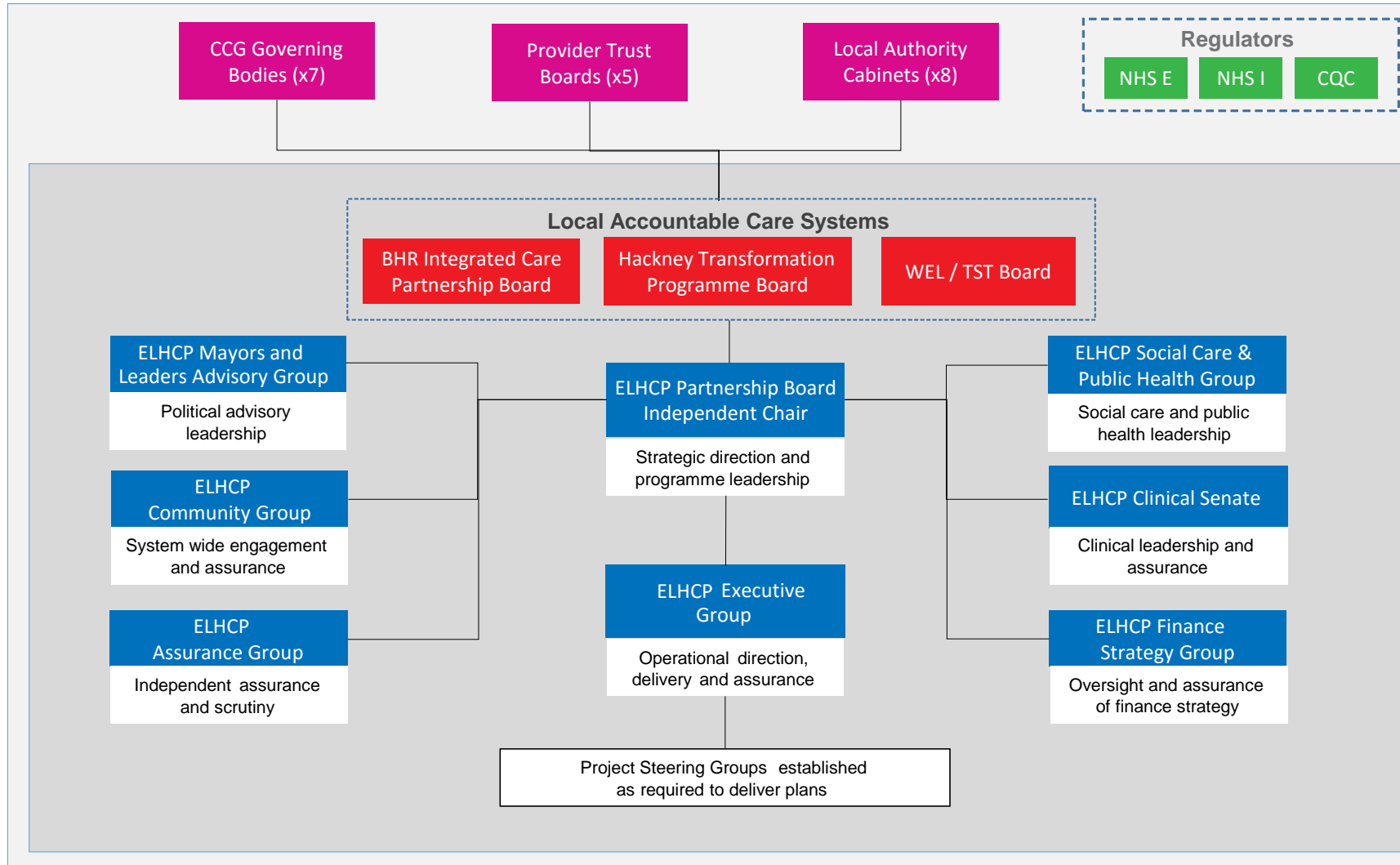
- Building better support into our hospitals, mental and community health services to help smokers quit.
- Improving workplace health across east London, starting with the NHS. Because happier, healthier NHS staff means better healthcare for patients.
- Improving screening processes to better identify those at risk of contracting Type 2 diabetes, and offering courses to help those people change their lifestyles.
- Standardising care for people with Type 1 and Type 2 diabetes in GP surgeries and hospitals across east London.
- Empowering people, through flexible self-care course, to better look after their diabetes and avoid unnecessary hospital trips.
- Working with local schools, education institutions, local employers, libraries and voluntary services, to provide better support for young people with diabetes, taking into account their social and economic context.

## **What does it mean local people?**

- Better support to quit smoking, with help and advice available at many health and care centres, workplaces and online.
- Better screening, treatment and support for diabetes.
- New services to help young people, and pregnant women, manage diabetes better.
- Better opportunities and more support to stay healthy at work.
- Greater consistency of healthcare opportunities and support across east London.



Governance structure



This page is intentionally left blank

# Barking and Dagenham Safeguarding Children Board

## Annual Report 2016/17



## Table of Contents

1. Chair's Introductions
2. Executive Summary
3. Key Facts: Barking and Dagenham
4. Safeguarding Snapshot
5. LSCB Core Business
6. Engagement with Children
7. Serious Case Reviews
8. Child Death Overview Panel
9. Allegations Against Professionals
10. Performance Management
11. 2016/17 Priorities Revisited
12. Direction of Travel
13. Priorities for 2017/18



## 1. Chair's Introduction

I have been the Independent Chair of London Borough Barking and Dagenham LSCB since September 2011. This is a statutory post as set out in the Children Act 2004 section 18.



My job is to hold agencies to account for the effective coordination of the commissioning and provision of services for children to ensure that children are safeguarded and the welfare of children in the area is promoted. I provide independent challenge so each Board agency partner and their representatives are held to account.

My strategic role is to hold partners to account for the safeguarding arrangements for children in Barking and Dagenham, the priorities of which are set out the LBB D LSCB business plan. To achieve this, I have quarterly Governance meetings with the Leader of the Council, the Lead member for Children, the Chief Executive of LBB D and the Strategic Director of People. I also have one to one meetings with the Strategic Lead officers for the statutory partner organisations on a regular basis.

These meetings are effective in influencing the LSCB agendas for successful delivery of the LSCB business plan. Meetings are well attended by partners and the Lead member for Children attends

the LSCB as a participant observer so that she is informed and can provide effective challenge to the Council officers.

My evaluation of the LSCB business plan is that partners have made good progress against the priorities, though there is further work to do on understanding performance data across the partnership and the arrangements to embed the voice of the child into LSCB business and the work of the sub-groups must be more robust to ensure that their voice makes a meaningful difference.

Partners have also made good progress against other significant areas of practice including reducing the numbers of children taken into police protection.

However, there is still too much variation in practice as evidenced through LSCB multiagency audit.

At the same time, the LSCB has been proactive in responding to emerging issues including the CQC inspections at North East London Foundation Trust and Barking, Havering, and Redbridge University Trust. There are also structural and associated operational changes in the Metropolitan Police as they move to a three Basic Command Unit which is being piloted across Barking and Dagenham, Havering, and Redbridge. The LSCB partners are working closely with the police to understand and support changes to ensure children are safeguarded

Partners give vulnerable children and their families the highest priority.

I am also the Independent chair of the Barking and Dagenham Safeguarding Adults Board, a statutory position under the Care Act 2014. I use my knowledge from both Boards to make links and find solutions for children and families including hoarding.

The LSCB is a multiagency partnership and is much more than the sum of its parts. Managers and front-line practitioners across the partnership all work extremely hard under significant resource pressures with some of the most vulnerable children in Barking and Dagenham. LSCB partners have demonstrated they give the highest priority to safeguarding children demonstrated through their commitment and attendance at LSCB meetings, engagement in multiagency audit of practice, serious case reviews and LSCB multiagency training.

However, challenges emerging from case file audit including partners response to Domestic Abuse and Sexual Violence and children experiencing Neglect are priorities for the coming year.

After 6 years it is time for me to step aside and in agreement with partners I will be stepping down from my role in July 2017.



**Sarah Baker | Independent Chair: Barking and Dagenham  
Safeguarding Children Board**

## 2. Executive Summary

### Purpose of the Annual Report

The report sets out the effectiveness of the Local Safeguarding Children Board (LSCB) in carrying out its core business under its statutory objectives, the effectiveness of multi-agency practice to safeguard and promote the welfare of children and young people and the progress made against the LSCB priorities of:

1. Board members are assured that arrangements are in place to identify and safeguard groups of children who are 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.

### Achievements

- Delivery of a comprehensive training programme that saw over **1500 participants**.
- The sub-groups drove forward work on progressing LSCB **priorities**
- The arrangements supporting the **Child Death Overview Panel** continue to manage and review all child deaths
- There are good systems in place for the **Serious Case Review** sub-group who are co-ordinating one SCR and one PLR.
- Several new initiatives planned in the next year. These include implementation of the **Pause Practice** for work with women who have had children removed to prevent repeat removals; **Caring Dads** group-work supporting fathers who are a source of safeguarding concerns to focus more on the needs of their children; and **Mockingbird** which is a project aimed at supporting foster carers and improving placement stability for looked after children
- A new electronic records system – **Liquid Logic** – has been commissioned for Children’s Care and Support and the plan is for implementation during the 2017-18 period. This will

provide a significant improvement as a working tool for social workers in their casework and for managers in overseeing this work.

## Challenges

- The arrangements to embed the **voice of the child** into LSCB business and the work of the sub-groups must be more robust and ensure that their voice makes a meaningful difference
- The engagement amongst **LSCB members** varies in terms of support in leading or chairing groups
- Whilst there are links with other **key strategic boards** in Barking & Dagenham there is a need for further development to ensure **clarity** regarding key responsibilities, identifying areas of joint work, and linking agendas
- Limited reporting on **performance data** across all partners on key safeguarding areas to the Board or Chairs Group.

## Priorities for 2017/2018

Barking & Dagenham LSCB must ensure it provides assurance that safeguarding arrangements are effective. These are some of the priorities identified with further detail toward the end of the report:

- **Reviewing** the current structure to ensure it is fit for purpose and meets the requirements of the Children & Social Work Act.

- **Reviewing** the LSCB budget and **agency contributions** against LSCB requirements
- **Reviewing** protocols with strategic boards to clarify responsibilities and **strengthen** joint working
- Establishing a **performance data set** and dashboard to develop a partnership understanding and provide the LSCB with **assurance** of safeguarding arrangements.
- **Understand** the reason children and young people are **missing** and the risks they face through the Return Interviews.
- **Re-fresh** the multi-agency CSE Operational strategy and action plan and **update** the CSE Problem Profile
- **Develop** an understanding of the relationships between **public health** concerns such as domestic abuse; sexual health; neglect and poverty and the health and wellbeing of children and young people.
- **Recognition** and **response** to **Neglect**: Recognising the signs of neglect, knowing the effects of neglect on vulnerable children and young people and understanding the role that we can play, to prevent neglect and support those experiencing it.
- **Assist** frontline practitioners and CP IRO's **reflect** on the causes and broad categories of **emotional abuse and neglect** - the two main categories used for Child Protection Plans.

### 3. Key Facts: Barking and Dagenham

Barking & Dagenham is in the East of London and has a projected population for 2017 of 209,149, of which 63,270 are under 18. 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.

The child population in Barking & Dagenham is estimated to be increasing by around 2-3% each year and at 30% of the population is above the London average of 22%. There has been a 14% increase in the 0-17 population since 2011 compared to the London average (7%).

It is predicted that this will increase by 11% over the next five years compared to the London average (6%). This increase continues to present rising demands for all services across the borough.

The ethnic breakdown of under 18's is projected to be: 27% White British and 9.5% White Other - predominantly Eastern European groups, with 63.4% from Black and Minority Ethnic (BME) backgrounds.

The BME figure can be further broken down to: 23.3% Black African, as 2.2% Black Caribbean, 4% as Black Other, 7.1% as Bangladeshi, 6.6% as Pakistani, 4.5% as Indian, 0.7% Arab, 0.4% as Chinese and 3.6% as Other Asian. A further 9.5% of 0-7 year olds were from a mixed ethnicity while 1.6% were from another ethnic group not shown above.

Barking & Dagenham has 44 primary schools, 10 secondary schools, 2 special schools and 1 pupil referral unit. 5.7% of Barking & Dagenham's 16 to 18-year-old cohort were not in Education, Employment, or Training (NEET), compared to London (3.4%) and England (4.7%) averages.

At least 174 languages are spoken in Barking and Dagenham. Within the school population, 38 of these languages have been identified as being spoken by individual children (source: DfE School Census Spring 2016). The percentage of pupils with an Education Health Care Plan / Statement is **2.3%**. (Source: DfE School Census Spring **2017**).

GLA projections on the gender of the Borough's residents for 2016 indicates that **51.5%** of under 18-year olds are male, whilst **48.5%** are female compared to the general population, where **49%** are male with **51%** being female.

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 and impacts on all service areas across the borough. It accounts for 46.2% of violence with injury offences in the borough (JSNA, 2016) and was a presenting factor for 15.8% of children's social care contacts in 2016/17.

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. Most 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 or anti-social behaviour.

Changing market dynamics, the lack of local affordable private rented housing and the progressive erosion of the purchasing power of those on benefits is expected to increase the number of

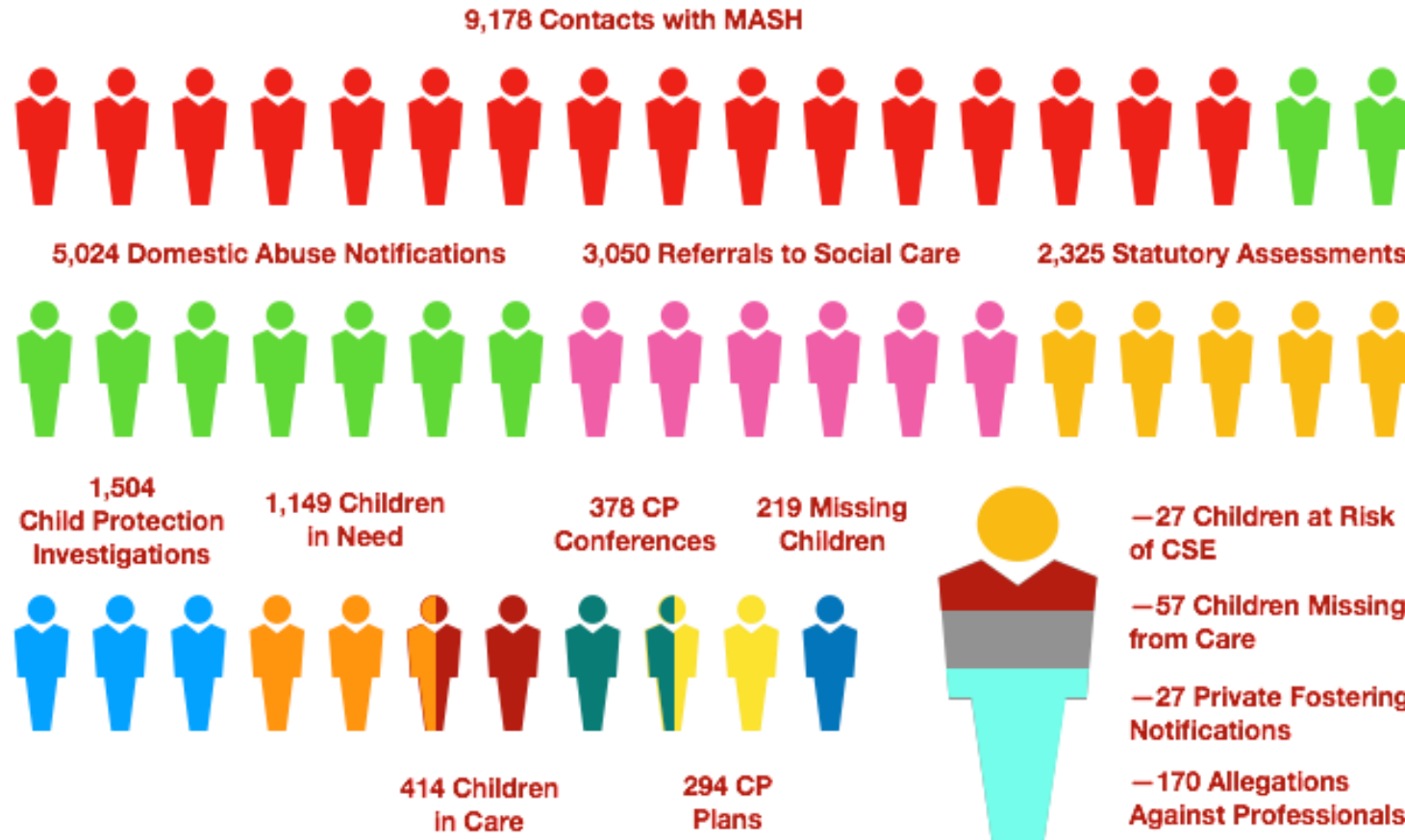
households needing assistance, with the number of households presenting as homeless expected to double by 2020.

Against a background of a projected increase in demand, there is a need to address the underlying causes of homelessness and to find ways to prevent households from becoming homeless in the first place.

There are some actions proposed for the coming year to help to reduce homelessness, these include:

- Early intervention
- Adopting a holistic, multi-agency approach
- Mediation in parental ejection cases
- Employment, debt management and benefits advice
- Working more closely with private landlords

## 4. Safeguarding 'Snapshot' 2016/17



2,024 Social Care Cases

18% of Children Receive Free School Meals

## 5. LSCB Core Business

### Policies, Procedures, and Guidance

Barking & Dagenham LSCB is part of the London Safeguarding Board and as such follows the Pan London Child Protection Procedures.

Locally, the LSCB has published an Early Help Strategy and revised and re-launched a Threshold document which is available on the website.

In response to a recommendation in the Serious Case Review (SCR) for Child B, the LSCB has re-circulated the “Arrangements for Escalation – Challenge and Resolution”. During the year the referral pathway for Child Sexual Exploitation has also been revised.

### Communication & Awareness

The LSCB has a responsibility to undertake communication & awareness raising activity for safeguarding.

The LSCB undertook a range of activity in 2016/17 targeting professionals, the community, children, and young people using a variety of methods to engage the various audiences.

- Practitioner Forum – regular meetings for practitioners across the partnership to raise awareness of the work of the Board, to focus upon various topics of interest and to encourage networking.

- Newsletters are circulated to partner agencies and put on the website

### Learning and Improvement Framework (Training)

The LSCB is required under Chapter 4 of Working Together 2015 to have a Learning and Improvement Framework in place that outlines how the board supports and embeds a culture of learning to drive quality and improve outcomes for children and young people.

The LSCB Training Strategy and Training Plan is underpinned by a model of continuous development and seeks to develop the core competencies of the children and family’s workforce.

The training programme is reviewed and developed each year based on:

- evaluation of the previous year’s training
- research and best practice
- learning from case audits
- learning from serious case reviews (national and local)
- consultation and needs analysis across agencies
- LSCB and national priorities and requirements.

During 2016/17, the LSCB ran an extensive multi-agency training programme offering **63** different courses to **1560** people across statutory and voluntary sectors which reached a range of professionals.



The LSCB also has a range of training methods available offering e-learning, face to face training and bespoke packages.

The LSCB pays for 'Gold' membership of the NWG (National Working Group) which provides online information on CSE, membership of the Association of Independent Chairs which provides up to date information via the Business Manager and the council has recently joined Research in Practice.

Evaluation of training demonstrates that the LSCB plan and quality of training is highly regarded and positively impacts on practice.

Overall **1540** people attended courses throughout 16/17 period and **764** responded to an evaluation survey. That works out to a **49.61%** response rate (**50%** if rounded up) overall.

The work on **Faith & Culture** has had a positive effect on safeguarding children and changing working practices for practitioners by providing training that helps workers understand the links to broader cultural concerns and other harmful practices linked to faith and belief. Multi-agency events have been arranged across the year, tying in with national campaigns to increase safeguarding awareness amongst the community and faith-based organisations that protect children from faith and culture abuse. High profile speakers have attended such as Karma Nirvana founder Jasvinder Sanghera CBE and Sarbjit Athwal, founder of True Honour. Both presenting on forced marriage / honour-based violence.

Strong links have been built with **schools, children's centres** and **early years** practitioners as Barking and Dagenham Somali Women's Association (BDSWA) delivered their summer campaign to 'Stop FGM'. Raising awareness before the summer holiday season and what is considered a time of 'high risk'.

**Seven** workshops have been held throughout the year with **445** multi-agency staff attending:

- Alternative Child Rearing Practices
- Forced Marriage & Honour Based Violence
- Female Genital Mutilation
- Witchcraft
- Trafficking

### **(Stage 1): Ensuring quality**

Members of the Performance, Learning & Quality Assurance Committee (PLQ) attend learning events and provide feedback to the committee on the quality of the training delivery and delegate engagement/learning.

### **(Stage 2): At the end of learning**

End of course evaluation is completed on line via Survey Monkey for all courses – each delegate that attends a course receives a link via email no later than the day after the training event inviting them to give their feedback.

The results are collated by Survey Monkey and analysed by the Training Coordinator, results are then shared with trainers.

**(Stage 3): Impact Assessment**

6-8 weeks after attending a training event, a selection of learners are contacted via survey monkey or telephone to seek further evidence of the impact of learning on practice and outcomes for service users.

Areas of training & development to be included in 2017/18 are:

- Effective early help provision and use of CAF
- Substance misuse and the impact on children
- Domestic abuse
- Violence to women and children including FGM
- Child Sexual Exploitation
- Neglect and the impact on children
- Adult mental health and the impact on children

Single agency safeguarding training by partners has been assessed as part of the Section 11 audit:

BHRUT monitor compliance for Safeguarding Children’s Training Level 1, 2 and 3 at the Trust’s Safeguarding Children’s Operational and Safeguarding Strategic and Assurance Groups. Compliance is reported quarterly to the LSCB. A Safeguarding Children’s Training Needs Analysis (TNA) and Strategy for 2016/17 was approved at the Trust’s Safeguarding Strategic Assurance Group meeting on 1 June 2016.

**Case Auditing**

The LSCB has revised and strengthened the case audit process through the Multi-Agency Audit Group (MAAG) to involve more partners enabling them to have a line of sight to frontline practice.

The table below sets out the audit activity for the year that incorporated Thematic audits, including those identified through the Ofsted Inspection in 2014 and those based on LSCB priority areas across neglect, child sexual exploitation, and domestic abuse.

The impact of these audits increased levels of contribution, competence, and confidence by agencies in the case audit process. Case audits have also generated a huge amount of intelligence about effective local practice and areas of development.

April 2016	Police Protection Quality of Strategy Discussions/Meetings
May 2016	Police Protection Quality of MARFs
June 2016	Police Protection Missing children/Return Interviews
July 2016	Police Protection Pre-birth Assessments
August 2016	Police Protection CP Conferences Stepping Down to CIN
September 2016	Police Protection Domestic Abuse
October 2016	Police Protection

	Second time CPP (Q1)
November 2016	Police Protection In-depth audit on second time CPP Q1
December 2016	Police Protection
January 2017	Police Protection Second time CPP (Q2)
February 2017	Police Protection Missing children/Return Interviews
March 2017	Police Protection Parental drug/alcohol misuse & mental health

The findings from completed audits are shared with individual agencies through the Performance, Learning & Quality Assurance Sub-Group members.

Each agency is then required to identify actions and improvements that are relevant to their organisation and ensure these are included in their own safeguarding development plan.

Outcomes are incorporated into training. The learning needs identified through the audit process are also considered by the Performance, Learning & Quality Assurance sub group to ensure that learning is incorporated into the multi-agency training plan.

### Key Learning Points:

Information from case audit has demonstrated that:

- **Police Protection** – All cases of children subject to Police Powers of Protection are audited and discussed with police colleagues to understand the reasons why Police Protection was taken. As a result, the number of children coming into care through police powers of protection during the 2016-17 period was 45 which is 22.1% of all admissions. This compares with 54 (24.5%) in 2015-16 and with 69 (25.3%) children in the 2014-15 period. This indicator was raised in the Ofsted inspection in 2014 as an area requiring improvement.
- **Disguised compliance** - in several cases the word of the parents was accepted
- Lack of **chronologies, genograms** and **ecomaps** evidenced.
- **Reactive** rather than responsive interventions evidenced.
- Lack of evidence of **multi-agency** assessments. Social workers are not consistently using the partnership to complete Core Assessments.
- **Multi-Agency Risk Assessment Conference** (MARAC) minutes not evidenced in social care records.
- **Self-reporting** by parents is accepted as factually accurate.
- **CAF** not considering all children e.g. in other schools no triangulation and a **Think Family** approach.
- Lack of involvement of **absent fathers**.
- Impact of **parental behaviours** on children needs to be considered by all agencies
- Lack of awareness of **Toxic Trio** and use of research and evidence based practice in all partners.
- **Strategy discussions** often taking place over the phone.

- Individual events are being recorded in isolation i.e. no evidence of a use of a **chronology** which would give the “bigger picture”
- Professionals often lack the **confidence / knowledge** to challenge decision making or make use of the LSCB **Escalation** procedure.
- There is no national dataset for **CSE** so difficult to benchmark
- Some cases showed no evidence of the **CSE Risk assessment** tool being used
- Assessments tended to focus on the parent’s relationship rather than the long-term impact on the child where **domestic abuse** was a factor
- History and parenting capacity must be captured in long term **neglect** cases.

### Key Strengths:

- ✓ Child sexual exploitation now becoming **recognised** as a causation of sexualized presenting behaviour.
- ✓ Some agencies evidenced good **communication**.
- ✓ Some good evidence of **partnership** working
- ✓ Timely response to referral, good assessment, reference to research, formulation of a **good plan** and review with other agencies.
- ✓ **Strong evidence** of management oversight, decision making and regular supervision.
- ✓ Evidence of **child’s involvement** in the CAF assessment.

- ✓ Good chronology from **school**.
- ✓ Evidence of **good direct work** with child with clear actions.
- ✓ Good **CAF** assessment.
- ✓ Positive agency involvement, partnership working and **information sharing**, prompt actions.
- ✓ **Pro-active** health visiting involvement in following up with SW team and arranging professionals meeting.
- ✓ Good evidence of **escalation** within NELFT using safeguarding Team to support escalation of concerns
- ✓ Clear **communication** between health and school.
- ✓ Good record of discharge planning meeting, good description of intoxicated attendance and impact on parenting, **good social history information**, good use of body map for strategy meeting,
- ✓ Good **information sharing** between professionals.

### Section 11 Challenge

The LSCB has a well-established process in place to measure the compliance of agencies with Section 11 of the Children Act 2004 which places duties on a range of agencies to ensure that they have regard to the need to safeguard and promote the welfare of children.

The Section 11 audit in Barking & Dagenham is from 2016 a two-stage process:

1. Self-assessment – where each organisation completes an assessment tool under eight standards, which is further broken down into 50 questions. Each organisation provides an explanation of the services or arrangements in place under the questions and provides evidence to support each requirement. A self-assessed grading is given for each question of red, amber, or green.
2. LSCB ‘challenge session’ is arranged upon submission of the audit where a senior manager from the agency meets a panel to discuss and moderate the completed audit. The agency will then update the audit and grading following the moderation.
3. A new, interactive tool has been introduced for this year’s audit, which has received positive feedback from those who are responsible for completing. As the tool is completed, an action plan is automatically generated by the responses given to each standard.
4. A workshop was held for all the designated officers nominated to complete the Section 11 audit tool to provide support and advice in completing it

### What is the impact of the S11 audit?

Overall the outcome of the Section 11 audit has been positive with most of the standards being judged ‘partially met’ or ‘fully met’.

- ✓ There is a good understanding of safeguarding across all agencies

- ✓ A designated individual has overall responsibility for safeguarding and there are established lines of accountability up through the organisation.
- ✓ Most agencies could demonstrate good arrangements in place to assess their contracted service providers under the Section 11 standards
- ✓ There are mechanisms in place that allow the views of children and young people to be taken into consideration
- ✓ Appropriate levels of Safeguarding training are accessed by all members of staff which includes; in-house single agency training and, multi- agency specialist training.
- ✓ All audits evidenced safe recruitment processes, with references taken up and relevant checks made.

### Schools Safeguarding Audit

On a bi-annual basis the LSCB implements a school safeguarding audit relating to Section 175 of the Children Act 2004 which measures compliance with statutory guidance ‘Keeping Children Safe in Education’. The audit tool is in line with a similar tool issued by the NSPCC and goes above the minimum standard to reflect the constantly changing picture of safeguarding and the responsibility on schools and their staff to safeguard children.

An encouraging picture has emerged from the report that many schools are demonstrating a proactive stance in executing their duties towards the safeguarding of children. Generally, there has

been an improvement in the quality of audits. The next audit will be undertaken in the spring / summer 2018

### What is the impact of the Audit?

- ✓ An improvement in the quality of audits
- ✓ 75% of schools returned an audit
- ✓ 63% of schools used the specifically devised training materials for 'whole school' training – the remaining schools use in part or outsource their training.
- ✓ 100% of schools have a clear 'e-safety' policy
- ✓ 81% of schools understood the requirements of CSE with 19% rated 'amber'
- ✓ 100% of schools are fully compliant with the recording and storing of information on child protection concerns
- ✓ A need for more specific training on safeguarding for school governors

### Safeguarding in Sport

In November 2016, a former footballer disclosed to the Guardian newspaper that he had been sexually abused as a youth player.

Since then, more people have also come forward with allegations of historical abuse in football including former footballers - including ex-youth players, trainees, and professionals.

The Football Association (FA) have set up an internal review, the Child Protection in Sport Unit, which has assisted the FA with its

safeguarding procedures since 2000, will also carry out an independent audit into the FA's practices and the NSPCC set up a helpline supported by the FA.

In response to these national and historical concerns the Barking & Dagenham LSCB have ensured that:

- all council run leisure/sports facilities must update a S11 audit.
- the principles of S11 must be used in all commissioning and contracting
- a letter is sent to all sports groups in the borough from the LSCB Independent Chair with a link to the NSPCC
- A 'leaflet' with information for parents circulated to all schools and sports facilities in the borough and placed on the LSCB website.

## 6. Engagement with Children

There are well established consultative and collaborative forums with children and young people to inform, shape and develop multi-agency work and priority safeguarding children areas. The engagement of children and young people in safeguarding is through:

- Barking and Dagenham Youth Forum, including Young Inspectors and Young Mayor
- Children in Care Council (Skittlz), including two annual CiC Consultations
- Young People’s Safety Group (sub-group of the BDSCB)
- LGBTQ Youth Group (FlipSide)
- Progress Project (Disabled Children’s Parliament)
- Child Protection and Looked After Review processes
- Locally commissioned Advocacy services for CiC.

The Young People’s Safety Group met twice over the past year. A session was held in in September 2016, led by the Youth Offending Service and themed on serious youth violence in response to recent incidents in the borough. 56 pupils attended, drawn from five schools in the borough.

A February 2017 session was themed on Child Sexual Exploitation, and was led by Barnardo’s. 45 pupils attended from six schools. In both cases, key questions raised by the young people at each session were shared with the Board for appropriate response and to raise awareness of the key issues experienced by young people.

In addition to the Young People’s Safety Group, young people took over the LSCB in November 2016 as part of national Takeover Day. The session saw BDSCB members interact with members of the BAD Youth Forum, Looked after Children and Young Carers to discuss the key safeguarding issues that affect them in the borough.

The voices of young people are additionally captured through generic and targeted youth provision, such as Vibe, Gascoigne, Sue Bramley and Marks Gate youth clubs. The voices of vulnerable young people are additionally captured through the commissioned services for young carers and AbPhab, a youth club for disabled children. Young people also sit on representative groups, such as the Children’s Services Select Committee and CCG’s Patient Engagement Forum.

The Annual Report for the 2016 BAD Youth Forum was presented to Assembly in January. It highlighted several key achievements, including the production of a powerful film raising awareness around mental health entitled ‘Breaking the Stigma’, which has been shared widely.

Young Inspectors have conducted 62 mystery shopping inspections of pharmacies that deliver the C-Card (condom distribution scheme) this year to date. The borough’s C-Card performance is now top in London, with Teenage Pregnancy figures continuing to fall. A future campaign will be Child Sexual Exploitation as a theme and will be developed in conjunction with Barnardo’s.

The Children in Care council continues to be very active, with its most recent consultation receiving responses from over 100 LAC. It

demonstrated improvements across many annual indicators, including frequency of contact with Social Workers and retention. FlipSide, our LGBT youth group, have also secured 50 places at this year’s London Pride parade, and recently conducted a training session for Members.

## 7. Serious Case Reviews (SCR)

In Chapter 4 of Working Together 2015 it sets out the requirement for LSCBs to undertake reviews of serious cases in specified circumstances stated as:

*“undertaking reviews of serious cases and advising the authority and their board partners on lessons to be learned.”*

A serious case is one where:

- 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 LSCB has a Serious Case Review (SCR) Sub-committee and all SCR decisions have followed the requirements in Working Together 2015 with the LSCB Independent Chair observing and listening to the conversation and recommendation to be better informed in coming to a decision.

During the year 2016/17 **3** cases were considered by the Serious Case Review panel.

One was progressed to a SCR – Child C which will be published in the summer 2017, one was deemed a multi-agency Practice Learning Review. Early lessons arising from these reviews are:

- disguised compliance by families
- ‘hidden father’ not assessed
- Over optimism of practitioners and acceptance of family’s self-reporting.
- Lack of understanding and knowledge of premature babies

A range of multi-agency learning events are set up to disseminate the messages from the reviews using a variety of methods



## 8. Child Death Overview Panel (CDOP)

The LSCB is responsible for ensuring that a review of each death of a child living in their area is undertaken by a Child Death Overview Panel (CDOP) as set out in Chapter 5 of Working Together 2015.

A CDOP is responsible for collecting and analysing information about each death with a view to identifying:

- any case which may require an SCR
- any matters of concern affecting the safety and welfare of children in the authority
- any wider public health or safety concerns arising from a death or from a pattern of deaths in that area and
- putting in place procedures for ensuring that there is a coordinated response by the authority, their board partners, and other relevant persons to an unexpected death.

The purpose of the CDOP process is to try and reduce the number of preventable child deaths by considering:

- the cause of death
- any modifiable factors that can be identified
- whether the modifiable factors mean the death was preventable
- what recommendations need to be made to agencies, the LSCB, regionally or nationally to prevent future such deaths.

In 2015-16 HM Government, commissioned Alan Wood to undertake a review of Local Safeguarding Children Boards (LSCB)

and Child Death Overview Panels (CDOP). The recommendations for CDOP included:

- Child deaths need to be reviewed over a population size that gives a sufficient number of deaths to be analysed for patterns, themes, and trends of death;
- Responsibility for CDOP should move from Department of Education (DfE) to Department of Health (DH);
- DH should determine how CDOPs can be organised on a regional basis with sub-regional structures to promote learning and dissemination;
- The DH should lead on policy on CDOPs, and consider how they can be supported within the arrangements of the NHS; and
- If the national study recommends the introduction of a national database for CDOPs, the DH should consider expediting its introduction

The Children and Social Work Act has now been finalised and a revised guidance and process is expected to be released during 2017-18. Once changes are ratified and statutory guidance released, CDOP structures will begin to change across all boroughs. Locally, Partners are beginning to have conversations in relation to regional structure changes, however updated legislation is awaited.

During 2016/17 in Barking & Dagenham there were 21 deaths notified and 25 reviewed by the CDOP, some deaths were reviewed more than once. This is an increase of 1 notified death on the previous year.

### Expected and Unexpected Deaths

The categorisation of expected child deaths in Barking and Dagenham, continues to follow the same trend as previous years. Unexpected deaths continue to be significantly lower than expected ones, with unexpected deaths being around 50% lower over the last five years.

Financial Year	Expected Deaths	Unexpected Deaths	Percentage difference	Total
<b>2016/2017</b>	<b>14</b>	<b>7</b>	<b>50%</b>	<b>21</b>
2015/2016	16	4	25%	20
2014/2015	15	8	53%	23
2013/2014	17	10	58%	27
2012/2013	15	9	60%	24

Of the 21 new cases notified to CDOP, six (6) Rapid Response meetings were held. All Rapid Response meetings were held within 5 working days of notification, across varying venues. Where possible, meetings were held at the Hospital where the child had

died. This enabled medical staff involved with the care of the child to attend and share information known. The Rapid Response meeting recommended to the Safeguarding Children Board (LSCB) that one case be considered for a Serious Case or Practice Learning Review.

On reviewing the details of this case, the SCR panel agreed that the case did not meet the threshold for a Serious case review or learning review, as detailed within Working Together 2015.

### What we know

- The small numbers of child deaths in the Borough make it difficult to identify trends or make comparisons.
- The neonatal age bracket (0-27days) remains the highest proportion of deaths (46%), which mirrors 2015-16 reported figures. Children under the age of 1 year represent 63% of total child deaths reviewed by CDOP over 2016-17.
- Child deaths within the Black African ethnic group continue to be highest cohort recorded. In 2016-17, there were 8 deaths reviewed (33%), four (4) male and four (4) female. This is an increase on 20% recorded in 2015-16, which equated to a total of four (4) cases.
- 75% of children reviewed who were identified as Black African (6), were aged between 0-4 years. 37% (3) cause of deaths were recorded as extreme prematurity as all were delivered between 22-24 weeks.
- Barking and Dagenham CDOP continues to request and record pregnancy and maternity information so factors like late

bookings, birth gestation, birth weight and any high-risk factors can be considered in the review.

### What we did

- The LSCB Chair met with the newly appointed Coroner at the start of the financial year, to develop stronger working relationships and further understand the Coroner’s role in relation to child deaths. This meeting enhanced communication and information sharing between CDOP and LSCB and explored enhanced learning which included promotion of learning following Regulation 28’s.
- Whilst undertaking new birth visits, Health Visiting teams were reminded to advise women who exclusively breastfeed, of the importance of Vitamin D supplements. Additional training sessions were held with the Designated Doctor and Nurse, alongside NELFT to disseminate these messages to the workforce.
- Barking and Dagenham CDOP continues to network outside its neighbouring boroughs and links with the National Network CDOPs (NNCDOP), the North-East London CDOP group, and Healthy London Partnership who, in conjunction with NHS England have been charged with reviewing the circumstances and contexts for the death of an infant or child and are contributing to shaping and strengthening services and resources.

### Challenges for 2017/18

- The timeliness of notification continues to be monitored. During 2016-17 two notifications were received outside of the 24-hour timeframe. Both were from a Hospital setting, and these were addressed within the Rapid Response meetings held.
- Obtaining timely information from General Practitioners continues to be an issue to the CDOP process. The Panel are working closely with the Named GP to eradicate these issues as information held by GPs are vital to the reviewing process.
- The local Registrar has a responsibility to inform CDOPs of all registered deaths for a person under the age of 18 years at time of death. Whilst these links appear to be robust within other boroughs, this appears to be a weaker link within Barking and Dagenham. The SPOC will continue to liaise with the Registrar to receive timely updates.

## 9. Allegations Against Professionals

The Local Authority Designated Officer (LADO) is well established, and based within the Safeguarding & Quality Assurance service and provides oversight of allegations against people who work with children as well as advice and guidance to agencies. An annual report is produced and presented to the LSCB.

When an allegation is made against a member of the children’s workforce, the safety of the children with whom the professional comes into contact is the priority. Employers, have an additional duty of care towards their staff and therefore the complexities involved in responding to such allegations require balance and careful judgement to ensure risk and support are measured at both levels.

The LADO supports this process through:

- **advice** on thresholds at the stage of notification;
- **mediation** with colleagues in other agencies,
- providing a **proportionate response** to investigations;
- **guidance** on individual risk management including careful consideration of whether suspension of the staff member might be necessary; and
- **support** in the analysis of information and evidence gained as investigations progress, to ensure risks are responded to and appropriately concluded.

Between April 2016 and end March 2017, the LADO recorded **170 allegations** against the children’s workforce (including volunteers) in Barking & Dagenham. Whilst this represents a 11% decrease on the previous year (190) the number of contacts for consultation and allegation management support remains high. These contacts mainly relate to staff conduct issues which, on consultation, are designated as below the allegation threshold or unlikely to result in a S47 investigation and are passed back to employers to manage as practice or competence issues. The contacts may also constitute historical matters where staff are no longer working within the children’s workforce, or could relate to matters of policy guidance.

The categorisation of a piece of work as a ‘consultation’ is deceptive and may suggest a lesser input from the LADO. Many consultations require considerable and significant follow-up and analysis by the LADO beyond the initial caller contact.

Working Together 2015 sets out the expectation that 80% of LADO cases should be resolved within one month of referral, 90% within three months, and all but the most exceptional cases, completed within one year.

In Barking & Dagenham 3 cases are outside of these timescales due to the length of police investigations to achieve a timely resolution.

The statistical distribution of allegations in the year indicates that professionals employed in education services including early years, account for 39% of the total LADO referrals (not consultations). Combined, social workers, foster carers, residential workers and youth workers, account for 36%. The remaining 24% are divided by

religious professionals, football coaches and others. It has been noted that there are very low or zero rates of contacts passed to the LADO from or about professionals working in the Health sector. Over the next twelve months work will be conducted to increase awareness within parts of the Health community.

<b>Agency</b>	<b>Number</b>
Education (Schools)	5
Early Years (Nursery)	3
Additional Education Settings	5
Foster Carers	6
Health Professionals	0
Residential Workers	1
Reg. Social Workers	3
Church / Religious Professionals	3
Youth Workers / Organisations	2
Registered Child Minders	0
Football Coaches	3
Others	2
<b>Total</b>	<b>33</b>

Referrals related to concerns regarding persons working or volunteering within additional education facilities, acting as a private tutor or independent sports coach have been identified as a

concern and are not regulated or safely recruited. Nationally, there is no duty on these organisations to adhere to statutory guidance in the safeguarding of children.

There is even less organisational oversight in circumstances where classes are set up in private homes or outbuildings and parents bring in an adult to teach their children.

The lack of statutory guidance in this area creates difficulty holding individuals and organisations to account for the safeguarding and harm of children. There can be no confidence that individuals working or volunteering in this capacity undergo robust safer recruitment checks.

When concerns are raised, there is limited scope for the LADO to exercise powers on behalf of the local authority if there is no independent regulatory body to refer to. The usual referrals to the Disclosure and Barring Service are often ineffective as many of these organisations do not adhere to the requirement for DBS checks before appointment. In the cases referred to the LADO in Barking & Dagenham, it has been reliant on Police to investigate and potentially prosecute to prevent those who are unsuitable to work with children from doing so. This issue will continue to be raised through regional and national forums.

## 10. Performance Management

The LSCB has a comprehensive performance management framework in place which supports the board in identifying and addressing areas of good performance as well as areas that require attention and challenge. During 2017/18 the LSCB will review and further develop its multi-agency performance management reporting.

The following areas of performance have been key areas of consideration for the LSCB. The provision of performance data from some partners remains a challenge and will be taken forward as a priority action for next year.

### Referrals to Children’s Social Work Services

The number of referrals received has decreased by 6% during the year (from 3255 to 3050). The rate per 10,000 has fallen from 539 to 505. This is below the statistical neighbour average (700) and the national average (532), but above the London average (491).

The most significant numbers of referrals are received from the Police (816) and from Education (618). 93% of referrals were acknowledged within 24 hours during the year, compared to 80% previously.

The repeat referral rate has reduced from 16.6% to 12.8% during the year.

There have been 241 contacts during the year to MASH for ‘Culturally Harmful Abuse’. Physical abuse was the highest referral criteria with Black or Black British/African children making up the highest cohort at 39% (34), with 64.7% (22) being boys and of those 81.8% (18) of them 10 years old or under.

### Statutory Assessments

A total of 2325 assessments were completed during the year, a decrease of 8%. 76.4% of these were completed with required timescales, a slight increase on previous performance but not where we would hope.

### Strategy Discussions/Section 47 Investigations

Reflecting significant levels of need and risk in the Borough, the number of Section 47 investigations has continued at a high level. Importantly, this has been looked at more closely as part of two independent reviews - in September 2015 and in October 2016 - and the standard of decision making has been considered as being appropriate.

The number of cases in 2016-17 which were progressed to Section 47 investigations was 1175 out of 1504 strategy discussions, a conversion of 78%. For the previous year this figure was 86%.

The number of Section 47 Investigations being completed remains comparatively high when considered against national and London averages, however this is reducing.

The number of strategy discussions taking place with involvement of other agencies has increased from 121 (8%) to 618 (41%). This area of practice had been shown as needing improvement as strategy discussions are often needed within short timescales. This has been achieved using technology and introduction of telephone conference facilities during the year.

### **Core Groups**

The number of core group meetings held in timescale for children subject to child protection plans has increased to 88% as of the end of 2016-17 compared to 84% a year earlier. This remains a positive story with a sustained improvement when compared to the performance of 2013-14 which was 34%.

### **Children Subject to a Child Protection Plan**

378 cases were considered at initial child protection case conferences during the year at a rate per 10,000 of 63, a higher number than in the previous year. The current rate per 10,000 of 63 compares with rates in 2015-16 period of 74 for statistical neighbours, 54 for London and 63 for the national rate.

At the end of the year 294 children and young people were subject to Child Protection Plans, an increase of 16% from the same point last year. This is notably higher than national and local trends.

The number of children becoming subject to a child protection plan for the second time in 2016-17 was 56 (16.8%). This compares with 24 children (7.7%) in 2015-16.

Although performance has increased over the last year, we remain below the national and statistical neighbour averages which were 17.9% and 17.1% respectively at the year-end of 2015-16.

This year has seen an increase in the percentage of children who were on a child protection plan for two years or more although the total number of children involved – a total of 19 - is relatively low. This equates to 6.5% and compares with 12 children in the 2015-16 period which was 2.9%.

This area of performance is above the target of 5% and higher than the national and statistical neighbour averages for the 2015-16 period which were 3.8% and 4.1% respectively

### **Child Protection Conferences**

There has been good performance in the work to achieve 97% of initial child protection case conferences within the 15-day timescale. This is significantly higher than all comparators (between 75% and 77%).

Child Protection Review Conferences being held in time has remained as a strength at 100%.

### **Child Protection Visits**

This year has seen an increase in the percentage of children who were on a child protection plan for two years or more although the total number of children involved – a total of 19 - is relatively low. This equates to 6.5% and compares with 12 children in the 2015-16 period which was 2.9%. This area of performance is above the

target of 5% and higher than the national and statistical neighbour averages for the 2015-16 period which were 3.8% and 4.1% respectively.

86% of children subject to child protection plans were visited and seen within 4 weeks in the period of 2016-17, no change on the 2015/16 performance.

### Missing Children

219 children with 584 reports/incidences

A total of 243 return interviews took place. Of these, 92 (37.8%) were held within the recommended 72-hour period following the child's return. 20 interviews were either declined by the child or could not take place because the young person was immediately taken into custody.

### Risk of CSE

Police investigate all cases where there is a suspicion or evidence of CSE. Those children and young people identified as at risk of or vulnerable to CSE are supported through several pathways ranging from early help to children's social care. The CSE Police in Borough are responsible for cases at Level 1 (suspicion of) and Level 2 cases including those involving on-line sexual exploitation.

Level 2 cases, where there is evidence of CSE are investigated by the Police Sexual Exploitation Team (SET).

At 31<sup>st</sup> March 2017, there were 27 children and young people from Barking & Dagenham subject to investigations by Police; 23 were open investigations to the local CSE Team and 4 were actively being investigated by the Police SET.

### Police Powers of Protections

At the end of March 2014 136 children had been removed via Police Powers of Protection which accounted for 43% of admissions to care. Work between Children's Social Care and the Police has reduced this figure to 45 children which is 22% for the 2016-17 period.

This reduction is hugely important for reducing the impact of trauma on individual children and continues to receive close attention through regular meetings with Senior Police Officers to review performance and consider individual cases highlighted in the audit of the cases.

### Private Fostering

During the period 2016/17, the Fostering Team received **27** private fostering notifications compared to **45** in 2015/16. Of the 27 new notifications, 6 met the criteria for Private Fostering. Of those 6 cases, 5 were closed during the financial year – 3x return to birth family, 1x turned 16 years, and 1x moved out of Borough. One remained open.

11 cases were carried over from 2015/2016 to 2016/2017, of the 11 cases, 8 were closed as 3 young people turned 16 and were no longer within the Private Fostering arrangement; 1 moved out of



borough and 1 returned to mother; 2 returned to birth family, and 1 was referred to the Assessment Team due to safeguarding concerns. As at 31/3/17, the Fostering Team held in total 4 active private fostering cases

## 11. Priorities for 2016/17: Revisited

**Priority One: Board members are assured that arrangements are in place to identify and safeguard groups of children who are particularly vulnerable**

### Reduce the harm from child sexual exploitation

#### What have we done?

Child sexual exploitation (CSE) is an issue of ever growing significance and is a fast-moving area with new reports, requirements and guidance being published on a regular basis. The LSCB partnership has been working hard to ensure that that our practice, policy, and procedures are updated in line with these.

Reducing the harm from CSE has continued to be a priority area of focus for the LSCB. A CSE Strategic Group has been in place, although the Board has now agreed that there will be direct reporting from the MASE and the Missing groups through to the Performance, Learning & QA group.

There are shared strategic priorities across partnership groups such as the Community Safety Partnership and Health & Wellbeing Board. A report on CSE was submitted for discussion in March to the Councils Children's Select Committee

The CSE Strategy and action plan currently being refreshed for 2017/18, outlines the accountability framework for tackling CSE within Barking & Dagenham.

A CSE Champions Forum take place termly and provides opportunities for training, presentations, and networking. Champions have been identified from partner agencies and from schools in the borough.

Our CSE Champions have developed and confirmed their Mission Statement setting out what they aim to do as individuals and as a collective and this will be published on the BDSCB website

Champions have also developed an Action Plan outlining what they need to achieve their goals. Work on this is ongoing and will be reviewed at Forums throughout the coming year.

We have revised our Pre-MASE Membership and updated the Terms of Reference and Agenda for this meeting to ensure that it appropriately supports the function of the MASE.

Work is underway to revise the Terms of Reference and Agenda for this meeting in line with the recently refreshed London CSE Operating Protocol – due to be published in June 2017. The revised documents will provide a focus on increasing the strategic oversight and value of this meeting.

We have strengthened the strategic and operational links between missing children and children in gangs in recognition of the cross-over of issues and increased vulnerabilities for this cohort of young people.

Following an HMIC inspection of the Metropolitan Police, our borough Police CSE team have been restructured and now form part of a 3 Borough East Basic Command Unit that works across Havering, Redbridge and Barking and Dagenham. The CSE element of this Unit remains located in the borough.

Police investigate all cases where there is a suspicion or evidence of CSE. Those children and young people identified as at risk of or vulnerable to CSE are supported through several pathways ranging from early help to children's social care.

A CSE toolkit was implemented by NELFT to support the identification of CSE and enable an appropriate response by staff. The CSE Services Self-Assessment Framework developed by NELFT was acknowledged by NHSE as a valuable resource to enable services to temperature check that they are ready to respond effectively to CSE.

### Missing and CSE

Not all children who go missing are at risk of CSE. Not all children at risk of CSE go missing. But the link between missing and CSE is very clear. 39 of the children reported missing were identified as being at risk of CSE. At the time, all of them had an allocated social

worker. Every case was discussed at Pre-MASE and/or MASE meetings.

Going missing is a dangerous activity. There are 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 those faced by a child/young person who regularly goes missing. The LSCB 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 eight 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.

### Return interviews

When a child returns from being missing, or is found, the police undertake a 'safe and well' check (a type of return interview). The purpose of this is to clarify if the child has been the victim, or perpetrator, of a crime.

The police will try to get the child to explain why they went missing but it is the Local Authority Return Interviews that is the key tool in understanding why a child went missing; what happened to them

whilst they were gone and what can be done to stop them going missing again.

A total of 243 return interviews took place. Of these, 92 (37.8%) were held within the recommended 72-hour period following the child's return. 20 interviews were either declined by the child or could not take place because the young person was immediately taken into custody.

There is no reliable data to compare to previous years. Ensuring that return interviews take place within 72 hours is a performance indicator and the focus is on trying to improve the percentage of interviews taking place within this time.

### What difference has it made?

- ✓ The risk management processes in place in relation to CSE are robust. The links between children who go missing and CSE are well understood and acted upon.
- ✓ The Missing Children Group considers data and themes from independent return interviews (IRI). This IRI information is fed back to lead professionals and the police to inform interventions.
- ✓ There are up to date policies and procedures in place for CSE and missing children tested out through case audit.
- ✓ Police continue to take the lead in training for CSE, both to Police personnel and other partners via a series of workshops. We have also commissioned "Advanced" CSE training through the NSPCC as well as training on Harmful Sexual Behaviour

(HSB) through Safer London. This training will take place toward the end of 2017.

- ✓ The BDSCB continues to work with Police colleagues to promote "Operation Makesafe" across the partnership and earlier in the year hosted an extremely successful breakfast for local hoteliers and taxi drivers.
- ✓ The police have issued several child abduction notices during the year to suspected perpetrators and have submitted applications for Sexual Harm Prevention Orders against specific offenders

### What will we do next?

The local profile will be updated to inform the local picture of the prevalence of CSE to enable resources to be targeted.

There will be a continued clear focus on preventing the risks and causes of CSE through education and prevention both with individuals and communities and through universal provision, early help, and targeted interventions. There continues to be a need to continue to raise awareness of CSE with children and young people so that they are educated and empowered to recognise this form of abuse including within their online world.

CSE is still an area that the LSCB will to focus on to ensure that risk locally continues to be managed effectively. CSE will remain a priority for 2017/18.

## Reduce the harm from neglect

### What have we done?

Reducing the harm from neglect continues to be a significant safeguarding priority nationally.

The proportion of children and young people the subject of a child protection plan because of neglect and because of emotional harm is increasing.

Neglect and Emotional harm have remained the most prevalent reasons for child protection plans locally over several years and remains the most prevalent form of child maltreatment nationally.

A multi-agency audit of cases to assess the quality of work across the partnership where neglect is a factor was carried out in December 2016. Further audits of children subject to a child protection plan for neglect have also been undertaken and reported to the Performance, Learning & QA group and to the Board.

A 'Home Conditions' tool is used by Early Help staff to assess neglect.

Training has been enhanced for social workers on attachment based approaches to support children and families.

Supporting parenting capacity is critical in reducing the harm from neglect and abuse, promoting healthy attachments between parents and children and providing help for parents who have

particular needs of their own which impact on their parenting capacity. These include substance misuse, mental health issues and domestic abuse. Outcomes from these audits also span across to neglect of children so recommendations are also considered as factors to ascertain neglect.

### What difference has it made?

- ✓ Learning from case audits has been disseminated through the LSCB, Multi-Agency Audit group and the PLQA group
- ✓ Revised and updated neglect training is part of LSCB training programme for 2016/17 and for 2017/18
- ✓ Training on attachment based approaches to supporting children and families is part of the Children's Care & Support training programme.
- ✓ Early help is proactive in supporting families through a range of approaches.
- ✓ Families whose children are made subject of a child protection plan for neglect make positive progress. Data demonstrates that; there are low numbers of children subject of a child protection plan for 2 years or more, and, there are few children with second/subsequent child protection plans.

### What will we do next?

In Barking & Dagenham, neglect and emotional harm have remained the most prevalent reasons for child protection plans. So,

understanding its consequences and the potential for prevention and early intervention is important. Evidence from our audits indicates connections to other forms of harm and vulnerability to CSE in children and young people.

There has been limited attention given to the social determinants (such as poverty, inequality, and availability of community based support) that contribute to neglect.

In Barking & Dagenham, a high proportion of the children and young people becoming subject of child protection plans for emotional harm and neglect had domestic abuse in their family background. Further exploration should be undertaken to ascertain links to neglect and identification at an earlier stage.

The Neglect Strategy and Action Plan is being reviewed and updated.

A multi-agency neglect tool and guidance is being reviewed and updated.

## Reduce the harm from Domestic Abuse

### What have we done?

The Barking and Dagenham Community Safety Partnership (CSP) oversees domestic and sexual violence which is a priority for the CSP and the LSCB.

Domestic and Sexual violence impacts on all service areas across Barking and Dagenham. It accounts for 46.2% of violence with

injury offences in the borough (JSNA, 2016) and was a presenting factor for 15.8% of children’s social care contacts in 2016/17.

Domestic and sexual violence are significant issues for Barking and Dagenham. The borough has the highest number of reported incidents of domestic violence per 1000 population in London. The available 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.

During 2016-17, the Independent Domestic and Sexual Violence Advocates (IDSVA) worked with 697 victims. Of these, the majority were referred via the Police. This trend reflects the profile of MARAC referral data with a high level of Police referrals and low levels of referrals from other key statutory and voluntary agencies. Consequently, in Barking and Dagenham most victims are identified if their case has come to the attention of the criminal justice system and not at an earlier stage of victimisation.

The Multi Agency Risk Assessment Conference (MARAC) meets monthly to conference the highest risk cases in the borough by developing robust multi-agency support plans. During 2016/17, the total number of cases discussed was **348**, which represented a **3.3%** increase compared to **337** cases the previous year. Of these, **28%** were repeat cases which is on par with the ‘Safelives’ national recommendation of **28-40%** repeats to MARAC.

A significant number of children (**419**) were attached to these cases, which represents a **10%** increase compared to **381** in 2015/16.

**57.8%** of referrals to MARAC were from police and **25%** from the IDSVAs service. Children’s Social Care accounted for **2%** with just **7** referrals over 2016/17 to MARAC. Referrals from other statutory and voluntary agencies remain low.

**3.9%** of cases referred in 2016/17 were for a victim who was 16 or 17 years old. This represents a **35%** increase compared to the previous year. The number of people harming others who are 17 years or younger has increased by **175%** compared to 2015/16 although the numbers in comparison to total cases heard (**3.2%**) are rationally low for a borough with a large population of children and young people.

The number of victims from black or minority ethnic (B&ME) backgrounds reflects the percentage of referrals of victims who are non-white British. We would expect referrals to the MARAC to be representative of the local B&ME population.

SafeLives recommendation for cases with LGBT victims is 5-7% of total cases. In line with the national average, Barking & Dagenham is lower than expected, sitting at 1.1% in 2016-17.

Both the local and national average for cases where the victim has a disability is lower than the expected 16% (or above) which is partly due to barriers in reporting, 3.7% of Barking and Dagenham MARAC cases had a victim who had a disability.

Compared to 2015/16 the total number of MARAC cases heard where the victim was male has not changed. Expected national average for male victims at MARAC is between 5 and 10% based on

the current understanding of the different experiences of domestic abuse by gender. Less than 3% of Barking and Dagenham MARAC cases discussed in 2016/17 were male victims.

**What difference has it made?**

- ✓ The jointly commissioned IDSVAs (Independent Domestic and Sexual Violence Advocate) service includes a young person’s IDVA and two Child Domestic Abuse Caseworkers. There are also IDSVAs and caseworkers available who will work with adult victims experiencing differing levels of risk. The IDSVAs service has experienced some difficulties in 2016/17 with high turnover of staff and lack of a dedicated resource in the police community safety unit. The formation of a Police tri-borough Basic Command Unit with Havering & Redbridge has also led to fewer referrals. This has been raised through formal channels and is anticipated to be part of the bedding in of new structures and processes. The children’s specialist posts have seen low referral rates and would benefit from internal promotion going forwards.
- ✓ The Domestic Violence Treatment Programme, commissioned by children’s services, is a 12-week programme for children between 4 and 19 years of age. The programme offers support and help to children to understand their experiences and develops their emotional resilience. The mothers can access a concurrent programme which explores reducing self-blame, helping them understand the impact of domestic abuse upon their children, increasing their own awareness of domestic abuse, a guide to healthy relationships, rebuilding their self-

confidence and relationships with their children. Throughout 2016/17 this service included access to psychotherapy and play therapy sessions.

- ✓ The Council commissions a refuge service for women who need to leave their homes because of the violence and abuse they experience. Service users may be referred from Barking and Dagenham but also from across the country.
- ✓ Additionally, there are regionally commissioned services providing support to Barking and Dagenham funded by various commissioners including London Councils. This includes the Ascent consortium – 22 specialist organisation’s accessible from one central hub and able to provide specialist services for victims facing multiple disadvantages such as no recourse to public funds.
- ✓ The IDSVA service has provided training to different agencies and continues to do so. A conference was held in November 2016, targeted at social workers, and sought to raise awareness of Domestic and Sexual Violence and VAWG issues, and increase confidence in responding to disclosures.
- ✓ There is increased visibility by the Independent Domestic Violence Advocate based at Queen’s Hospital who also provides support at King George Hospital.
- ✓ There has been a significant increase in referrals made by NELFT practitioners to MARAC across the 3 boroughs during the year. This evidences the impact of training and the application of the Safe Lives risk assessment tool.

### What will we do next?

Areas for development in 2017/18 include the formation of a VAWG sub-group reporting to the Community Safety Partnership. This group will provide strategic oversight of the borough response to Domestic and Sexual Violence and VAWG and will support and steer the MARAC and Domestic Violence Forum.

A MARAC self-assessment is recommended which will inform a MARAC improvement plan.

A mapping exercise of support available, a comprehensive communications plan including the development of a multi-agency training offer are also areas of development.

## Priority Two: Board partners will own and share accurate information which informs understanding of safeguarding practice and improvement as a result

### What have we done?

Through the S11 audit we have checked that agencies fulfil the requirement to have effective systems, processes, and policies

We have challenged agencies to provide evidence of the work that they are undertaking to improve outcomes overall and in relation to specific areas of business

We have undertaken audits to understand how effectively the whole system is working and to make sure that the child's journey is always the focus.

We have made sure there are strong governance arrangements in place with Children's Trust, Health & Wellbeing Board, and Community Safety Partnership; and that there is evidence of two-way communication and challenge.

The CDOP Annual Report shares learning & performance data, and escalates concerns to the Board

Performance, Learning & Quality Assurance subgroup scrutinise performance data on behalf of the Board

Increased visibility of the LSCB through regular newsletters, updates on the website and use of social media – Facebook & Twitter

In 2016, The Named GP and Designated Nurse started a GP Forum, meeting quarterly, to enable GP leads in Safeguarding to meet, discuss, and work together for the benefit of the whole B&D Primary Care / General Practice community. Work has started looking at ways of improving time limited information sharing between Primary Care and Children's Social Care.

The Named GP has produced supportive documentation / policy templates for all GP practices to help them prepare for their personal CQC inspections. This will assist practices in having all necessary Safeguarding processes and pathways and assuring CQC of robust safeguarding practices.

### What difference has it made?

- ✓ A new, interactive tool has been introduced for this year's S11 audit, which has received positive feedback from those who are responsible for completing. There is a good understanding of safeguarding across all agencies
- ✓ In 2016/17, the LSCB continued to have consistent leadership through its Independent Chair and Director of Children's Services. Local political leaders have a clear line of sight of the safeguarding agenda in Barking & Dagenham and the work of the LSCB.



- ✓ The board has clarity about its role and function, which is described in the memorandum of understanding, signed up to by all board members.
- ✓ Partnership working is established at all levels
- ✓ Partners are engaged in the safeguarding agenda and share a clear vision and commitment for safeguarding children
- ✓ Partners demonstrate mature relationships with respectful challenge.
- ✓ The LSCB has strong links with other strategic groups and this ensures that priorities for children are shared and embedded across the strategic partnerships
- ✓ The LSCB has responded quickly and proactively to national changes in safeguarding children in 2016/17. The 'Wood Report: Review of the role and functions of LSCBs' and the response from the government were published in 2016 with the Children & Social Work Act 2017 receiving Royal Assent in 2017. The reports set out changes about the strategic and statutory arrangements for the organisation and delivery of multi-agency arrangements to protect and safeguard children. The new arrangements include greater flexibility regarding local arrangements and that the three key agencies being the local authority, health and the police should determine the multi-agency arrangements for protecting and safeguarding children in their area. The LSCB in Barking & Dagenham have proposed a different structure beginning in the Autumn of 2017 that brings together the Chief Officers and Chairs from all the strategic partnership groups to act as a single 'umbrella'

group by which to lead safeguarding across the borough. It is envisaged that this will reduce crossover and duplication whilst incorporating safeguarding priorities across the partnership. The LSCB structure will be further reviewed in response to the revision of Working Together 2015.

### **What will we do next?**

The LSCB will further strengthen the case audit process to involve all board members

Case audits generate a huge amount of intelligence about effective local practice and areas of development. During 2017/18 we will communicate with practitioners and use these areas of learning to change practice.

## Priority Three: 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

### What have we done?

Learning from National Serious Case Reviews indicates that in too many cases the child was not seen enough by professionals involved, or was not asked about their views and feelings; that agencies did not listen to adults who tried to speak on behalf of the child; that parents and carers prevented professionals from seeing and listening to the child and that practitioners often focused on the needs of the parents, overlooking implications for the child.

The LSCB has a Young People's Safety Group as part of its structure. The Young People's Safety Group continues to be a popular forum through which the borough's schools can engage collectively around issues of safeguarding. The existence of the Group allows the LSCB to respond quickly to specific issues, such as theming the September 2016 meeting around Serious Youth Violence.

The dissemination of key messages by schools following each meeting, ensures that the learning goes beyond just those young people that attend the sessions. In addition, the identification of two key questions for the Board following each meeting retains a strong and progressive two-way link between the YPSG and LSCB.

A survey regarding the Young People's Safety Group has recently been conducted with schools. Results indicate that schools largely value the sessions, but would like additional resources to use back in school linked to successive YPSG themes. Most schools share learning back in school (usually through pupil assemblies), which indicates that the issues and learning from the YPSG is having a wider reach than the meetings themselves.

We have listened to the views of children and young people and used these to inform best practice. For the second year, the Young People's Safety Group organised and 'took over' the November Board meeting as part of Young People's Takeover Day. Young People from the BAD Youth Forum, Young Carers and Arc Theatre, used presentations and 'round table' discussions for items they wanted the Board to take forward. This not only provided LSCB members with an insight into current safeguarding issues as experienced by the young people of the borough, but also provided an opportunity to ask questions, discuss these issues directly and plan actions to address the issues raised.

### What difference has it made?

The YPSG continues to triangulate LSCB priorities with the needs and wishes of young people and local triggers, such as Serious Youth Violence. The delivery of a Young People's Takeover Day session in November 2016 helped provide some new priorities for the Group, particularly around substance misuse, which is a theme that has not been explored by the YPSG for some time.

Link the work of BDSCB members to the YPSG and provide them with opportunities to consult with young people.

Ensures participation from all schools in the YPSG. Meeting dates and themes for YPSG are planned for the academic year and align with BDSCB priorities

### **What will we do next?**

More detailed analysis is needed of YPSG participants to accurately monitor participation from vulnerable groups and act in response.

Discussions have been held with the Barking College regarding their participation in the YPSG. The College have launched a student forum, which is looking to link with the work of the YPSG and BAD Youth Forum. The College are seeking to send representatives to future YPSG meetings and to potentially host future meetings. YPSG themes may also be explored through their own student voice forum.

## Priority Four: Arrangements for Early Help will be embedded across agencies in Barking & Dagenham who work with children, young people, and their families.

The Early Intervention Foundation states that “early intervention involves identifying children and families who may be at risk of running into difficulties and providing timely and effective support”. The terms ‘early intervention’ and ‘early help’ are used interchangeably, and describe a range of services, programmes or interventions to help children and families resolve problems before they become more difficult to reverse or require more interventionist support.

Early Help services in Barking & Dagenham are changing to include the triage of early help through the Multi-Agency Safeguarding Hub (MASH) or Single Points of Entry and multi-agency support. Known as Community Solutions, the changes have been part of deliberate change to provide more efficient and targeted support, transforming the role of services from a ‘fixer of problems’ to a stimulator of family owned change.

The Integrated Working Team currently covers the CAF support across the borough, by supporting practitioners to identify children with additional needs, complete an assessment to identify the areas that would benefit from support and help in deciding what

services to put in place to support the child, young person, or their family.

The team oversees three Multi Agency Panels (MAPs) that receive all the Police MERLINS that have been rated as ‘Green’, referrals that do not meet the threshold for social care, step down assessments from the assessment team and case presentations from staff either in or out of borough with a concern for a child, young person, or family where they would benefit from a targeted intervention. Of the Total Number of referrals to MAP’s – 4404 - 3206 (72.7%) were made up of MERLINS rated ‘Green’. Of these: Number escalated to Social Care: 172 / 5.3%

Number referred to YOT: 106 / 3.3%

Number allocated to a Targeted Service: 963 / 30%

Number allocated to a Universal Service: 830 / 25.8%

Number closed as No Targeted Intervention Required: 1134 / 35.3% (Cases can be closed to MAP as no targeted intervention required either once the MAP chair has undertaken the screening, or after the case has been discussed at a MAP meeting and a task has been undertaken, for example a home visit to clarify the concerns in the referral received or when families decline services).

The team provides multi-agency training on CAF throughout the year through a 1-day course named Integrated Working Through Information Sharing and Assessment (IWISA) and CAF briefings that

are half a day. The Integrated Working Team is represented on the LSCB Multi Agency Audit Group as well as completing single agency audits.

### What have we done?

- ✓ Work has been undertaken to clarify thresholds with partners to ensure a more consistent application and to reduce a 'risk averse' practice by some partners reluctant to apply the threshold.
- ✓ The team has moved into the second year of traded services to schools for CAF support. Over forty schools have bought into the traded services for 2016-17, which was the second year of being a Traded Service. The team has continued to support schools in the CAF process, supporting the settings with their processes for recording, identifying children with additional needs and with data for Governors reports and Ofsted visits. The team has undertaken briefings at the schools to ensure they are aware of the process of CAF and highlighting any concerns and areas of good practice. The team also supports schools with their threshold application for referrals to social care and other services.
- ✓ The Multi-Agency Panels worked with the Police and Social Care to agree a Pathway for the 'Green MERLIN's to be passed straight to the Multi-Agency Panels rather than going to MASH, which has greatly reduced the number of contacts needing to be screened at the 'front door'. The process for Green

MERLINS to be passed through began in January 2016 and has continued to date. During 2016-17, the team worked closely with Social Care and Police colleagues to ensure the threshold applied was consistent, met with Police staff to advise them of the Multi-Agency Panel processes to ensure they are aware of the Early Help response and continued to escalate MERLINS to social care where a safeguarding concern has been identified.

- ✓ A team member now attends the MARAC and MASE meetings to provide information from a CAF and MAP perspective to assist the multi-agency discussion for families.
- ✓ The Barking and Dagenham Early Intervention Worker works in partnership with BHRUT Safeguarding Team and supports front line staff across the organisation in accessing services for children and families. There is demonstrative evidence that this post holder has worked alongside staff and families as the number of referrals increased during this reporting period.
- ✓ The CAF is now in use within the Midwifery Department, Neonatal Unit, Paediatric Wards, Children Home Care Team, Emergency Department, and Sexual Health in Queens Hospital.
- ✓ Trust Staff are provided with CAF training as part of level 2 and 3 Safeguarding Children training and BHRUT continues to be supported by an Early Intervention Worker.
- ✓ During the reporting period 283 Pre CAFs were completed by front line staff.
- ✓ A Liaison Social Worker and an Early Intervention Worker (EIW) are based within the Safeguarding Children Team at Queen's Hospital, providing advice and support for the

Emergency Departments, Maternity and Paediatric inpatient areas. The EIW supports the completion of Pre CAFs in the clinical areas and in the community, and helps with the facilitation of Pre-CAF training at mandatory update meetings for staff. The Social Worker attends all Psychosocial and Maternity Partnership meetings across sites.

**What difference has it made?**

The continued support to schools is valued and has ensured that the working relationships between the team and the settings has been maintained.

The team have enabled long term relationships which has been a factor in the success of the Traded Services.

It has allowed a varied focus including new ways of working with schools, for example, concentrating on specific groups of vulnerable children, supporting the schools to design new recording systems and identify training gaps for staff.

The receiving of the Green MERLINS has ensured that the number of contacts to social care has reduced. It has also meant that families that require targeted support are receiving it sooner than they would have previously, as a level of screening has been removed by taking the social care element out of the process.

30% of the MERLINS now result in a targeted service being allocated to the families, whereas previously, it could have been dealt with by a MASH social worker and closed with no onward work undertaken. The team discuss cases where the threshold

needs some discussion through a MASH manager and have an agreed process for escalating cases to MASH.

The team’s attendance at MASH and MARAC has provided more Tier 2 information being shared to assist decision making. It has also assisted workers from a Tier 2 perspective being aware of a family being discussed at a MASE or MARAC meeting.

It has also assisted the team’s knowledge with screening of MAP cases, as the team now consider referrals to the MARAC meeting or is able to seek advice from a member of staff in that area.

**What will we do next?**

The schools will continue to be supported through the Traded Services offer and will have the opportunity to personalize the support that is on offer through the service level agreement.

The Green MERLINS will continue to be screened by the team and targeted and universal services will continue to be recommended. Cases will be escalated to MASH as and when required.

The multi-agency involvement and impact will be assessed and reported to the LSCB as the early help work moves into the new service of Community Solutions.

**Priority Five: 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.**

**What have we done?**

The LSCB has a Serious Case Review (SCR) Subcommittee and there is a robust scheme of delegation from the LSCB Independent Chair. All SCR decisions have followed the requirements in Working Together 2015.

The SCR committee has considered three referrals during the year:

- 1 did not meet the criteria for a Review
- 1 is being considered as a multi-agency Practice Learning Review
- 1 met the criteria for a Serious Case Review and will be published during the summer 2017

Following the last Serious Case Review – Child B published in 2015, there has been a substantial programme of awareness raising and publication of the lessons learnt to include, staff briefing sessions, presentations at strategic partnerships, staff information included in the LSCB newsletter and incorporated into training.

A multi-agency audit has been undertaken and jointly co-ordinated by a Quality Assurance and Audit officer on behalf of the LSCB and the Named Nurse – Safeguarding Children NELFT. The case was raised using the LSCB Escalation process. All practitioners with involvement in the case met with the two auditors to describe their involvement in the case and the outcomes and learning from the subsequent report was agreed and signed off by the agencies represented at the Performance, Learning & Quality Assurance sub group and disseminated to practitioners through a learning day. Learning points were also included in the LSCB Training plan.

A multi-agency audit on Neglect using the Ofsted JTAI Framework has been carried out and outcomes reported to the BDSCB.

Work on the Ofsted improvement action plan put in place in 2014 has continued to be reviewed to ensure that recommendations and actions completed.

The key elements of practice that remain a focus, include the quality of referrals, assessment work and planning, capturing and being influenced by the voice of the child and ensuring good supervision and management oversight.

The CQC carried out an unannounced inspection in the Barking, Havering, Redbridge University Trust (BHRUT) in September and October 2016, to review progress of the improvements that had been implemented, to apply ratings, and to make recommendations on the status of special measures.

The resultant report identified that the Safeguarding Team had made significant progress in ensuring that it effectively executes its duties and responsibilities by maintaining a focus on the welfare of all children and young people, adults, and services users. The result of this progress meant the Trust has been removed from ‘special measures’.

The National Probation Service National Safeguarding Reference Group has produced an Action Plan with many key themes; learning from DHRs, SCRs, audits, inspections, etc. It was instrumental in the Safeguarding Children launch in the last financial year within NPS and it has also promoted an Audit Tool for Assurance Processes.

#### What difference has it made?

- ✓ Better understanding of the use of all multi-agency meetings and attendance thereby improving communication
- ✓ Highlighted the lack of local knowledge about what is available for families experiencing domestic abuse.
- ✓ Arrangements to distribute invitations, minutes, and update about child protection plans, particularly with Health agencies is better understood
- ✓ Review of communication re safeguarding processes in paediatrics
- ✓ Poor use of CSE risk assessment tool across agencies
- ✓ Multi-agency neglect ‘task -to-finish’ group set up to consider the requirements of the JTAI across the partnership

#### What will we do next?

A Meeting Matrix has been compiled setting out what each multi-agency meeting is for and circulated across the partnership, placed on the LSCB website and in procedures

Update of directory listing DV services locally & nationally. Two MARAC workshops held. Review of DV training for frontline staff.

Generic e mail accounts have been set up across the health agencies and a revised document for the setting up of CP Conferences for social work staff

Review and revision of pathway, including documentation and nursing input on ward rounds

CP IRO’s will ensure CSE and the risk is included in plans for children and young people. CSE Champions training to include the use of the CSE tool.

The JTAI group will progress actions arising from the Neglect audit and initiate work across adult services, including the SAB to review understanding of staff working with adult substance and alcohol misuse where they are parents to reduce neglect.

The findings from the serious case review for Child B have been disseminated to staff across the service during 2015-16 but this also carried over in to 2016-17 to complete implementation of the actions, which included:

- guidance about practice for pre-birth assessments;



- training on working with fathers; and
- further communication about resources for working with domestic abuse and substance misuse.

## 12. Direction of Travel

This Annual Report provides evidence of changes in activity, characteristics of the Borough and the needs of children and young people. Collectively, it presents a busy terrain of interlocking factors, challenges, and enablers. Being able to focus on what has, or could have the biggest impact and identifying those which offer both challenge and support improvement is critical for the coming year.

The year 2017-18 will see significant organisational changes which will include:

- supporting the safe transition of management of the Multi-Agency Safeguarding Hub (MASH) across to the new Community Solutions service.
- The Youth Offending Service (YOS) will be managed within Children's Care & Support.
- The Disabled Children's Team will join the Disability Service for all ages.

Another key development to note for 2017/18 is that the Children's Assessment and Care Management services will be aligned to the new locality model for health and social care.

This will enable closer working relationships to develop between, for example, schools, health services and children's services. There will be closer links with the Multi-Agency Partnership (MAP)

arrangements for the localities and this will bring benefits through strengthening working relationships for early help.

Two new initiatives are planned for 2017/18.

Implementation of the '**Pause Practice**' for work with women who have had children removed and to prevent repeat removals into care.

**Caring Dads** groupwork which aims to support fathers who are a source of safeguarding concerns to focus more on the needs of their children. These initiatives will be reported on in the next Annual Report.

### Challenges

- To develop the right culture that is less 'risk averse'
- Improvement in the collation and reporting of data and performance management across all agencies
- Workforce – the recruitment and retention of staff across all agencies is a challenge. Attracting staff with experience and reducing 'churn' as staff move around London due to greater incentives has been a difficulty.
- The level of risk and vulnerability of children is likely to increase because of the social and economic pressures on families.
- Children's needs are becoming increasingly complex
- Improvement in the Metropolitan Police after the HMIC inspection in 2016 and the regional changes to work across a tri-borough in east London.

## 13. Priorities for 2017-18

### 1. Board members are assured that arrangements are in place to identify and safeguard groups of children who are particularly vulnerable

- Learn from the feedback from Missing children and Return Interviews.
- The local Problem Profile will be updated to inform the local picture of the prevalence of CSE to enable resources to be targeted.
- The Neglect Strategy and Action Plan and multi-agency tool will be reviewed and updated.
- Review the current structure to ensure it is fit for purpose and meets the requirements of the Children & Social Work Act 2017.
- Whilst there are links with other key strategic boards in Barking & Dagenham there is a need for further development to ensure clarity regarding key responsibilities, identifying areas of joint work, and linking agendas
- Review the LSCB budget and agency contributions against LSCB requirements

- Challenge greater engagement amongst LSCB members in terms of support in leading or chairing groups
- ### 2. Board partners will own and share accurate information which informs understanding of safeguarding practice and improvement as a result
- The performance information for 2016-17 shows some change in the volume of traffic at the front door through reductions in the number of referrals being received and the number of open cases.
  - It is important for the safeguarding partnership to understand the complexity of cases and the increase over the year in the numbers of children subject to child protection plans and becoming looked after. This complexity leads to pressure on caseloads across all agencies.
  - There is limited data available from some partners, so we must review and establish a performance data set and dashboard to develop a partnership understanding of the story behind the data and provide the LSCB with assurance about safeguarding arrangements
  - The LSCB will further strengthen the case audit process to involve all board members and ensure that practice is improved 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**

- The arrangements to embed the voice of the child into LSCB business and the work of the sub-groups must be more robust and ensure that their voice makes a meaningful difference
- More detailed analysis is needed of YPSG participants to accurately monitor participation from vulnerable groups and act in response.

**4. Arrangements for Early Help will be embedded across agencies in Barking & Dagenham who work with children, young people, and their families**

- The current trends highlighted in the analysis of data demonstrate the need for continued analysis, understanding and discussion about demand for services in the Borough and how this is managed. Most particularly what further can be done about prevention and early help at a challenging time of demographic change and of reduced resources, including the impact of Community Solutions.
- The multi-agency involvement and impact will be assessed and reported to the LSCB as the early help work moves into the new service of Community Solutions.

**5. Board partners will challenge practice through focused reviews or audit based on performance indicators, practitioner experience and views from children and young people. Collectively we will learn and improve from these reviews.**

- Re-refresh the multi-agency CSE Operational strategy and action plan and update the CSE Problem Profile
- Put children’s needs onto the public health agenda. Develop an understanding of the relationships between public health concerns such as domestic abuse; sexual health; neglect and poverty and the health and wellbeing of children and young people. Identify triggers to support joined-up commissioning and service delivery.
- Assist frontline practitioners and CP IRO’s reflect on the causes and broad categories of emotional abuse and neglect - the two main categories used for Child Protection Plans.
- The JTAI group will progress actions arising from the Neglect audit and initiate work across adult services, including the SAB to review understanding of staff working with adult substance and alcohol misuse where they are parents to reduce neglect.

## Appendix 1: Finance

### Income

Partner Contributions	£
LBBB Children's Care and Support	92,240
LBBB Housing	10,221
Barking, Havering, Redbridge Hospital Trust (BHRUT)	3,716
North East London Foundation Trust (NELFT)	3,716
Barking and Dagenham Clinical Commissioning Group	37,034
Police	5,000
Children & Family Court Advisory and Support	550
National Probation Service (NPS)	1,050
Community Rehabilitation Company (CRC)	1,000
<i>Total Partnership Income</i>	<i>154,527</i>
Schools Forum	50,000
Fire Service	500
Training Income	12,252
<i>Additional Income</i>	<i>62,752</i>
<i>Carried Forward 2015-16</i>	<i>98,048</i>
<b>Total BDSCB Income</b>	<b>315,327</b>

### Expenditure

Expenditure	£
BDSCB Chair	21,819
BDSCB Training	11,811
Staffing costs (including on costs)	59,338
Staff expenses	735
Serious Case Review	8,495
Other	2,856
<b>Total BDSCB Expenditure</b>	<b>105,054</b>

### Balance

<b>Total Income</b>	<b>315,327</b>
<b>Total Expenditure</b>	<b>105,054</b>
<b>Carry forward 2017-18</b>	<b>210,273</b>

This page is intentionally left blank



# Safeguarding Adults Board Board Annual Report 2016 - 17



---

# Contents

---

	<b>SECTION</b>	<b>PAGE</b>
<b>Foreword</b>	<b>1</b>	<b>3</b>
<b>Introduction</b>	<b>2</b>	<b>5</b>
<b>The SAB's Vision</b>	<b>3</b>	<b>8</b>
<b>The Board and Committees</b>	<b>4</b>	<b>9</b>
<b>Safeguarding at a Glance</b>	<b>5</b>	<b>11</b>
<b>SAB Progress Against Priorities</b>	<b>6</b>	<b>12</b>
<b>SAB Self Assessment</b>	<b>7</b>	<b>13</b>
<b>Partnership Achievements and Challenges</b>	<b>8</b>	<b>17</b>
<b>Safeguarding Adult Reviews</b>	<b>9</b>	<b>20</b>
<b>Learning and Development</b>	<b>10</b>	<b>22</b>
<b>Performance and Assurance</b>	<b>11</b>	<b>24</b>
<b>External Inspections</b>	<b>12</b>	<b>26</b>
<b>Partnership Priorities for 2017/18</b>	<b>13</b>	<b>29</b>
<b>Healthwatch</b>	<b>14</b>	<b>31</b>
<b>Further Information About Safeguarding</b>	<b>15</b>	<b>32</b>





**Foreword by Sarah Baker, Independent Chair of the Barking and Dagenham Safeguarding Adult Board.**

Welcome to the 2016/17 Annual Report of the Barking and Dagenham Safeguarding Adults Board (SAB). The Annual Report presents the work of the Safeguarding Adults Board as it works under the auspices of the Care Act 2014.

I have been the independent chair of London Borough Barking and Dagenham Safeguarding Adult Board since October 2014. This is a statutory post as set out in the Care Act 2014. My job is to hold agencies to account for the effective coordination of the commissioning and provision of services for adults, to ensure that adults at risk are safeguarded. I provide independent challenge so that each Board agency partner and their representatives are held to account.

To achieve this, I have quarterly governance meetings with the Leader of the Council, the Lead Member for Social Care and Health Integration, the Chief Executive of London Borough Barking and Dagenham and the Strategic Director of Service Development and Integration. I also have one to one meetings with the Strategic Lead officers for the statutory partner organisations on a regular basis. These meetings are effective in influencing the SAB agendas for successful delivery of the SAB business plan. Meetings are well attended by partners and the Lead Member for Social Care and Health Integration attends the SAB meetings so that she is informed and can provide effective challenge to Council officers.

My evaluation of the SAB business plan is that partners have successfully completed five of the eight priorities set out in the business plan, however there is more work to do against the remaining three priorities. At the same time, the SAB has been proactive in responding to emerging issues including the CQC inspections at BHRUT and NELFT and serious incidents in general practice.

I attend the Health and Wellbeing Board and have had the opportunity to contribute to debate and discussion to ensure safeguarding issues are considered with the wider health and social care agenda. I also presented the SAB Annual report for 2015/16.

I am also the independent chair of the Barking and Dagenham Safeguarding Children Board. This has provided the opportunity to consider safeguarding issues across adults' and children's services, including hoarding and associated fire and mental health issues. I use my knowledge from both boards to make links and find solutions for children and families. Examples of joint work include working with the fire brigade and workshops on hoarding.

The SAB evaluated itself against the Care Act 2014 and whilst progress has been made from last year's audit there is still work to do to ensure full compliance. Key areas of focus are:

- advocacy
- Mental Capacity Act and Deprivation of Liberty
- Making Safeguarding Personal, and
- information sharing.

The SAB has set up the Multi Agency Safeguarding Case File Audit group, inviting practitioners to present cases identifying best practice, safeguarding issues and areas for development. It was interesting to note that the areas for front line development mirrored those featuring in the Care Act Compliance audit as above.

This year the SAB has commissioned three Safeguarding Adult Reviews (SARs), one of which will not be completed until later in 2017. A more detailed account of the completed SARs is available at chapter 9. Themes arising from both completed SARs include discharge planning and application of the Mental Capacity Act. The SAB will be providing briefings for staff across the partnership and reports for completed SARs have been published on the SAB webpages of the London Borough of Barking and Dagenham website.

The Barking and Dagenham SAB is a multiagency partnership and is much more than the sum of its parts. Managers and front-line practitioners across the partnership all work extremely hard under significant resource pressures with some of the most vulnerable adults in Barking and Dagenham. There is always much work to do but I am confident that will continue to give the highest priority to safeguarding adults as already demonstrated through their commitment and attendance at SAB meetings, engagement in multi agency audit of practice, safeguarding adult reviews and SAB multi agency training.

The SAB partners have agreed the following priorities for next year:

- Making Safeguarding Personal
- Disseminate the Hoarding Policy
- Develop and embed the Performance and Quality Framework
- Increasing community awareness around safeguarding
- Enhance joint working with the CSP and LSCB
- Applying the Mental Capacity Act to practice.

I would like to thank all partners and front-line practitioners for their commitment to safeguarding adults in Barking and Dagenham.

*R Sach Bever*

Independent Chair of the Safeguarding Adults Board

The Care Act 2014 came into force on 1<sup>st</sup> 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 risk, abuse or neglect. The Local Authority, Clinical Commissioning Groups and the Police are all statutory partners of the Safeguarding Adults Board (SAB) and other partners are involved via the committees and working groups.

The Care Act identifies six key principles that should underpin all safeguarding work. These are accountability, empowerment, protection, prevention, proportionality and partnership.



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 (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.
- 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. Three SARs were commissioned during 2016/17 one of which will not be completed until later in 2017. An overview of the SARs is given in chapter 9.

This Annual Report of the Barking and Dagenham SAB looks back on the work undertaken by the SAB and its committees, throughout 2016/17 and provides an account of the work of the partnership including achievements, challenges and priorities for the coming year.

Over the past year partnership working, co-operation and involvement in adult safeguarding has been strengthened. This is evidenced through frontline engagement in learning events including the hoarding workshops, which has culminated in the development of a hoarding policy and the initiation of a Complex Case Panel.

All statutory partners make financial contributions to the Safeguarding Adults Board. For 2016/17 the partner contributions to the SAB were as follows:

CCG - £30,000

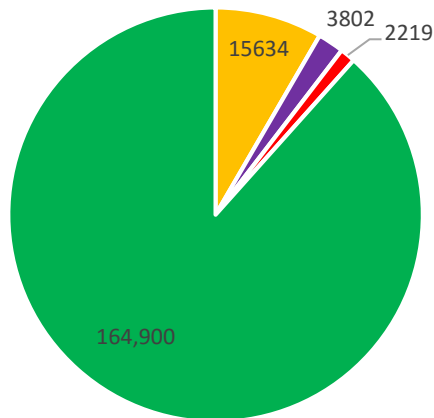
Police - £5,000

London Fire Brigade - £500

LBBB - £227,720 (including a Support Services budget of £164,900).

The following chart shows how the SAB budget has been spent in 2016/17. The majority of the budget covers support services including staffing costs (for the independent chair and the Safeguarding Adults Board Business and Policy Manager). The second largest spend is on Safeguarding Adult Reviews, followed by single agency reviews. The remaining spend enabled the board to deliver briefing events to share the learning from SARs and single agency reviews with front line practitioners and managers across the SAB partnership. These were very well attended and we reached out to around 170 professionals.

## SAB Expenditure (£) 2016/17



- SARs
- Single Agency Reviews
- Learning events & meetings
- Support Services

## Our Vision

Every adult living in the London Borough of Barking and Dagenham has the right to live in safety, free from fear of abuse or neglect. The Safeguarding Adults Board exists to make sure that organisations, people and local communities work together to prevent and stop the risk of abuse or neglect.

In the London Borough Barking and Dagenham we want to embed a stronger and safer culture that supports adults who are at risk of harm. We know that to achieve this we have to work in partnership with the people who use local services and with the wider local community. All agencies working with adults at risk have an essential role in recognising when these people may be in need of protection. Agencies also have a responsibility to work in partnership with adults at risk, their families, their carer(s) and each other. The introduction of the Care Act 2014 has brought in many changes in Adult Social Care Services. The Safeguarding Adults Board has a statutory duty to ensure it uses its powers to develop responsibility within the community for adults who need care and protection.

The prime focus of the work of the Safeguarding Adults Board is to ensure that safeguarding is consistently understood by anyone engaging with adults who may be at risk of or experiencing abuse or neglect, and that there is a common commitment to improving outcomes for them. This means ensuring the community has an understanding of how to support, protect and empower people at risk of harm. We want to develop and facilitate practice which puts individuals in control and generates a more person-centred approach and outcomes.

The Safeguarding Adults Board has developed a Strategic Plan which sets out how we will work together to safeguard adults at risk.

The Safeguarding Adults Board has a responsibility to:

- **protect** adults at risk
- **prevent** abuse occurring, and
- **respond** to concerns.

You may suspect that someone is at risk of harm because:

- you have a general concern about someone's well being
- you see or hear something which could put someone at risk
- someone tells you that something has happened or is happening to them which could put them or someone else at risk.

---

# The Board and its Committees 4

---

The Barking and Dagenham Safeguarding Adults Board is made up of the following statutory partners:

- The Local Authority (representing Adult Social Care and Children's Services)
- The Borough Police
- The Clinical Commissioning Group (CCG).

Other members of the Board include:

- Chairs of the Committees
- Officer advisors.

In addition, the SAB may invite other organisations or individuals to attend and speak at the meetings where they have contributions to make.

The SAB has three standing committees, which are chaired by different partner organisations:

- The Performance and Assurance Committee (chaired by the Clinical Commissioning Group)
- The Safeguarding Adult Review Committee (chaired by the London Borough of Barking and Dagenham)
- Learning and Development Committee (chaired by North East London Foundation Trust).

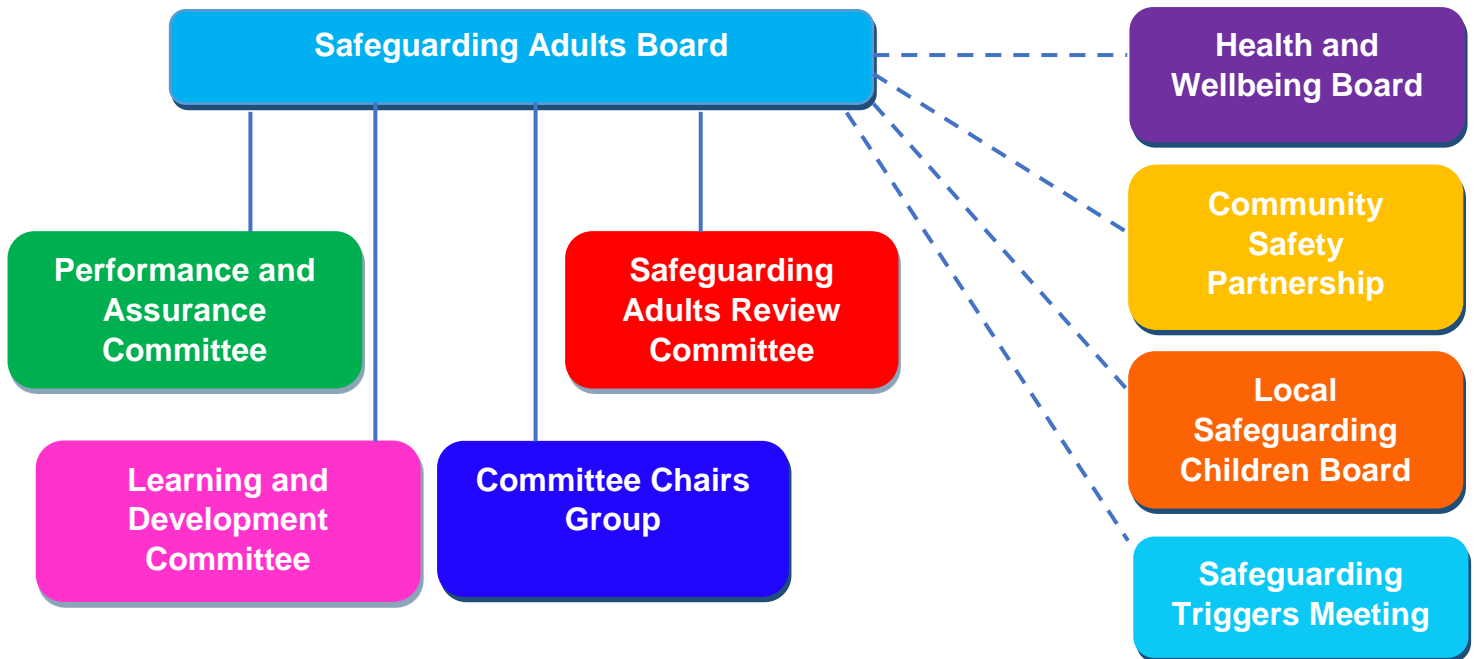
The Chair of each committee is responsible for:

- Developing a work programme which will be incorporated into and monitored through the SAB strategic plan.
- Resourcing the meetings of the committee.
- Reporting on the progress of the committee's work to the SAB and ensuring that the membership of the committee draws in the required experience.

The independent chair of the SAB meets quarterly with the committee chairs to provide a forum for reviewing progress of the work plans and to discuss and debate specific topics to progress their work.

Working groups have also been established by the SAB to undertake specific pieces of work on behalf of the board.

## The Safeguarding Adult Board Structure



The independent chair is the chair of both the Barking and Dagenham Safeguarding Adults Board and the Safeguarding Children Board. This allows for opportunities to consider safeguarding adults and children at risk, and the issues affecting both.

The independent chair attends the Health and Wellbeing Board to allow for further consideration and debate regarding the issues of safeguarding within the agenda.

The independent chair meets quarterly for a *Triggers Meeting* with the Leader of the Council, the Lead Member for Social Care and Health Integration, the Chief Executive of the London Borough of Barking and Dagenham and the Deputy Chief Executive and Strategic Director for Service Development and Integration, to review performance data for adult social care, including workforce data and associated risks and mitigation. This allows for open debate, discussion, challenge and demonstrates a climate of openness and transparency.

Partners' attendance at the SAB in 2016/17 was as follows:

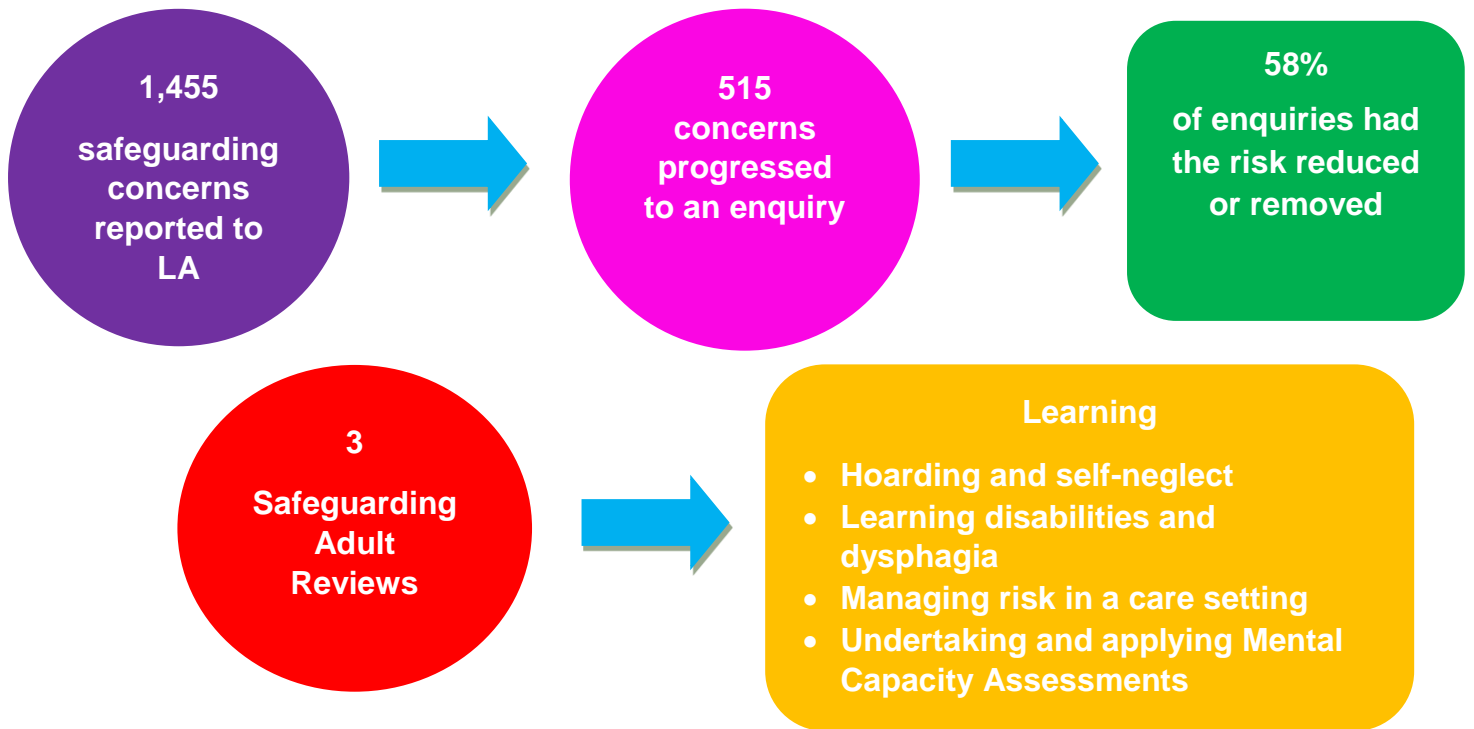
Independent Chair	100%
London Borough of Barking and Dagenham	100%
Police	100%
Clinical Commissioning Group	100%

The board is supported by the Lead Member for Social Care and Health Integration as a participant observer. This enables Councillor colleagues to be kept up to date with safeguarding adult matters. In addition, the Committee Chairs and officer advisors also attend board meetings.

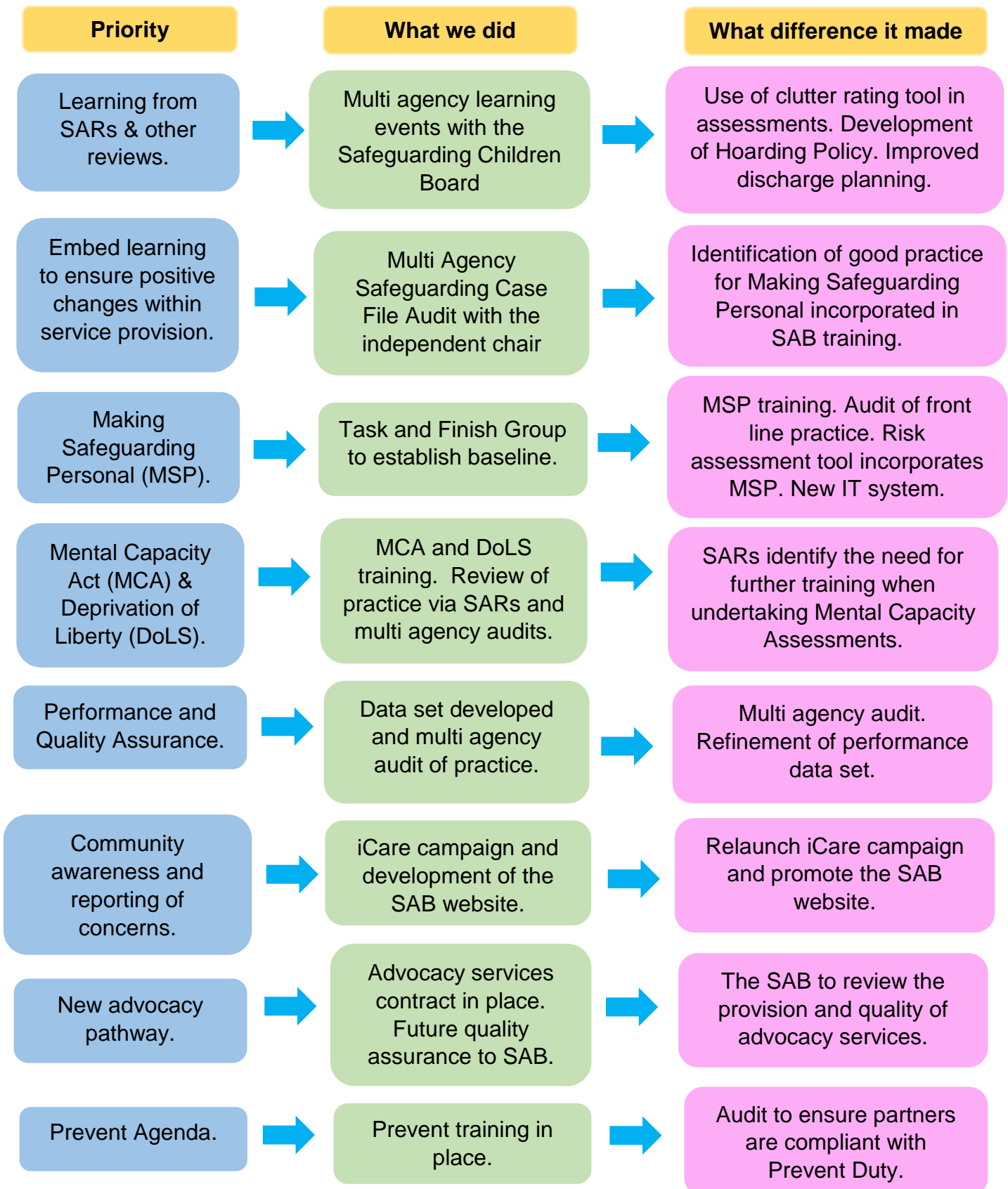


# Safeguarding at a Glance

5

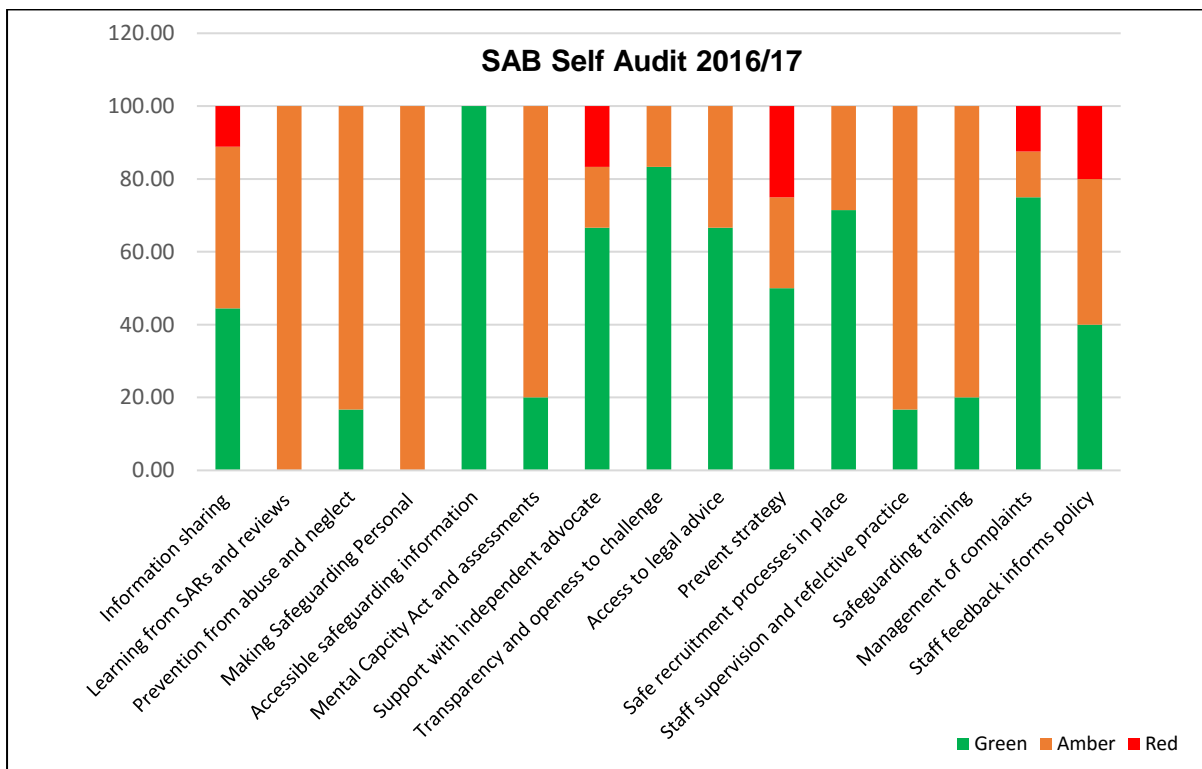
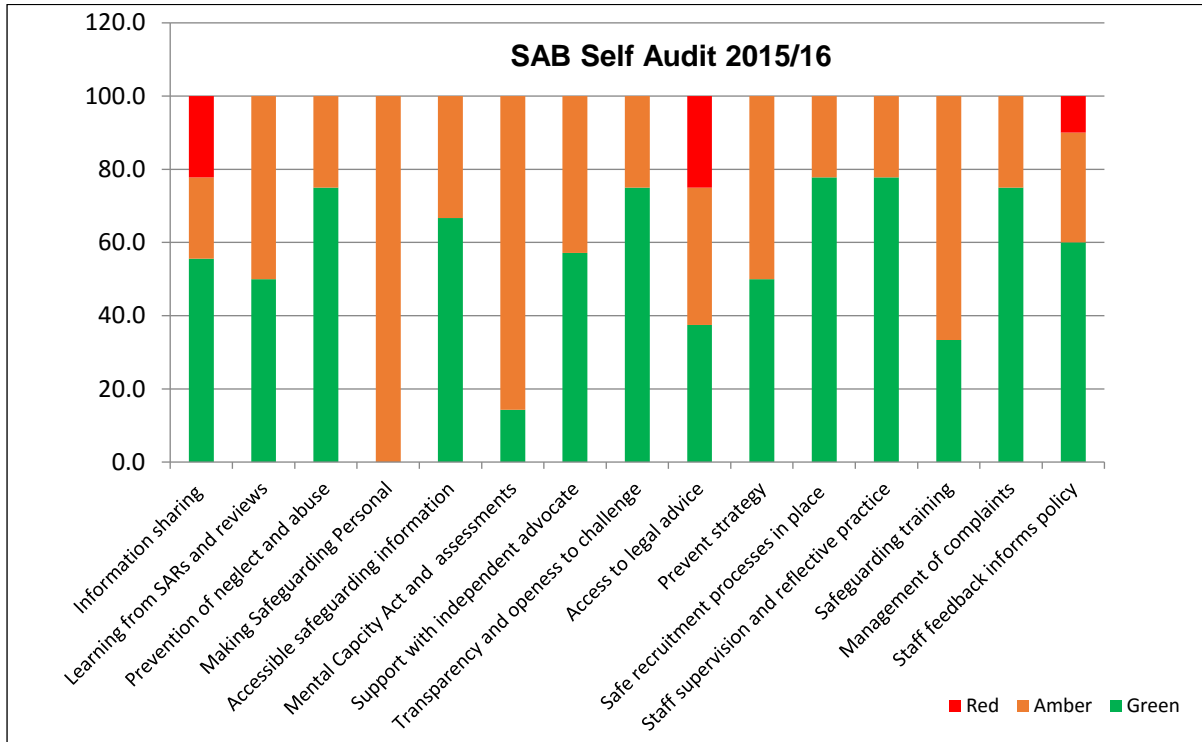


# SAB Progress Against Priorities 6



# SAB Self Assessment

The Safeguarding Adults Board holds an annual development session to review progress against the Care Act and the priorities from the previous year. The graphs below shows the results of the SAB's self-audit in 2015/16 and 2016/17.



At the March 2017 development session, the partners undertook a self-assessment of the work of the SAB. This graph shows the partners' analysis across a number of areas for 2016/17.

Comparison of the scores for 2015/16 and 2016/17 show that whilst the SAB has made progress in some areas, there are areas where the SAB partners believe that progress has slipped. This is particularly evident in relation to the learning from Safeguarding Adult Reviews. Board members scored the partners as amber overall. This relates to a concern that whilst learning is disseminated there is evidence that this is not being embedded in practice as similar themes are arising in subsequent reviews.

Making Safeguarding Personal remains amber. This has been identified throughout the year as an area for requiring further work. A working group was established to undertake some background research.

The self-assessment identified that compliance with the Mental Capacity Act remains low. This accords with findings from SARs undertaken this year. The Board will be working with partners to strengthen the confidence of practitioners in the application of the Mental Capacity Act in their practice. Staff supervision and reflective practice is being incorporated into the Multi Agency Case File Audit process led by the Independent Chair of the Board and supported by partner representatives.

Theme	What did we do?	Actions for the future
<b>Information Sharing</b>	Information sharing agreement and SAR Procedure which sets out information sharing requirements and commitments of partners.	Increase in information sharing across partners. Performance data information sharing processes need improvement.
<b>Learning from SARs and other reviews</b>	Learning events for SARs. Complex Case Panel in place. Development sessions to explore learning from Regulation 28 reports.	Strengthen learning from DHRs, SARs and national SARs. Measure the impact of learning from SARs.
<b>Making Safeguarding Personal (MSP)</b>	Audit tools and processes in place. Safeguarding Case File Multi Agency Audit used to identify examples of MSP. Complex Case Panel meetings to support practitioners to manage risk. Roll out of the risk management tool to front line staff.	MSP training programme to be developed. MSP learning to be incorporated into SAB Learning and Development programme. New IT system will make it easier to record MSP. SAB Audit Tool to be rolled out across the partners in 2017/18.

<p><b>Prevention from abuse and neglect</b></p>	<p>Care Act training in place. Adult Safeguarding Multi Agency Policies and Procedures adopted. iCare campaign information distributed. Training/resources available for hoarding and self-neglect cases. SAB web pages include resources for the community and professionals.</p>	<p>iCare campaign relaunch. Hoarding Policy to be agreed and launched. Disseminate information about the role of the Designated Adult Safeguarding Manager.</p>
<p><b>Staff supervision and reflective practice</b></p>	<p>Multi Agency Case File Audit and Complex Case Panel meetings to reflect on practice. Learning events for SARs and other reviews provide an opportunity for reflective practice.</p>	<p>The SAB requires further assurance that partners are providing supervision at all levels. Partners to review supervision process to ensure that they include safeguarding issues and MSP.</p>
<p><b>Mental Capacity Act (MCA) &amp; undertaking assessments</b></p>	<p>SARs have identified that undertaking MCA assessments and recording of information is still an issue. The Safeguarding Case File Audit provides an opportunity to explore the application of MCA in practice and recording of information.</p>	<p>Training on undertaking MCA assessments and recording of information.</p>
<p><b>Transparency and openness to challenge</b></p>	<p>Care Act Multi Agency Policy and Procedures training undertaken. Regulation 28 report board session. Challenge to partners in respect of demonstrating Duty of Candour, openness and transparency. Quality assurance work with provider market and CQC. Implementation of the safeguarding audit tool enables practitioners to assess themselves. Independent chair and SAR reviewers meet with clients and families.</p>	<p>Continue to raise challenges to ensure openness and transparency to safeguard adults at risk.</p>
<p><b>Safeguarding training</b></p>	<p>Single agency and multi agency training plan in place. Learning events related to SARs and other themes. Safeguarding online training available to providers. Adult Safeguarding Level 2 Training packages being implemented at GP Protected Time Initiative events.</p>	<p>Further development of multi agency training plan. The training programme needs to reflect learning arising from local and national SARs and other reviews.</p>

<b>Access to legal advice</b>	The SAB has access to legal advice which has informed decision making at board level. All front line practitioners have access to legal advice to support decision making at a case management level.	The SAB will access independent legal advice where required.
<b>Prevent strategy</b>	All partner organisations have Prevent training in place.	Continue to ensure Prevent training is available to all partners.
<b>Feedback informs policy</b>	Feedback from learning events used to inform policy and practice. Team meetings, one to ones and reflective practice give practitioners opportunity to review and feedback.	Work more closely with Healthwatch to contribute to questionnaires and surveys.
<b>Accessible safeguarding information available</b>	Multi Agency Safeguarding Policies and Procedures adopted and on website. iCare campaign undertaken. Production of an 'easy read' reviews guidance leaflet.	Continue to improve SAB web pages to provide accessible information to the community and professionals. Relaunch iCare campaign.
<b>Support with independent advocate</b>	Advocacy services contract in place. Language Shop contract in place to support people to access advocacy services.	Quality assurance reports to the SAB in relation to advocacy services.
<b>Safe recruitment processes in place</b>	Partners and commissioned providers follow safer recruitment guidelines including references, DBS checks and audit these processes.	The SAB to seek assurance that safe recruitment systems and processes are in place.
<b>Management of complaints</b>	Sharing of the Local Government Ombudsman guidance of complaints about SABs. Partners and commissioned providers have complaints and whistle blowing procedures in place.	The SAB to seek assurance that partners comply with their complaints and whistleblowing policies.

---

# SAB Achievements and Challenges

---

8

## SAB Achievements

The board and the committees have worked hard to establish effective partnership working and undertake work to improve safeguarding practice across Barking and Dagenham.

The Safeguarding Adult Review process has been tested and embedded with the commissioning of three SARs in 2016/17. Following the success of a hoarding training event that was the outcome of a single agency review, the board led further hoarding events, in partnership with the LSCB, recognising the safeguarding risk to children and other family members.

A Multi Agency Case File Audit is undertaken quarterly, led by the Independent Chair, to identify areas for improvement and also best practice that can be shared across the partnership.

As a result of single agency reviews, SARs and a Domestic Homicide Review, the Complex Case Panel has been set up to provide support to practitioners who are dealing with complex cases.

The board have undertaken a learning session around Regulation 28 reports and invited the Coroner and partners to share the learning that has been undertaken in relation to these.

There has also been partnership working around quality assurance reviews to improve standards in the care market.



## SAB Challenges

In June 2016 the Safeguarding Adult Board discussed Dr Haq, a General Practitioner (GP) who had practiced at Abbey Medical Centre, in Barking between 2004 and 2014. In March 2016 he was found guilty of five counts of indecent assault while working as a GP in Hatfield in the 1970s and early 1980s. He was jailed in March 2016 for 18 months.

Dr Haq has been removed from the General Medical Register and has not worked as a doctor since 2014.

This was reported in the media in March 2016. The SAB asked NHS England (London), in line with the Duty of Candour, how former patients at Abbey Medical Centre would be informed of the offences so that they could raise any concerns regarding the care they had received from Dr Haq. NHS England (London) were reluctant to inform patients, believing that because the case had been reported in the national press, patients who had concerns would have raised these. The board and



independent chair rejected this rationale and sought a more robust response from NHS England (London). Ultimately, after 11 months, in February 2017, all patients who were registered with Dr Haq, were written to by NHS England (London) and the national contact centre was available for any patient who wished to report an incident or ask for further information or advice.

The SAB invited the Medical Director from NHS England (London) to a board meeting to allow for lessons learnt to be identified. These included:

- The paramountcy of safeguarding all patients in line with The Duty of Candour.
- The role of the Local Authority Designated Officer in providing advice to safeguard adults and children at risk of harm.
- Cultural issues which may impact on patients feeling able to share sensitive information.
- Ensuring learning is shared across the General Practitioner community.

In addition to this, the SAB has undertaken a review to strengthen the Safeguarding Adult Review process, as a result of partnership issues regarding the agreement of findings, recommendations and final sign off of SAR reports.

# Safeguarding Adult Reviews 9

The Safeguarding Adult Review committee, under the Care Act, has responsibility for commissioning and leading on SARs and single agency reviews.



During 2016/17 the Safeguarding Adults Board commissioned three Safeguarding Adult Reviews. Independent reviewers were appointed to lead on these. The Safeguarding Adult Review Committee oversaw the reviews and presented the final report to the Safeguarding Adults Board for sign off and agreement for publication.

## Safeguarding Adult Review 'Lawrence Beasley'

The Safeguarding Adult Review Panel commissioned this review using the 'Learning Together' methodology. Two reviewers from Social Care Institute of Excellence (SCIE) led the review along with a 'review' group, who oversaw who undertook the conversations and gathered further information. The 'case' group were made up of front line staff from partner agencies who were interviewed and provided further information to the review. The review group and case group were given the opportunity to come together to discuss the 'key practice episodes' and the findings.

Lawrence was a 63 year old man living in sheltered accommodation. He had a medical history of Type II Diabetes, paranoid schizophrenia and hyperthyroidism. He received insulin injections twice daily from the district nursing service although sometimes he was not compliant with this. On 9<sup>th</sup> March 2016, Lawrence was admitted to hospital with haemoptysis. On 17<sup>th</sup> March 2016 Lawrence was discharged from hospital. He was found deceased in his flat on 21<sup>st</sup> March 2016.

The key findings from this SAR were:

- Managing safe hospital discharge

- Mental Capacity Assessments, and
- Managing risk.

### Safeguarding Adult Review 'Mary'

Mary was an elderly woman who lived on her own in Dagenham. During February 2016 several calls were made to the Police, regarding an intruder. These were unfounded. A merlin was raised and in early March a social care assessment was carried out. Mary was offered an extensive care plan but she was not keen to accept this. After some persuading Mary agreed to one visit per day (Monday to Friday only). On 9<sup>th</sup> June at around 5pm, Mary's neighbour called an ambulance as Mary was again complaining of shortness of breath. The ambulance took her to King Georges Hospital where she was seen in the emergency department, treated and identified as fit for discharge at around 9pm. Due to a shortage of available hospital transport Mary was not taken home until 5am on 10<sup>th</sup> June. The care agency attended to carry out the scheduled visit on the Friday morning, however the neighbour (who was unaware of Mary's return from hospital) told the carer she was still in hospital. He also voiced his anger at the carer about Mary's key being left in the door. He had taken in the key when it was discovered in the door rather than putting it back in the key safe. Mary was not due to have another carer visit over the weekend. The neighbour saw Mary on the Friday afternoon. The care agency did not attend on the Monday 13<sup>th</sup> June. On 14<sup>th</sup> June the neighbour called the police as he had not seen Mary for a few days. The police called for an ambulance and the ambulance crew found Mary deceased in her home.

The key findings from this SAR were similar to the previous one in terms of:

- Managing safe transfer home from the Emergency Department
- Effective communication and information sharing
- Mental Capacity Assessments, and
- Managing risk.

The third SAR that was commissioned in 2016/17 is still ongoing.

The full Safeguarding Adult Review reports and the executive summaries can be found at this link

<http://careandsupport.lbbd.gov.uk/kb5/barkingdagenham/asch/advice.page?id=cGthvG2UuNE>

The Learning and Development committee has responsibility for developing and commissioning the training plan for the SAB. The training plan is based on statutory requirements in line Care Act, recommendations arising from SARs and other reviews and emerging themes from multi agency audits and the Complex Case Panel.



The Safeguarding Adults Board, colleagues from partner organisations and the Safeguarding Children Board have led and taken part in a number of learning and development opportunities over the last year.

## Safeguarding Adult Review Learning

A learning event was held on the SAR RC case that was published at the end of 2015/16. The independent reviewer presented the case and talked through the findings. The learning event focussed on:

- Issues around people with learning disabilities and dysphagia
- Managing risks in a care setting
- Joint working
- The Mental Capacity Act
- What has been implemented to improve processes and practices in response to the case.

## Hoarding

Following a management review around hoarding that took place in 2015/16 and subsequent feedback which stated that further events would be useful, a hoarding learning event took place. Around 40 SAB partners and front line staff attended. There were presentations from a psychologist, the Fire Service and Environmental Services. Attendees took part in workshops and used the hoarding risk and audit checklists and looked at case studies to increase their knowledge and understanding of the issues facing hoarders. Positive feedback was received and a further event has taken place aimed specifically at commissioned providers. The SAB have developed a hoarding policy that includes hoarding assessment tools to support frontline practice.

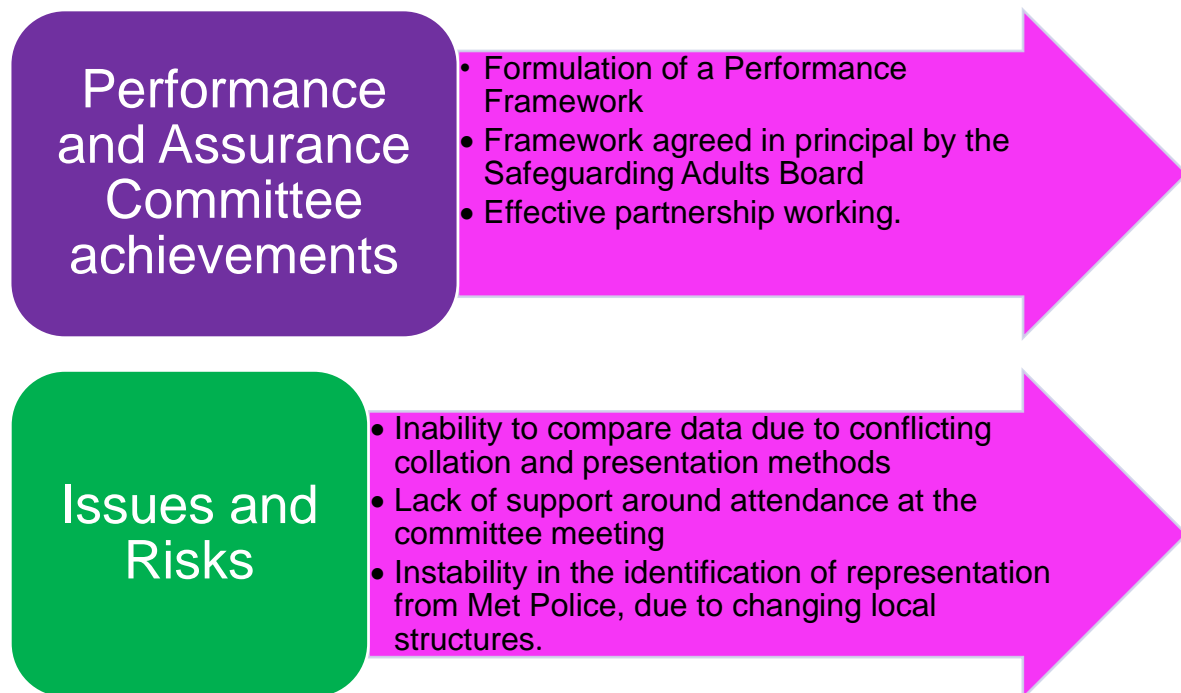


---

# Performance and Assurance 11

---

The Performance and Assurance committee has responsibility for developing the performance framework to enable the SAB to understand safeguarding performance across the partnership. This informs future quality assurance activity including audit and deep dives.



## Regulation 28

The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a 'report under regulation 28' or a 'preventing future deaths report'. The report is sent to the people or organisations who are in a position to take action to reduce the risk. They then must reply within 56 days to say what action they plan to take.

A number of these reports have been sent from the Coroner to our partners. The board invited the Coroner to a SAB meeting along with the partners, to give a verbal update on what measures have been put in place to ensure that similar issues do not occur in the future and how they intend to manage the risks. The SAB is interested in the safeguarding and learning from these reports and how it can facilitate learning across partners and organisations.

The board committed to undertaking learning from Regulation 28 report in the coming year.

## **Complex Case Panel**

A new Complex Case Panel has been set up. The purpose of this meeting is to share information on cases presenting with the highest risk and complexity. The panel is made up of representatives of the local authority, community health services, the environmental and housing services, the police, the fire brigade and other professionals, as and when required. The panel will consider complex cases that may require multi agency communication and approach to addressing risk. After sharing all relevant information about the adult at risk, the panel members will discuss options and support to address the issues. The main focus of the Complex Case Panel is to review the risk to the adult and consider other persons affected and the wider community. The panel will support professionals in decision making for ongoing case management.

## **Multi Agency Safeguarding Case File Audit**

The purpose of the Multi Agency Safeguarding Case File Audit meeting is to share, discuss and audit multi agency safeguarding practice. The aim is to gain greater understanding of practice, issues and challenges at the front line in order to encourage multi agency thinking and share the outcomes across the partnership. It also an opportunity for the SAB independent chair, to find out more about safeguarding processes in the borough and assess whether there is anything that the SAB partnership can do to improve or review systems and processes to support practitioners. The good practice and learning is shared more widely. Key themes have included Mental Capacity Assessment, Making Safeguarding Personal and management supervision.

## **Safeguarding Quality Assurance Audit**

A quality assurance audit process has been developed and implemented for safeguarding enquiries. The purpose is to assure the board of the compliance to the Care Act and the Multi Agency Adult Safeguarding Policy and Procedures across all partners. The results of the audit are being fed back to the board and managers to support them to take forward any learning with their staff. As a result, this has identified that compliance with the London Multi Agency Safeguarding Policy and Procedure was variable across partners. This has led to training with staff teams and providers and the development of a new safeguarding concern form to ensure compliance with the Care Act, as well as new tools for enquiry officers and Safeguarding Adult Managers.

## Barking Havering and Redbridge Unitary Trust (BHRUT) CQC Inspection

In 2013 the Trust was inspected by the Care Quality Commission (CQC) and due to concerns, was placed in special measures. The CQC returned to inspect the Trust in March 2015. Overall, the CQC found that improvements had been made, however it was evident that more needed to be done to ensure that the Trust could deliver safe, quality care across all core services.

The CQC carried out an unannounced inspection in September and October 2016, to review the progress of the improvements that had been implemented, to apply ratings, and also to make recommendations on the status of special measures.

The CQC inspected four of the core acute services including urgent and emergency care, medical care (including older people's care), services for children and young people, and outpatients and diagnostic services, at both the Queen's Hospital and King George Hospital sites.

To understand patients' experiences of care, the CQC asked the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The Trust has now come out of special measures.

The key safeguarding findings were:

- In line with statutory guidance the Trust had named nurses, named doctors, and safeguarding teams for child protection and safeguarding adults at risk.
- The safeguarding adult and children policies were available on the Trust intranet and were up to date. Safeguarding was part of the Trust's annual mandatory training.
- Staff we spoke with were aware of their responsibilities in relation to safeguarding adults and children. Staff were able to give examples of what would constitute a safeguarding concern and told us they would seek advice from senior staff members and the trust safeguarding team if they had any concerns.



- All staff we spoke with knew the safeguarding team and could identify where to find the contact details if required.
- There was a monthly safeguarding and learning disability operations group, where any issues around safeguarding or staff awareness of processes were shared.
- Staff had a good understanding of female genital mutilation (FGM) and knew they could access the safeguarding lead for any support.
- In the Emergency Department at the King George Hospital completion of safeguarding training by doctors was low. Compliance with safeguarding adults level 2 was 73% and safeguarding children level 3 was 60%.

Areas of safeguarding good practice identified were:

- A dedicated paediatric learning disability nurse had introduced support resources for patients, including a children's hospital passport and visual communication tools. This helped staff to build a relationship with patients who found it challenging to make themselves understood. This had been positively evaluated and received a high standard of feedback from parents and patients.
- Child to adult transition services were comprehensive and conducted with the full involvement of the patient and their parents. This included individualised stages of empowering the person to gradually increase their independence, the opportunity to spend time with paediatric and adult nurses together and facilities for parents to spend the night in adult wards when the young person first transitioned.

### **North East London Foundation Trust (NELFT) CQC Inspection**

The inspection took place in April 2016. Overall NELFT were rated as 'requires improvement'. The Trust had a number 'must do' actions that it undertook to improve care. As with the BHRUT inspection, the same five questions were asked of every service and provider.

The key safeguarding findings were:

- In the community health services there were major staffing shortages and recruitment challenges across all staff groups and localities. There was a high use of agency and bank staff across these services which impacted on the services provided.
- Within the community health services for adults there was a lot of variation in referral to treatment times for accessing specialist nursing services. The trust did

not have a system in place for monitoring referral times to treatment in district nursing.

- In acute inpatient settings risk assessments, risk formulations and care plans were not always being updated and reviewed.
- Patients' personal preferences were not always reflected in care plans. Not all patients had been given a copy of their care plan.
- Access to psychological therapies for people with mental health problems was not consistently provided across the trust.

Areas of safeguarding good practice identified were:

- 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. The service has been highly commended and has won a national patient safety award in partnership with the London Ambulance Service.
- The trust had a positive approach to equality and diversity amongst its workforce. Their work on this agenda led to the trust winning the inclusive networks award. The trust had been nominated for the Diverse Company of the Year award at the National Diversity Awards 2016 and had been 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.

Following the CQC inspection a Quality Summit was held where an action plan to address areas of improvement was agreed with partner agencies which is being taken forward.

# Partnership Priorities for 2017/18

13

The board considered the work of the SAB in light of the changing context of health and social care and of partner organisations, emerging risks and financial pressures. The board recognises the need to have oversight of safeguarding practice to ensure that quality of care is not compromised. The SAB has a role to play in supporting the workforce across the partnership, ensuring that they have the skills and competencies to fulfill their roles.

*"Some thoughts on future challenges..."*

Barking & Dagenham  
Safeguarding Adults Board  
Development Session  
22 March 2017

Mark Topp  
Communications Director, Adults' Care & Support



## Safeguarding Adult Board Priorities for 2017/18

The Safeguarding Adult Board priorities for 2017/18 are set out below. These are incorporated into the SAB's strategic plan and committee work plans.



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 believes 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 to ensure that this continues to happen.

---

# 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](mailto:intaketeam@lbbd.gov.uk)

### Out of Hours Emergency Social Work Duty Team

020 8594 8356

[intaketeam@lbbd.gov.uk](mailto: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.



## “CQC finds continued improvement at London Ambulance Service and praises ‘Outstanding’ staff”

### London Ambulance Service CQC report

#### Improvements since our last inspection:

- **Improvements made in every one of the five inspected areas** – the Service has moved up a rating to **Requires Improvement**
- ☆ Londoners are receiving **Outstanding** care from staff who ‘go the extra mile’
- Effectiveness has improved from Requires Improvement to **Good** with significant improvement in emergency preparedness, resilience and response
- Responsive has improved from Requires Improvement to **Good**
- Safe and Well-Led domains have improved from Inadequate to **Requires Improvement**.

#### Key findings:

- Our patients report staff go ‘the extra mile’ and told inspectors they were very positive about the service they received and the way they were treated
- Significant improvements had been made in Emergency Preparedness Resilience and Response. Response times to incidents classified as a HART (Hazardous Area Response) had been met
- Patients could receive advice from clinicians in order to manage their own health, including advising patients of alternative services, such as their GP or local urgent care centres
- Different parts of the service worked well together. The services were co-ordinated to support seamless care, admission avoidance and alternative care pathways
- The service was able to cope with different levels of demand, and was accessible via a number of routes
- The governance arrangements were much stronger and organised in a manner which enabled better scrutiny and oversight
- There had been a shift in the culture across all areas, and generally staff were positive about working for the Service
- Staff were supported to access training and had their skills and competencies assessed. There were opportunities for development, eg. through the Advanced Paramedic Practitioner role.

#### The CQC highlighted several areas of outstanding practice, including:

- Staff behaviours and interactions which demonstrated outstanding care, with staff committed to providing a caring and compassionate service, recognising and respecting the totality of people’s needs
- Employment of mental health nurses in our control room to provide expert opinion and assistance to frontline staff attending patient’s with a mental health condition
- Our maternity education programme and employment of a consultant midwife to support and guide staff.

#### Further improvements:

We still have work to do to:

- Improve uptake of mandatory training
- Enhance our infection prevention and control practices
- Further improve our medicine management
- Allocate ambulance personnel appropriately and ensure protected time for vehicle checks
- Improve the leadership and management style across the Trust
- Meet our performance targets for highest priority calls.

During our inspection we observed – and people told us – that staff were providing excellent care.

“There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people’s dignity. Relationships between staff and people who used the service, were strong, caring and supportive. Staff recognised and respected people’s needs. They always took people’s personal, cultural, social and religious needs into account.”

“Overall, the trust has made sustained progress since our last inspection.

**CQC Chief Inspector of Hospitals,  
Professor Sir Mike Richards**

This page is intentionally left blank





# ACTION NOTES

**Meeting:** Integrated Care Partnership Board

**Date:** Wednesday 28 June 2017

<b>Attendees:</b>	Maureen Worby (Chair)	<b>MW</b>	London Borough of Barking and Dagenham
	Conor Burke	<b>CB</b>	BHR CCGs
	Dr Atul Aggrawal	<b>AA</b>	Havering CCG
	Kash Pandya	<b>KP</b>	BHR CCGs
	Richard Coleman	<b>RC</b>	BHR CCGs
	Anne Bristow	<b>AB</b>	London Borough of Barking and Dagenham
	Barbara Nicholls	<b>BN</b>	London Borough of Havering
	Cllr Wendy Brice-Thompson	<b>WBT</b>	London Borough of Havering
	Cllr Roger Ramsay	<b>RR</b>	London Borough of Havering
	Nicola Parry (for Caroline Maclean)	<b>NP</b>	London Borough of Redbridge
	John Brouder	<b>JBr</b>	NELFT
	Joe Fielder	<b>JF</b>	NELFT
	Dr Caroline Allum	<b>CA</b>	NELFT
	Jeff Buggle	<b>JBu</b>	BHRUT
Eric Sorensen	<b>ES</b>	BHRUT	

**In attendance:** Jane Gateley, Rowan Taylor, Debbie Harris

**Apologies:**

Cllr Jas Athwal, Cllr Darren Rodwell, Dr Nadeem Moghal, Matthew Hopkins, Maureen Dalziel, Dr Waseem Mohi, Caroline Maclean, Andrew Blake-Herbert, Vicky Hobart, Adrian Loades, Cllr Mark Santos, Dr Anil Mehta

Agenda item	Summary	Action
<b>Welcome, introductions and apologies</b>	Introductions and apologies noted as above.	
<b>Notes from the previous meeting</b>	Notes agreed with no alterations	
Page 240  <b>System Delivery and Performance Board progress update and next steps</b>	<p><u>PwC/Board to Board</u></p> <p>JBr updated members on the Board to Board meeting between BHRCCGs, BHRUT and NELFT. Key points were:</p> <ul style="list-style-type: none"> <li>• Opportunity to determine where we are as an economy and generate thinking</li> <li>• Agreement of 3 high value areas to take forward – Referral Management; Pressure ulcers and System Wide Discharge to Assess</li> <li>• NELFT and BHRUT talking about innovative projects to improve health and how they best collaborate going forward as part of the BHR ACs</li> <li>• Clinical engagement will be essential</li> <li>• Opportunities in area’s such as estates infrastructure and other key enablers</li> </ul> <p><u>Latest System Delivery Plan position</u></p> <p>JBr updated members. Key points were:</p> <ul style="list-style-type: none"> <li>• Mind-set that transformational monies must be targeted to transformational change, not business as usual</li> <li>• Co-chairing with clinician working well</li> <li>• Need for Social Care engagement in Clinical Cabinet</li> <li>• Important to re-focus on Localities at next meeting</li> <li>• Importance of building relationship with Care City going forward</li> </ul> <p>AA advised he is meeting with Networks and Federation on 6 July to gain their perspective on how to move forward and what area’s they want to concentrate on</p>	

	<p>RT has started developing some communication for wider use which has been shared with LA colleagues. It is hoped that the July session will confirm what needs to be produced and shared more widely</p> <p><u>SDPB draft action notes 19 June meeting</u></p> <p>Members noted the action notes</p> <p><u>Clinical Cabinet update</u></p> <p>CA updated members on the Clinical Cabinet. Key points were:</p> <ul style="list-style-type: none"> <li>• Meetings now to take place monthly (previously 6 weekly)</li> <li>• Membership to be broadened to include associate medical directors, nurses and PH etc. Local Authority colleagues also to be added to the circulation list and be invited to attend when appropriate. CA and Cabinet to take on board comments made on engagement</li> <li>• Offer of CEPN monies to help facilitate a pathway across health and social care, this could be for one of the 3 already identified targeted area's or End of Life which would need further discussions. JG suggested that we formally add CEPN as an agenda item to the System Delivery and Performance Board so resources support the priorities being agreed through there</li> </ul> <p>CB said it was important for the Clinical Cabinet to be clear of its purpose as a strategic planning unit</p>	<p>CA</p> <p>JG</p>
<p><b>Joint Commissioning Board progress update and next steps</b></p>	<p><u>Action notes 5 June meeting</u></p> <p>CB updated members. Key points were:</p> <ul style="list-style-type: none"> <li>• NEL commissioning proposal for implementation has been pushed back to September</li> <li>• Reviewed work carried out by CCGs/LA's on ambitions of joint commissioning and pre-requisites</li> <li>• Informal meeting took place on 23 June with good progress on a joint proposition that will emerge mid-July which will set out proposed ambition and arrangements to move this forward in the context of the emerging ACS</li> <li>• Working group preparing a paper for July ICPB meeting</li> <li>• CB advised that he felt these two conversation need to be joined up, ie. Board to Board work with Mike Farrar and work with LA's with CCGs support on what is our common ambition.</li> </ul> <p>BN gave an update from John Green</p> <ul style="list-style-type: none"> <li>- Commissioners met to work up a set of proposals to approach the ACS in two phases 1: pick up community based commissioning arrangements in terms of community health and social care 2: BHRUT coming into the frame. It is clear that there needs to be more collaboration between commissioner and provider thinking.</li> </ul> <p><u>Update from 23 June meeting</u></p>	

	Covered above	
<b>Next steps/July session</b>	<p>JG suggested that the July ICPB meeting be in the format of a workshop to bring together the two workstreams discussed this morning along with updates on the STP/London Devolution agenda. Jane Milligan asked JG to meet her programme director, Nicholas Gardner, on 29/6, to further discuss how as NEL we align with the London agenda and how the work we are developing at BHR level can help frame the NEL piece. JG also suggested playing in the outputs from the Primary Care Network Federation workshop taking place on 6/7.</p> <p>CB advised that of all the systems in London, BHR is the one with the most potential to move forward at pace to an ACS. MW endorsed this view. JBr stated the need for BHR system to drive its local vision forward and in doing so push for central funding.</p> <p>There was concern that the next meeting is in holiday time and that there will be enough engagement. 31 July date to be reviewed.</p> <p>MW reiterated the need for executive leads on the respective programmes to bring back firm proposals to the July session.</p> <p>Members agreed to the workshop with a facilitator and consideration of extending the time.</p>	DH  CEOs
<b>AOB</b>	None raised	
<b>Time of next meeting</b>	31 July 2017 – 10.00 – 11.30 – Boardroom, Barking and Dagenham CCG, Ground floor, Maritime House, 1 Linton Road, Barking	

Page 24/27

**ACS – Integrated Care Partnership Board- action log**

	<b>Action 28 June 2017</b>	Responsible	Due date	Status
1.	CA and Cabinet to take on board comments made on engagement	CA/clinical cabinet	27/7	
2.	CEPN to be added as a standing item to the System Delivery and Performance Board agenda	JG	19/7	Complete
3.	31 July attendees list to be reviewed	DH	29/7	

4.	CEOs to bring back firm proposals to the July session	CEOs	31/7	
----	-------------------------------------------------------	------	------	--

This page is intentionally left blank

# ACS development event Summary output

Barking and Dagenham, Havering and Redbridge

10am - 12am on 31<sup>st</sup> July 2017  
Maritime House, Barking



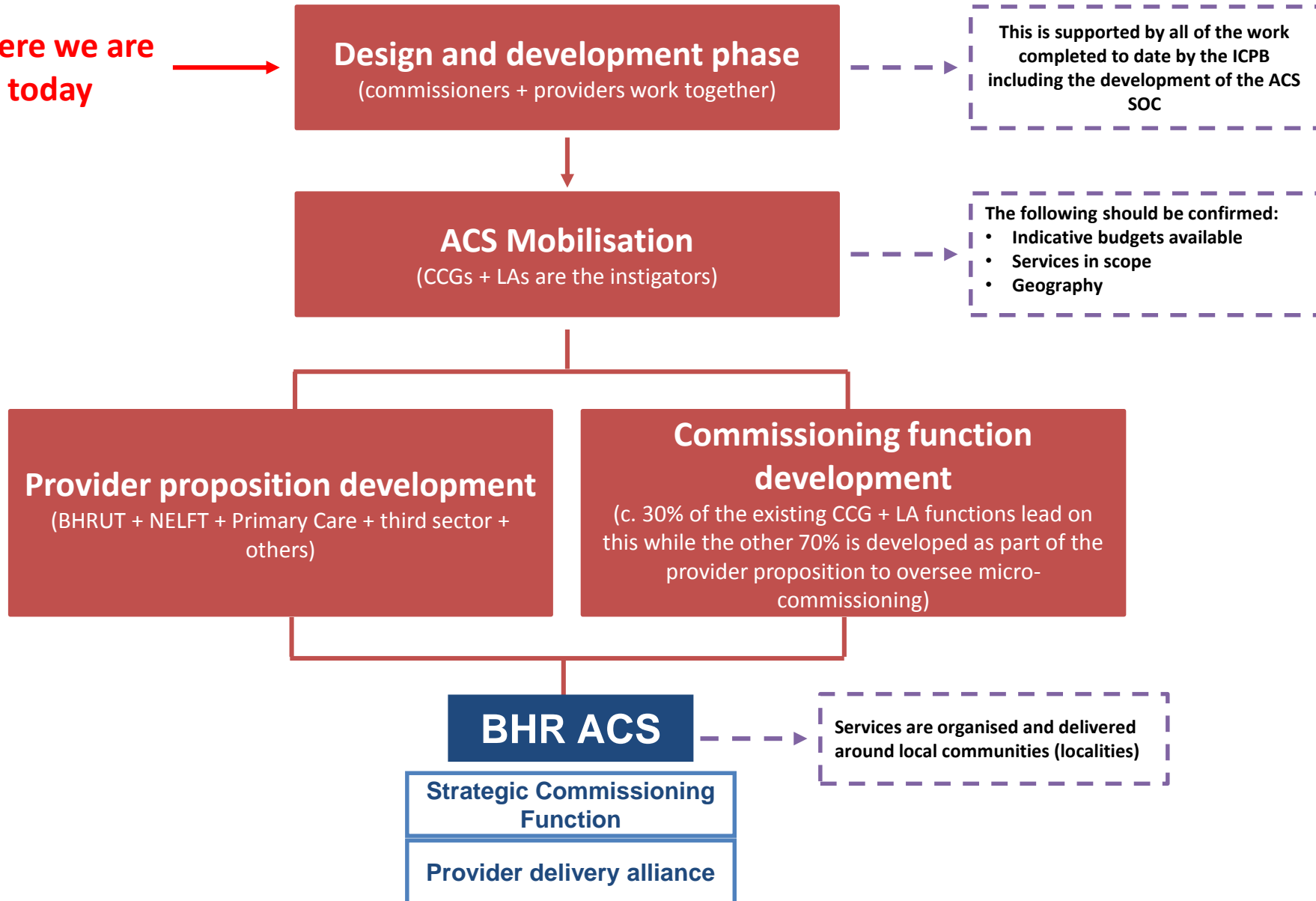
# Attendees

- Andrew Blake-Herbert, LBH
- Anne Bristow, LBBD
- Christopher Bown, BHRUT
- Cllr Wendy Brice, Thompson - LBH
- Conor Burke, BHR CCGs
- Dr Adedeji on behalf of Dr Arun Sharma, B&D Federation Chair
- Dr Anil Mehta, Redbridge CCG
- Dr Dan Weaver, Havering Federation chair
- Dr Nikal Rao, Havering Network chair
- Dr Shabnam Quraishi
- Dr Siva Ramakrishnan, Redbridge Federation Chair
- Emily Plane, BHR CCGs
- Eric Sorensen, deputy chair - BHRUT
- Jacqui Van Rossum, NELFT
- James Langford, PwC
- Jane Gateley, BHR CCGs
- Joe Fielder, NELFT
- John Brouder, NELFT
- Kash Pandya
- Keith Cheesman, LBH
- Mark Tyson, LBBD
- Maureen Worby (**Chair**), LBBD
- Richard Coleman, BHR CCGs
- Sarah See, BHR CCGs
- Steve Collins, BHRUT
- Vicky Hobart, LBR Director of Public Health
- Vincent Perry (for Dr Caroline Allum), NELFT
- Mike Farrar, PwC
- Rowan Taylor, BHR CCGs
- Cllr Mark Santos



# The ACS development journey

Where we are today



The objective of this session was to make a decision about how to proceed with the BHR ACS and – if possible – to identify concrete next steps

- During the discussion around each of the presentations it became clear that partners in BHR would need four things to proceed with the ACS:
  - An investment fund (having a clear plan would help the system to make the case for access to transformation funding)
  - Alignment of the contract incentives for clinicians in the system
  - Longer term commissioned contracts to incentivise provider investment in services
  - Regulatory flexibility during the transition to give providers the space they need to develop (it was noted that this was likely to relate more to NHS I regulation as opposed to CQC standards)
- It was recognised that the role and scope of social care was wider than perhaps other partners traditionally associated – need to ensure this is understood across the BHR landscape
- It was recognised that the three boroughs / CCGs / Primary Care had clearly defined geographical boundaries whereas both NHS Trusts had significant interests outside of the BHR region

## ACS Strategic Outline Case

- This is the local case for change and includes a lot of detail about the current population / health challenges / other challenges which the ACS will need to address

## Localities

- Localities in each borough have been identified. GPs have now organised and brought together their networks around each locality. Some NELFT services are already organised on this basis (in Redbridge)

## The willingness to move towards a new model of care

- All three presentations showed a clear appetite for working together as a system to move towards the development of a new model of care

## The vision for Accountable Care

- All three presentations contained a consistent vision about what the new model of care would look like with services being delivered on a locality basis. Work to integrate services around a locality has already begun but needs to be rapidly extended and accelerated. A formal written vision which corresponds to these ambitions is set out in the ACS SOC

## Some aspects of the vision need more work

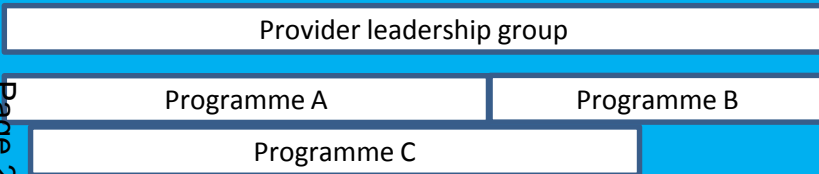
- More granular understanding of implications of current ambitions
- Certain “mindset issues” need addressing e.g. role of competition
- Approach to risk transfer needs further development

# ACS development – next steps

## Providers

- The providers agreed to explore forming a sub-group to look at the options for formal collaboration in response to the commissioners intent to begin to offer shadow place based budgets
- As part of this, providers will need to agree the future ways of working / structure / governance around the provider collaboration

### Suggested structure:



These are programmes which will span multiple organisations / localities. The progress of each programme should be tracked by the leadership group



- Providers recognise that they will have to work together at multiple levels (as a single leadership group and at a locality level) to deliver the change programmes required to build out an ACS
- Other specific requirements included:
  - A joint programme of work between primary and social care to better understand each other's roles and contributions
  - Specific activities to bring all local GPs up to speed
  - Baseline of current spending at service level

## Commissioners

- A sub-group of the JCB will now look at the budgets available for the ACS with a view to putting an initial shadow budget in place by April 2018

As part of this work to develop the ACS shadow budget, commissioners will need to consider:

- What's in – services and associated contracts
- What geography – areas / localities covered and phasing
- What risk – how will risk be shared with the providers
- Outcomes and contracting – what type of model do commissioners want to move towards?

- Continued development of plans to set up a BHR strategic commissioning function with pooled budgets (as per 17/18 to do list in commissioning slides – Appendix B)



Across both providers and commissioners, there was agreement to establish a system wide programme leadership function that bridges commissioner/provider governance arrangements and to ensure the delivery of the ACS is aligned

# Appendix 1: Primary care slides

# The role of General Practice in the BHR Accountable Care System

Dr Dan Weaver and Dr Shabnam Quraishi

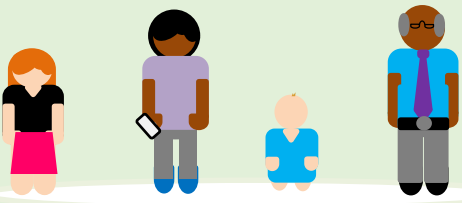
July 2017

 **The local GP Network/Federation Partnership is mature enough to take a lead role in Population Health Management**

 **BHR has Established Networks & Federations; Symbiotic single voice**

**Together delivering:**

- ✓ Cradle to Grave
- ✓ Pan-specialty
- ✓ Gate-keeping and signposting
- ✓ 90% of contacts

 **Meeting our challenges to impact on outcomes**  
 → Less secondary/Social Care Burden/Disability

Page 253

Challenges	Achievements
Variability / Quality	<b>Quality Improvement</b> <ul style="list-style-type: none"> <li>▪ Reduce Variability</li> <li>▪ Consistent Approach &amp; Message</li> <li>▪ Nursing Home scheme</li> <li>▪ AF/Diabetes</li> </ul>
Workforce and Workload	<b>Workforce Solutions</b> <ul style="list-style-type: none"> <li>▪ Clinical Pharmacists</li> <li>▪ New 2 Nursing</li> <li>▪ International recruitment</li> <li>▪ Access Hubs / UCC</li> <li>▪ Workflow</li> </ul>
Premises and Regulatory Standards	<b>CQC Practice readiness support</b>
Training	<b>CEPN / PTI</b> Up-skilling existing workforce



## The Networks / Federations have a clear vision

### Consistent Message

Network / ACS wide:

- Advice & Signposting
- Addressing Expectations
- Joined up - IT/DATA SHARING

### Right Person – Right Place – Right Time

- More Self Care
- Less variability in Primary Care
- → Less Secondary/Social Care burden

Page 254

### Pan ACS pathways

Locally developed & agreed **pan ACS Pathways** – Enabling **Quality** Primary Care:

- Management Steps
- Investigations
- When to REFER
- Templates under development by Networks
  - EG Cardiology Video Conferencing;
  - **AF**, PSA, Osteoporosis, Menstrual Bleeding disorder
- Primary Care Training and Accessible Guidance from BHRUT/NELFT

### Variability

Network Led 'Searches' & Templates; EG:

- Atrial fibrillation – Stroke prevention
- Diabetes – vascular disease prevention
- Reduce complications/outcomes → **Less Secondary/Social Care burden**

### Seamless handover and information sharing

- Avoid Duplication/Pathway Delay
- Less Secondary/Social Care burden

### Access and efficiency

- With investigation results → 1 Stop
- Conversion to surgery ratio for surgical out patients

### Handover back to primary care

Reciprocal, appropriate **handover back to primary care** on discharge from out patient or inpatient care:

- Minimising re-referral/re-admission
- → **Less Secondary/Social Care burden**

# SPEND EVERY £ BETTER

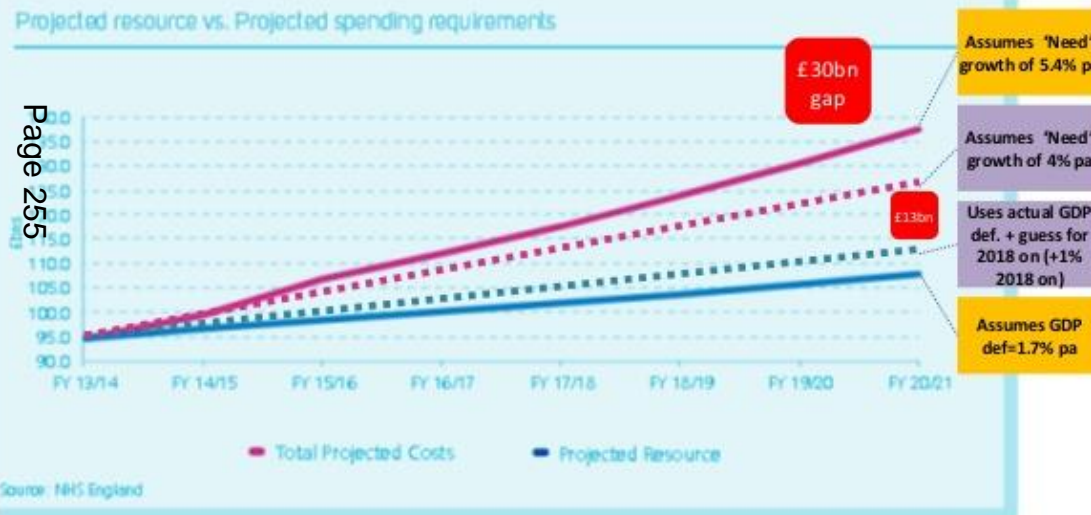






## General Practice needs to take a leading role in our Accountable Care System

NHS England: *Call to Action*: £30bn gap by 2020/1 (could be smaller.... But still a gap)



“The broad consensus is that for the next decade, the NHS can expect its budget to remain flat in real terms, or to increase with overall GDP growth at best.” *Call to Action*

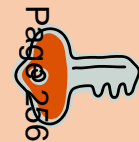
- 30% productivity demand
- Inclusive ACS
- Meeting the needs and challenges of all stakeholders
- Acknowledge stakeholders strengths & fixed costs
- Fair funding for work done
- Population Health Management is what General Practice does best
- General Practice leadership → vision which grass root GPs can buy in to:
- Population Health management depends on primary care performance & engagement:
- Fundamental foundation blocks of adding value in an ACS
- Solution = ↑ spending @ front of Care Pathway → ↓ secondary/Social care burden



## What we need; next steps



Agreement and engagement to start work on developing the transformation - building a new model of care based around our geographical networks / localities



Agreement to explore how we upscale Primary Care resources as a proportion of the local care budget

- *deliver better care at the beginning of the patient pathway*
- *Apply initiatives across all networks*
- *→ Less Secondary/Social Care burden*



Management support including resource sharing with other community providers as appropriate



Sharing of data

# Appendix 2: Commissioning slides

# Towards Joint Commissioning

31 July 2017

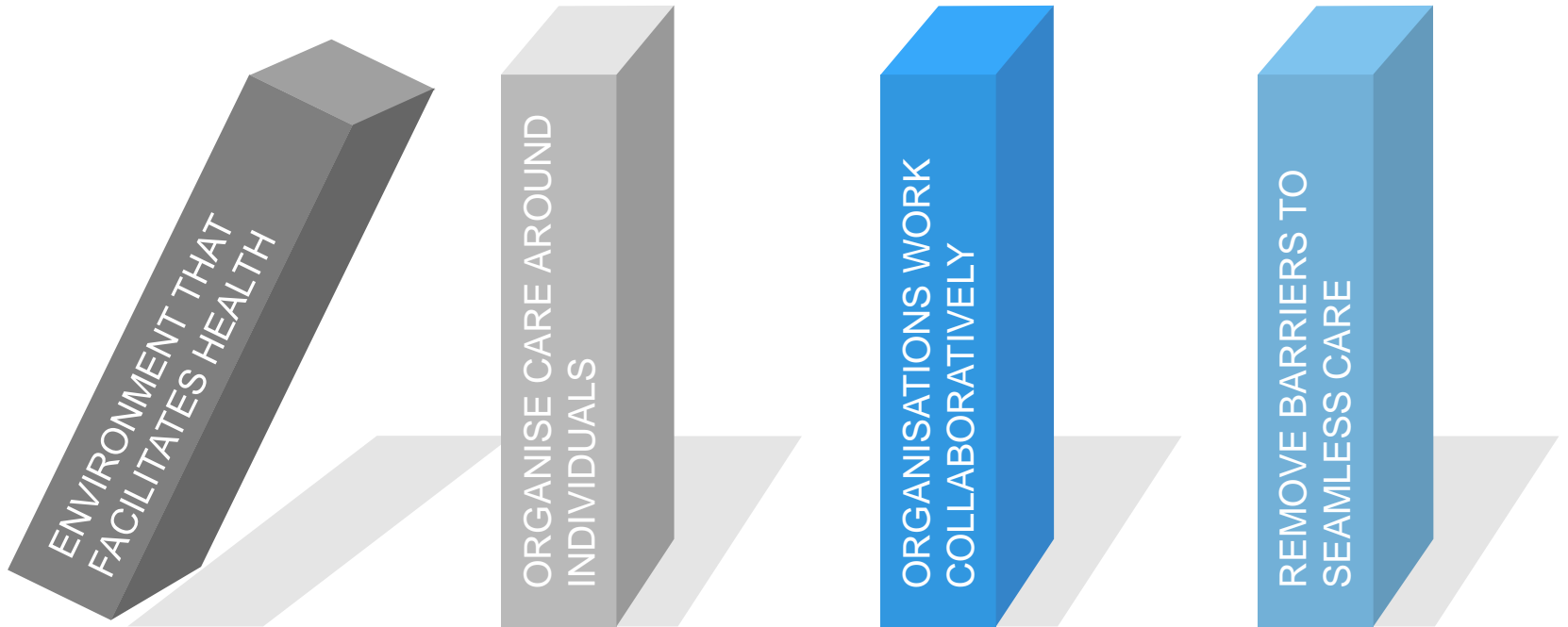
Page 258



## Our ambition, restated...

Our vision is to accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and deliver sustainable provision of high quality health and wellbeing services

Page 259



enabling and empowering people to live healthily, to access preventive care, to feel part of their local community, to live independently for as long as possible and to manage their own health and wellbeing

involving and empowering, integrating across agencies, single point of access, and providing locally where possible. It will meet best practice quality standards and provide value for money

sharing data where appropriate, and maximise effective use of scarce/specialist resources (e.g. economies of scale).

bringing together not only health and social care, but a range of other services that are critical to supporting our population to live healthy lives.

## Structures – the ‘end state’

The opposite diagram illustrates the current proposition for what the BHR ACS ‘end state’ will look like.

Strategic commissioning and providing are shown as separate, with a strong two-way connection between them, but we expect providers to potentially have a greater role in commissioning within an ACS/capitated budget system.

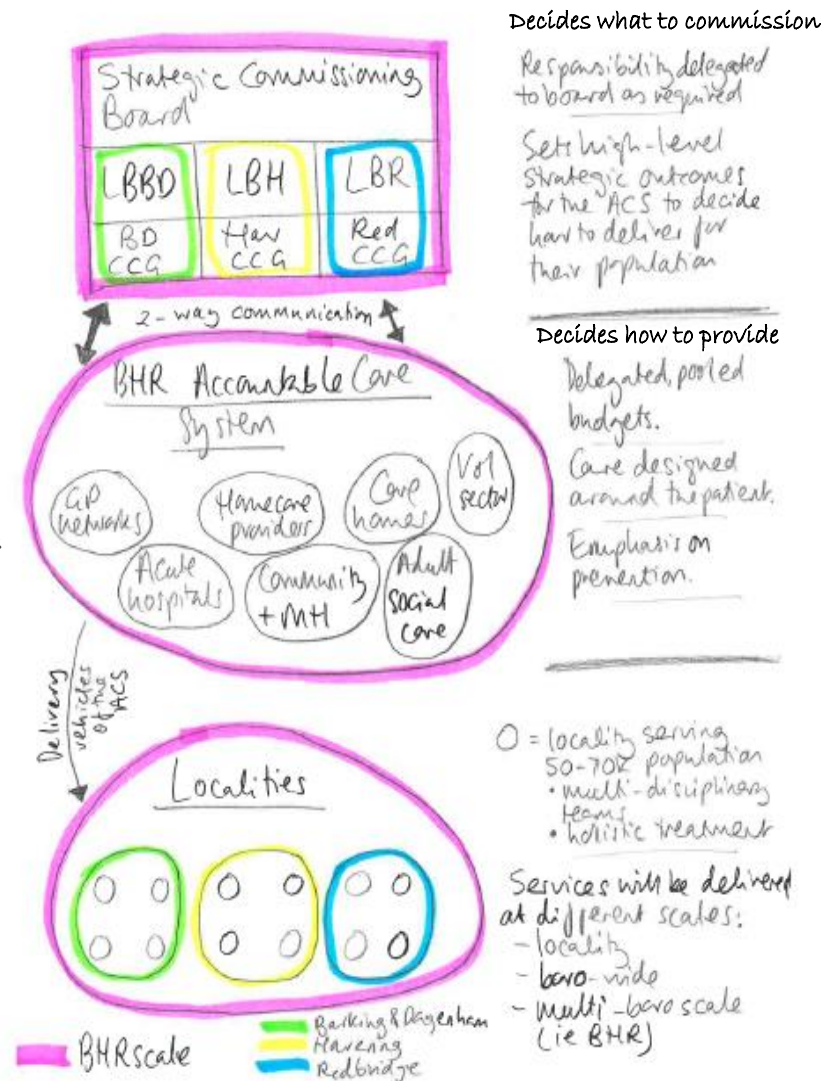
Localities are units of integrated provision but could also carry out a more local commissioning function as well (eg local community asset-based approaches).

ICPB members are asked to build upon this at their workshop on 31 July so that all partners have a shared understanding and single clear vision of the end state that we are all working towards.

Joint accountability for health and wellbeing for the local population

Providers working together as an alliance, responsible for the health and social care needs of defined populations to deliver outcomes set out in a contract, with a clear budget

## BHR ACS – the end state



## 1: ACCOUNTABILITY

Cementing moves over the recent 18 months to bring both democratic and clinical leadership to health and social care planning.

## 3: SYSTEM LEADERSHIP

To make an Accountable Care System work effectively, commissioners must act in harmony and provide, as far as possible, a single voice to ACS partners. Most of all, conflicts of direction must be avoided if the ACS is to deliver for residents.



## 2: FINANCE

It is not expected that savings in joint commissioning alone are significant: care markets in particular are already under significant pressure.

Joint Commissioning of an ACS model must drive out the inherent financial perverse incentives of separate organisational interests

# Complexities of Accountable Care

## 1. System management

Resolving competing contracting drivers, internal tensions, and demands on the system from different stakeholders.

## 2. Procurement and contracts

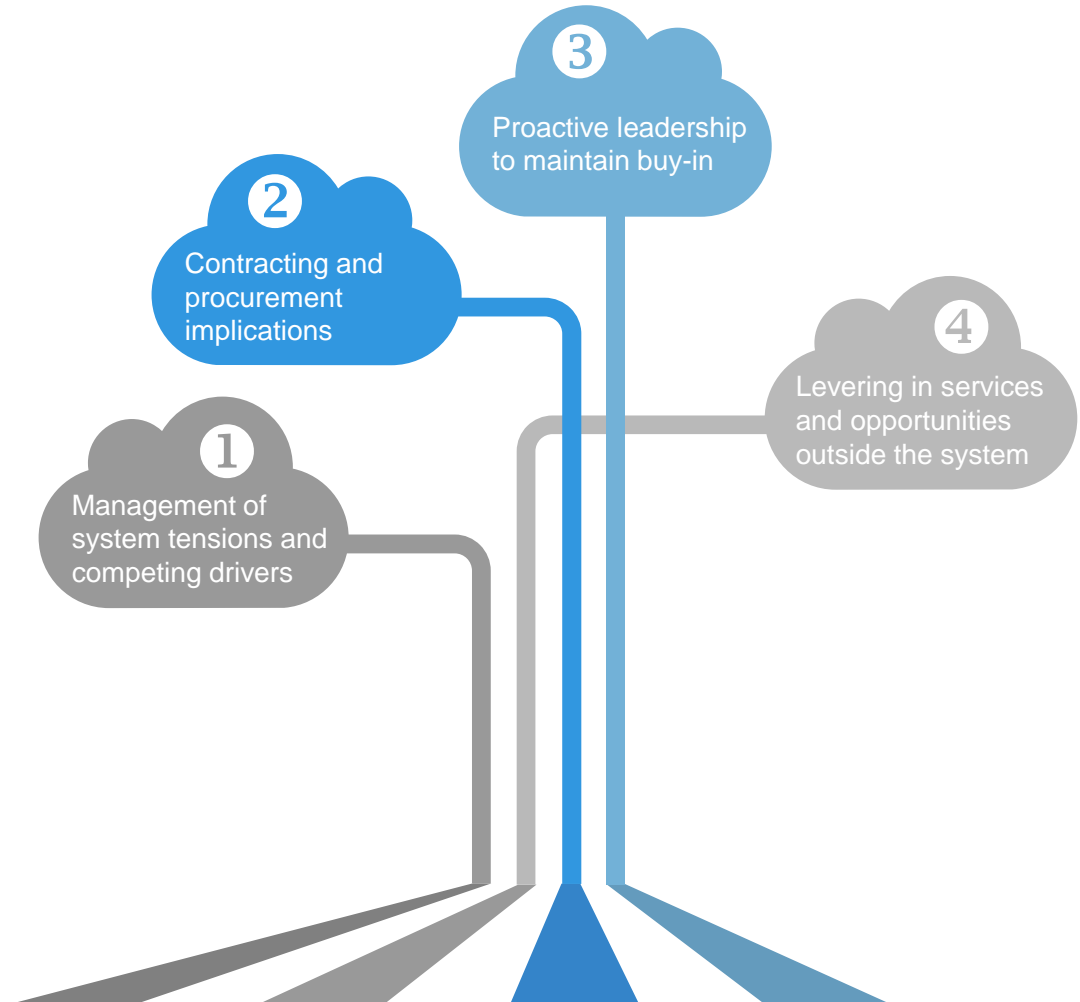
Determining and delivering the most appropriate path to structural form

## 3. Leadership and buy-in

Ensuring senior leaders have mechanisms for debating issues that arise, addressing wider stakeholder concerns, and ensuring that the ACS meets wide-ranging need.

## 4. Levering in opportunities

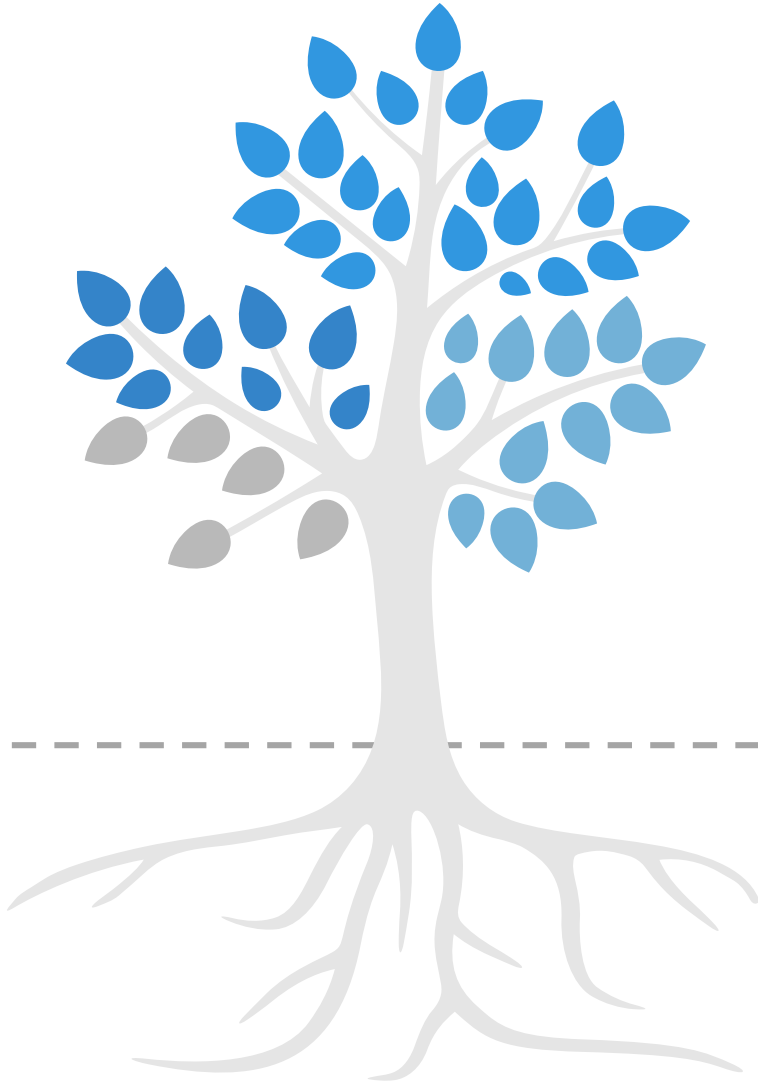
Ensuring that the wider determinants of health are addressed through strategic relationships with services and policy areas outside of the ACS (e.g. housing, welfare)





## Current and planned joint commissioning

Page 263



Prevention  
Re-commissioning of community services  
to support a new intermediate care tier  
Better Care Fund  
Learning disabilities (incl. TCP)  
Mental health  
Equipment

### **Current/future opportunities**

**Positive developments**  
Sexual health services  
Joint Assessment & Discharge Service  
Riverside Mental Health  
Equipment

## A transitional development...



### First Steps

Shared initial products for BHR: JSNA, Market Position Statement, specific strategies.

Initial scope of support structure.

Joint Commissioning Board take real, practical first steps on joining up, e.g. Intermediate Care

Legal scoping for ACS procurement issues. First draft ACS outcomes set.

### Focused joint work; building trust

Decisions on specific risk share commissioning programmes, delegated authorities and budgets.

Decisions on an integrated support structure, by secondment or shared staff teams.

ACS Outcomes, contracting mechanisms and finance flows in draft form.

### Integrated operations across the system

Full delegated control over whole outcomes-based budgets for health and social care.

Integrated commissioning operations, governed by agreements with contributing partners.

Supports fully functioning Accountable Care System now operating to Outcomes Framework.

# **HEALTH and WELLBEING BOARD FORWARD PLAN**

Draft November 2017 Edition

Publication Date: 9 October 2017

Decision taker/ Projected Date	Subject Matter  Nature of Decision	Open / Private (and reason if all / part is private)	Sponsor and Lead officer / report author
<b>Health and Wellbeing Board:</b> <b>8.11.17</b>	<p><b>Domestic and Sexual Abuse Strategy : <i>Community</i></b></p> <p>The report will present the Board with the draft Domestic and Sexual Abuse Strategy.</p> <p>The Board will be asked to discuss and approve the Domestic and Sexual Abuse Strategy.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)
<b>Health and Wellbeing Board:</b> <b>8.11.17</b>	<p>Older People's Housing Strategy - Discussion</p> <p>The Board will be asked to consider and discuss the Older People's Housing Strategy.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)
<b>Health and Wellbeing Board:</b> <b>8.11.17</b>	<p><b>Contract: Public Health Primary Care Service - Procurement Strategy : <i>Financial</i></b></p> <p>The current contract for the Public Health Primary Care service will expire on 31 March 2018.</p> <p>The Board will be asked to approve the procurement strategy for the competitive procurement of this service from 1 April 2018 to 31 March 2020, with the option for the Council to extend the contract for a further two-year period, and to the delegation of the award of the contact.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)

<b>Health and Wellbeing Board:</b> <b>8.11.17</b>	<p><b>Sustainability and Transformation Plan Update and Partnership Agreement</b>  <b>All Issue Categories</b></p> <p>The Board will be provided with an update on the progress made in the development and delivery of the North East London Sustainability and Transformation Plan (NEL STP).</p> <p>The Board will be asked to approve the Partnership Agreement for the East London Health and Care Partnership, and to authorise delegated authority for its signing to the Strategic Director of Service Development and Integration and Deputy Chief Executive and Director of Law and Governance.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	<p>Mark Tyson, Commissioning Director, Adults' Care &amp; Support  (Tel: 020 8227 2875)  (mark.tyson@lbbd.gov.uk)</p>
<b>Health and Wellbeing Board:</b> <b>8.11.17</b>	<p>Health and Wellbeing Outcomes Framework Performance Report - Quarter 2 (2017/18)</p> <p>The Board will be presented with the Health and Wellbeing Outcomes Framework Performance Report for the period ending 30 September 2017.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	<p>Matthew Cole, Director of Public Health  (Tel: 020 8227 3657)  (matthew.cole@lbbd.gov.uk)</p>
<b>Health and Wellbeing Board:</b> <b>16.1.18</b>	<p><b>Suicide Prevention Strategy : Community</b></p> <p>In November 2016, a Mental Health Strategy for LBBB was agreed. Since then LBBB and Havering have partnered in the development of a suicide prevention strategy and localised action plans.</p> <p>The Board will be asked to approve the Suicide Prevention Strategy.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	<p>Sue Lloyd, Public Health Consultant    (sue.lloyd@lbbd.gov.uk)</p>

<b>Health and Wellbeing Board: 13.3.18</b>	<b>Barking and Dagenham Pharmaceutical Needs Assessment (PNA) : <i>Community</i></b>  The Pharmaceutical Needs Assessment (PNA) is a statutory document required to be produced by every local authority's Health and Wellbeing Boards (HWB) every three years. The PNA assesses the pharmacy needs of the local population and provides a framework to enable the strategic development and commissioning of community pharmacy services to help meet the needs of the local individual population.  The London Boroughs of Barking and Dagenham (LBBD), Havering (LBH) and Redbridge (LBR) have recently (May 2017) awarded the contract for the production of three PNA's to PHAST CIC (one for each borough)  The HWB will be asked to sign-off the final PNA upon its completion.  <ul style="list-style-type: none"><li>• Wards Directly Affected: All Wards</li></ul>	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------	-----------------------------------------------------------------------------------------------