Notice of Meeting

HEALTH & WELLBEING BOARD

The legal status, role and detail about the governance of the Health & Wellbeing Board can be found in Part B, Article 5 of the Council Constitution. Full terms of reference for Board can be found in Part C, Section D. More information about the work of the Board is listed on the Council's website www.lbbd.gov.uk

Tuesday, 16 July 2013 - 6:00 pm

Venue: Conference Room, Barking Learning Centre
2 Town Square, Barking, IG11 7NB

Date of publication: 05 July 2013

Graham Farrant
Chief Executive

Contact: Glen Oldfield, Clerk of the Board, Democratic Services

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Membership for 2013/14:

Councillor M Worby (Chair)	(LBBD)
Dr W Mohi (Deputy Chair)	(Barking & Dagenham Clinical Commissioning Group)
Councillor J Alexander	(LBBD)
Councillor L Reason	(LBBD)
Councillor J White	(LBBD)
Anne Bristow	(LBBD)
Helen Jenner	(LBBD)
Matthew Cole	(LBBD)
Frances Carroll	(Healthwatch Barking & Dagenham)
Dr J John	(Barking & Dagenham Clinical Commissioning Group)
Conor Burke	(Barking & Dagenham Clinical Commissioning Group)
Martin Munro	(North East London NHS Foundation Trust)
Dr Mike Gill	(Barking Havering & Redbridge University NHS Hospitals Trust)
Chief Supt. Andy Ewing	(Metropolitan Police)
John Atherton (Non-voting member)	(NHS England)

AGENDA

1. **Apologies for Absence**

2. **Declaration of Interests**

   In accordance with the Council's Constitution, Members of the Board are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. **Minutes - 4th June 2013 (Pages 1 - 8)**

4. **North East and North Central London Health Protection Unit Annual Report 2012 (Pages 9 - 13)**

5. **Health & Wellbeing Strategy Priority - Maternity Services (Pages 15 - 21)**

6. **Summary and Key Recommendations of the Joint Strategic Needs Assessment 2012/13 (Pages 23 - 45)**

7. **Progress on Winterbourne View Concordat (Pages 47 - 87)**

8. **A Review of Services for Those Affected by Domestic Violence (Pages 89 - 118)**

9. **Managing Performance of the Health & Wellbeing System (Pages 119 - 132)**

10. **Longer Lives: A Summary for Barking and Dagenham (Pages 133 - 149)**

11. **Referral from Development Control Board (Pages 151 - 152)**

12. **Chair's Report (Pages 153 - 156)**

13. **Report of Sub-groups (Pages 157 - 164)**

14. **Forward Plan (Pages 165 - 173)**

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

16. **To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.**

Private Business

The public and press have a legal right to attend Council meetings such as the Health and Wellbeing Board, except where business is confidential or certain other sensitive information is to be discussed. The list below shows why items are in the private part of the agenda, with reference to the relevant legislation (the relevant paragraph of Part 1 of Schedule 12A of the Local Government Act 1972 as amended). ***There are no such items at the time of preparing this agenda.***

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

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MINUTES OF
HEALTH AND WELLBEING BOARD

Tuesday, 4 June 2013
(6:05 - 8:10 pm)

Present: Councillor M M Worby (Chair), Councillor L A Reason, Councillor J L Alexander, Councillor J R White, Anne Bristow, Helen Jenner, Matthew Cole, Conor Burke, Dr Waseem Mohi, Martin Munro, Dr Mike Gill, Chief Superintendant Andy Ewing, Frances Carroll and Dr John

Also Present: Cllr T Ramsay, Cllr M McKenzie MBE

Apologies: None.

12. Declaration of Interests

There were no declarations of interest.

13. Minutes - To confirm as correct the minutes of the meeting held on 23 April 2013

The minutes of the meeting held on 23 April 2013 were confirmed as correct.

14. Joint Assessment and Discharge Team

Anne Bristow (Corporate Director, Adult and Community Services) introduced the report to the Board. It was noted that the proposal requires a cross-borough decision and there is a short time period in which to implement the service. The main challenges to progress include identifying a host organisation and establishing the common operating features of the service.

The Board noted that the ultimate aim of the new service is to remove peoples' dependence on services and have people lead independent lives with care delivered in the home-setting. It was acknowledged that to achieve this aim there is a need to develop community capacity and utilise social networks (family/friends/neighbours).

The Board asked whether it would be necessary to consult with the public on the proposal. Bruce Morris (Divisional Director, Adult Social Care) explained that there is no intention at this stage to do so as it is not considered a change in service from a patient perspective. However, consultation with staff involved will be important.

The Board asked how the proposal would improve the patient experience when leaving hospital. Anne Bristow advised the Board that between now and the service going live professionals will work together to find and address bugs in the service/pathway to ensure patients receive a better service. Once the work has been done and the proposal is more developed it will be clearer what differences patients can expect to see.

The Board felt it was important to be robust in analysing and critiquing the service in order so that meets key performance targets. Dr Mohi (Chair of Barking and Dagenham Clinical Commissioning Group) advised the Board the joint Assessment and Discharge Team proposal will be discussed on 19 June, at the next Integrated Care Coalition meeting, that discussion will feed into further reporting on this matter.

The Board noted the progress of this project and the milestones for implementation as set out in paragraph 5 of the report. The Board will receive a further report in September asking for decision to proceed to the next phase. The Board agreed the design principles as described in paragraph 2 of the report.

15. Community Sickle Cell / Thalassaemia Service

Dr Mohi (Chair of Barking and Dagenham Clinical Commissioning Group) introduced the report to the Board and highlighted the rising prevalence of sickle cell within the Barking and Dagenham population. Dr Mohi recognised the efforts of Dr Ian Grant in lobbying for, and developing this service. Dr Mohi reported that by the end of June the first clinic will have met in Barking Hospital. There are some staffing issues that need to be resolved by August.

The Board noted that local people with sickle cell are excited about the launch of the community-based service. Dr John (Clinical Director, Barking and Dagenham Clinical Commissioning Group) commented that at his practice alone there significant numbers of people with sickle cell disease that this service would benefit.

Helen Jenner (Corporate Director, Children's Services) alerted the Board that there is a lack of awareness about sickle cell disease and its health implications in schools and teachers especially would benefit from being more aware of the disease and local services. The Board suggested that the communications teams from the Board's constituent organisations work together to raise awareness about the new sickle cell service. Further to sign-posting from local GPs to the service the Board agreed that there needs to be publicity about the launch. Dr Mohi confirmed press releases were on standby for the launch. Dr John added that the service is also being pushed through GP patient groups.

The Board noted the report and the status of developing a community-based sickle cell service.

16. Francis Report

Further to the report, Matthew Cole (Director, Public Health) delivered a thought provoking presentation to the Board which brought to life some of the harrowing testimony from the Francis Report and the comments and reactions of key individuals, including; Sir Francis QC, Sir David Nicholson, and local Staffordshire campaigner Julie Bailey. The Board, in its debate on what its role is and contribution is to recommending the recommendations made by Francis. In

particular its licence around the whole-system view. The following points were noted in the discussion:

- The Board should give collective thought to how we arrive at an index of suspicion and when it is appropriate to call-time on a poor performing provider. How might the Health and Wellbeing Board take a leading role in ascertaining the index of suspicion through the triangulation of evidence?

- Complaints must be listened to and taken seriously. Trends in complaints should be analysed and problems resolved with due diligence, with meaningful service change where necessary.

- Professionals from across the health and social care economy and wider partnership need to be alert to standards of care and have the strength and resolve to report bad care that is witnessed.

- Commissioners must change performance reporting so that it relates to the patient experience and gives a true account of quality. Furthermore, all contracts must contain quality levers and be vigorously monitored. Commissioners must cut bureaucracy and reporting issues to understand how patients view services and treatment.

- All Health & Wellbeing Board member organisations confirmed that they did not have gagging clauses preventing whistleblowing.

- Electronic surveying of patients upon discharge could be an effective means of collecting intelligence that can be evaluated and acted upon instantly.

- Following publication of the Francis Report the North East London NHS Foundation Trust (NELFT) board begin every meeting with a patient story. The H&WBB was asked to think of other ways in which governance structures can bring through the patient voice.

- The friends and family test is now being used as another way to test quality in the NHS.

- The Board needs to take a leadership role and ensure that the post-Francis culture (paragraph 6.2 of the report) is enacted.

- At Mid-Staffordshire a major problem was the lack of connection between clinicians and managers. Relationships between clinicians and managers are much closer in the outer North East London sector but there is still a need to guard against management issues getting in the way of good quality healthcare and clinical decision-making.

- The Board considered what could be learned from previous failures of care in mental health. The outcome has been at NELFT has been the introduction of a very organised patient engagement and representation of any local NHS or Foundation Trust.

- The Board considered the role of the Council's Health and Adult Services Select Committee and how its role can be strengthened and how it can perform better to avoid the mistakes and passivity of Staffordshire Borough and County Councils scrutiny committees. The Board noted that a separate report will be presented to the Health and Adult Services Select Committee on the Francis recommendations focussing on the specific implications for scrutiny.

- The Board recognised that post-April 2013 the commissioning system is more complex with several commissioners and even more providers of services. In light of this, how can there be whole system accountability in new NHS landscape?

- Further to the above point, how can Barking and Dagenham GPs be held to account as a local provider. What is the role of NHS England in monitoring GP quality?

- Poor performance by providers cannot be excused by pressure on resources. Commissioners must set high standards and review the provider's performance. Where standards are not being me there must be mechanisms to engender changes to service delivery.

- Dr Mike Gill (Medical Director, BHURT) was clear that the public should not have low expectations with regard to health and social care services and that the expectations of services user should not be impacted by resource issues (perceived or real). Patients should expect high standards and have their expectations met.

- The Board recognised that the themes running through Francis are not isolated to the acute hospital setting. The lessons from Francis equally apply across all health and social care settings and the home environment in which people can be especially vulnerable.

There was consensus that the NHS Barking and Dagenham Clinical Commissioning Group (CCG) is the best placed organisation within the health economy to lead on working through next steps to implement the Francis recommendations and provide assurance to the H&WBB that local NHS action plans around Francis have been implemented. Although led by the CCG, the task and finish group will be inclusive and accountable to local Health and Wellbeing Boards. It was felt that a CCG-led approach would result in less duplication and less competition for similar actions among the local authorities involved.

The Board agreed to write to local safeguarding boards requesting participation and input into the task and finish group.

The Board agreed the following actions:

- That the group established by the CCG develops a local response to the Francis Report involving all partners on behalf of the Health & Wellbeing

Board.

- That the CCG-led task and finish group take into consideration the following issues:
    - the role of GPs in reviewing care standards
    - formalised early warning systems and the part they might play
    - how patient /user involvement can be strengthened and the mechanisms
    - needed for the patient/user voice to be heard by decision makers
    - whether the single agency action plans are adequate and what changes are needed to ensure a whole systems approach
    - how the Health and Wellbeing Board can gain assurance on behalf of local residents about the quality of our local health and care system
    - consider how to communicate more widely to those using services what they have a right to expect from these services
    - review progress made by the Clinical Commissioning Group, local NHS Trusts and Foundation Trusts in the implementation of their action plans
    - consider the views of the Safeguarding Adults Board and Local Safeguarding Children Board.
- The Director of Public Health meets with his colleagues from neighbouring boroughs to agree an approach to both the identification of problems and solutions required from the analysis of hospital mortality rates.
- To receive a progress report to its September meeting.

17. CQC Inspection Report on A&E and Emergency Care Plan

Dr Mike Gill (Medical Director, BHRUT) presented the report to the Board.

Dr Gill reported that CQC visited the Trust for an unannounced inspection recently. The report is not yet published but the Trust expects to see positive progress confirmed in that inspection report.

The Board challenged the Trust on its resilience with regard to infection control. Dr Gill advised the Board that the Trusts record with infection control is good and the appointment of a new director has made a big impact on compliance with infection control.

From the report the Board felt it was difficult to draw out the elements from the

action plan that directly responds to CQC's concerns. Dr Gill explained that the action plan is comprehensive and is drawn together from a collection of problems that must be addressed hospital-wide. Responding only to CQC's concerns would be insufficient to drive the change that is required elsewhere at Queen's hospital. Dr Gill referred the Board to paragraph 3.4 of the report which outlines the five operational priorities and workstreams to deliver the Emergency Care Programme.

The Board asked for an update on the closure of King George Hospital's A&E department. Dr Gill advised the Board that the Trust is still working to the Health for North East London plans. The A&E department will not be closed until Queens Emergency Department has demonstrated improvement. The Board was reminded of the plan to open a 24/7 urgent care centre at King George Hospital.

Dr Mohi (Chair of Barking and Dagenham Clinical Commissioning Group) assured the Board that commissioners were reviewing performance regularly. The CCG expressed its concerns over the format of reporting and whether it was sufficient enough in detail to judge if operational changes were making an impact on quality.

Conor Burke (Accountable Officer, CCG) reported that the CCG has established an Urgent Care Board which is scheduled to meet on 19 June. Its terms of reference are to address problems with urgent care system including relationship with A&E. Briefings for Board members will be circulated if it is thought helpful.

The Board noted the actions being taken by BHRUT to improve emergency care at the Hospital, and gave their comments on the plans and progress described in the report. The Board gave its views about the system wide implications of this work and the future co-ordination of urgent care improvement activity.

18. Diabetes Scrutiny Review: Planning our Response

Matthew Cole (Director, Public Health) presented the report to the Board.

Cllr Ramsay, in a question to the Board, raised his concern that testing strips were being rationed by GPs and warned against the problems infrequent testing can cause diabetics. Dr Mohi stressed the importance of testing, especially when people are newly diagnosed with diabetes. Dr Mohi assured the Board that patients were being prescribed enough testing strips to ensure regular testing of blood sugar levels.

Helen Jenner (Corporate Director, Children's Services) wished to go beyond the recommendations proposed by the HASSC and investigate further what can be done to improve services for children and young people who because of unhealthy lifestyles are being diagnosed with Type 2 diabetes. Helen Jenner volunteered Children's services input into the implementation of the recommendations that relate to young people.

Anne Bristow (Corporate Director, Adult and Community Services) commented that the scrutiny review managed to draw out some inconsistencies with diabetes health checks which need to be addressed by the CCG. Dr Mohi accepted that

there is room for improvement and stated that GPs are monitoring patients at risk of becoming diabetic and looking at compliance and quality with regard to the nine checks.

The Board discussed using this piece of work as an opportunity to define what patients should expect of diabetes services and aspiring to commission and deliver services that reflect that vision.

The Board agreed that ownership of implementing the recommendations should rest with the Public Health Programmes Board. Cllr Worby will report progress back to the HASSC on behalf of the Board and its sub-groups.

The Board agreed:

- the Action Plan set out in Appendix B
- to Review the Action Plan quarterly
- to Provide a summary of progress to HASSC in six months at their meeting in November 2013
- to refer the ongoing monitoring of the Diabetes Action Plan to the Public Health Programmes sub-group.

19. Draft Engagement Strategy

The Board noted the model used at the Learning Disability Partnership Board for determining how it will conduct its engagement.

The Board agreed to pull together a high level set of proposals around engagement, the following specific actions were proposed:

a) That sub-groups have engagement as an early item (first or second meeting), specifically to review how they link to existing forums, what gaps they have, and what tools and techniques they intend to deploy to ensure their work is grounded in the views of those affected;

b) This work to be collated into an engagement strategy 'map' showing the connections, information flows, and early specific plans for events, consultations and web developments;

c) That Healthwatch, the Health & Wellbeing Board support team and the CCG Operations team join together - with others who may be keen to contribute - to shape how the Board itself can use information being gathered through the emerging strategy, including online, written and face-to-face methods, and the expectations on how reports are crafted to include reference to feedback from residents and service users;

d) That the Health & Wellbeing Board support team pull together an overview of how the Council's social media channels and the website may be used by the Health & Wellbeing Board, with input from the Corporate Communications

team, in order to feed this into the developing strategy.

20. Chair's Report

Sign Translate

The Chair highlighted to CCG colleagues the lack of take up for the free 'Sign Translate' service and webcam. Dr Mohi stated that he would promote the service among local GP practices.

Measles

Further to his update at the last meeting (23 April) Matthew Cole confirmed to the Board that the measles immunisation catch-up programme will begin in June.

The Board noted the Chair's Report

21. Report of Sub Group(s)

Anne Bristow (Corporate Director, Adult and Community Services) reported to the Board developments from the Learning Disability Partnership Board's away day. It was noted that thought was given among delegates about how the sub groups would interact and communicate. Also, delegates opted for a set of core members, drawing from a pool of relevant associates as required. Overall the delegates were accepting of the changes presented to them and felt well engaged by the event.

22. Forward Plan

The Chair asked Board Members to put forward suggestions to the Forward Plan and to be mindful of the Council's requirements to publicly list decisions 28 days in advance of meetings.

The Board noted the Forward Plan.

HEALTH AND WELLBEING BOARD

16 JULY 2013

Title:	**North East and North Central London Health Protection Unit Annual Report 2012**
Report of the Corporate Director of Adult & Community Services	
Open	**For Information**
Wards Affected: ALL	**Key Decision:** NO
Report Author: Dr Deborah Turbitt, Deputy Director Health Protection, London (Public Health England)	**Contact Details:** Tel: 020 7811 7100 Email: Deborah.turbitt@phe.gov.uk
Sponsor: Matthew Cole Director of Public Health	

Summary:

The North East and North Central London Health Protection Unit Annual Report for 2012. This will be our last report under the banner of the "Health Protection Agency" (HPA): from 1 April 2013 we became part of Public Health England (PHE), an executive agency of the Department of Health.

The report details the activity carried out by the health protection team during 2012 to limit the impact of infectious disease within the communities of north east and north central London. The report looks at the cases and during 2012.

Recommendation(s)

The Health and Wellbeing Board is asked:

- To note the reported levels of infectious disease within the community
- To use the report to inform the Joint Strategic Needs Assessment

Reason(s)

Under the Health and Social Care Act 2012 the statutory Health and Wellbeing Board has a duty to protect the health of the population. This includes assuring that steps are taken to protect the health of their populations from all hazards[1], ranging from relatively minor outbreaks and contaminations, to full-scale emergencies, and to prevent as far as possible those threats arising in the first place.

1 Background

1.1 Public Health England (PHE) is the expert national public health agency which fulfils the Secretary of State for Health's statutory duty to protect health and address inequalities, and executes his power to promote the health and wellbeing of the nation.

1.2 PHE has operational autonomy. It has an Advisory Board with a non-executive Chairman and non-executive members. It employs scientists, researchers, public health professionals and essential support staff

1.3 It works transparently, proactively providing government, local government, the NHS, MPs, industry, public health professionals and the public with evidence-based professional, scientific and delivery expertise and advice.

1.4 PHE ensures there are effective arrangements in place nationally and locally for preparing, planning and responding to health protection concerns and emergencies, including the future impact of climate change. PHE provides specialist health protection, epidemiology and microbiology services across England.

1.5 Improvement in the public's health has to be led from within communities, rather than directed centrally. This is why every upper tier and unitary local authority now has a legal duty to improve the public's health. Local health and wellbeing boards bring together key local partners (including NHS clinical commissioning groups who have a duty to address health inequalities) to agree local priorities.

1.6 PHE will support local authorities, and through them clinical commissioning groups, by providing evidence and knowledge on local health needs, alongside practical and professional advice on what to do to improve health, and by taking action nationally where it makes sense to do so. PHE in turn is the public health adviser to NHS England

1.7 PHE works in partnership with the Chief Medical Officer for England and with colleagues in Scotland, Wales and Northern Ireland to protect and improve the public's health, as well as internationally through a wide-ranging global health programme

2. Legislative Framework

2.1 Under section 2A of the NHS 2006 Act (as inserted by section 11 of the Health and Social Care Act 2012), the Secretary of State for Health has a duty to "take such steps as the Secretary of State considers appropriate for the purpose of protecting the public in England from disease or other dangers to health". In practice, Public Health England will carry out much of this health protection duty on behalf of the Secretary of State

2.2 Under new section 252A of the NHS Act 20065, the NHS Commissioning Board (NHS England) will be responsible for (a) ensuring that clinical commissioning groups and providers of NHS services are prepared for emergencies, (b) monitoring their compliance with their duties in relation to emergency preparedness and (c) facilitating coordinated responses to such emergencies by clinical commissioning groups and providers.

2.3 The Health and Social Care Act 2012 also amends section 253 of the NHS Act 2006 (as amended by section 47 of the 2012 Act), so as to extend the Secretary of State's powers of direction in the event of an emergency to cover an NHS body other than a local health board (this will include the NHS Commissioning Board and clinical commissioning groups); the National Institute for Health and Care Excellence; the Health and Social Care Information Centre; any body or person, and any provider of NHS or public health services under the Act.

2.4 The Council has statutory duties for controlling risks to public health arising from communicable diseases and other public health threats and must appoint a Proper Officer to undertake key functions. The Public Health England provides the expertise to support local authorities in these functions and Consultants in Communicable Disease Control are generally appointed as the Proper Officer.

The Proper Officer appointed under the Public Health (Control of Disease) Act 1984 should be medically qualified. The main responsibility of the Proper Officer is to require information or action in relation to people, premises or objects which may be infected, contaminated or could otherwise affect health.

3. Local Health Protection Arrangements

3.1 As of April 2013 the responsibility for the delivery of Public Health Services is now with the London Borough of Barking and Dagenham. The new arrangements seek to build on existing partnerships and additionally aim to provide a streamlined, integrated process for prevention, planning and response to health protection incidents and events[1].

3.2 The delivery of Health Protection in this new environment will need strong working relationships and the legislative framework that unpins this objective ensures that organisations do what is required. At the local level NHS Barking and Dagenham Clinical Commissioning Groups and the NHS England have a duty to cooperate with the Council in respect of health and wellbeing.

3.3 Unitary and upper tier local authorities have a new statutory duty to carry out the Secretary of State's health protection role under regulations to be made under section 6C of the NHS Act 2006 (as inserted by section 18 of the Health and Social Care Act 2012) to take steps to protect the health of their populations from all hazards, ranging from relatively minor outbreaks and contaminations, to full-scale emergencies, and to prevent as far as possible those threats arising in the first place.

3.4 Directors of public health will be employed by local authorities and will be responsible for exercising the new public health functions on behalf of local authorities. Directors will also have a responsibility for "the exercise by the authority of any of its functions that relate to planning for, and responding to, emergencies involving a risk to public health".

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[1] http://www.dh.gov.uk/health/2012/08/health-protection-guidance/

3.5 Within this context, the Council has established a Health Protection Committee which supports the Director of Public Health in their role of leading the response, planning and preparedness to Health Protection challenges. The Committee reports through to the Board.

3.6 The purpose of the Committee is to put this into practice through facilitating, reviewing and instigating actions to protect the health of the local population

4. The Annual Report of North East and North Central London Health Protection Team

4.1 Dr Deborah Turbitt, Interim Deputy Director Health Protection, London will give a short presentation to the Board on the impact of infectious disease within the communities of north east and north central London

5. Public Health England Priorities for 2013-14

5.1 Reverse the current trends so that we reduce the rates of tuberculosis infections. We will work with local authorities and the NHS in those areas with high levels of tuberculosis infections to put in place effective strategies.

5.2 Lead the gold standards for current vaccination and screening programmes, reverse the current increase in cases of measles, and support the delivery of the new vaccine programmes for rotavirus, childhood flu, pertussis in pregnancy and shingles.

5.3 Tackle antimicrobial resistance through surveillance of patterns of resistance to antibiotics, supporting microbial stewardship and other national strategies to address the rise of antimicrobial-resistant organisms.

5.4 Develop and implement a national surveillance strategy to ensure the public health system responds rapidly to new and unexpected threats to health of all kinds, bringing together the full range of PHE surveillance and intelligence capabilities.

6. Mandatory Implications

6.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) has a strong overall health protection analysis including detailed immunisation, screening and communicable disease sections within it. There is general agreement that cross-sector working in the borough with involvement from the NHS, employment, housing, police and other bodies, in addition to the Council's children's services and adult and community services is good

6.2 Health and Wellbeing Strategy

The Health and Wellbeing Board mapped the outcome frameworks for the NHS, public health, and adult social care with the children and young people's plan. The strategy is based on eight strategic themes that cover the breadth of the frameworks in which health protection is picked up as a key issue. These are Care and Support, Protection and Safeguarding, Improvement and Integration of Services, and Prevention. Actions, outcomes and outcome measures for immunisation, screening and communicable disease control are mapped across the life course against the four priority areas

6.3 **Integration**

Currently, health protection at the local level is delivered by a partnership of the NHS, the Public Health England and local authorities. Public Health England leads and delivers the specialist health protection functions to the public and in support of the NHS, local authorities and others through local health protection units a network of microbiological laboratories and its national specialist centres.

The Public Health Outcomes Framework published on 23 January 2012, contains a health protection domain. Within this domain there is a placeholder indicator, "Comprehensive, agreed inter-agency plans for responding to public health incidents". The Department of Health is taking forward work to ensure that it can effectively measure progress against this indicator.

6.4 **Financial Implications**

(Implications completed by: Dawn Calvert, Group Manager, Finance)

There are no direct financial implications for Barking and Dagenham as a result of the 2012 annual report. It is recommended the report is used to inform the Joint Strategic Needs Assessment (JSNA). Any actions from the JSNA that require resources from the Local Authority are most likely to be funded from the Public Health Grant.

6.5 **Legal Implications**

(Implications completed by Lucinda Bell, Solicitor Social Care and Education)

The Board is asked to note the contents of the report and use it to inform the JSNA. Section two of the report contains detail of the legislative framework relating to its contents.

6.6 **Risk Management**

Health protection needs constant appraisal and will always be in need of strengthening. Complacency is the greatest danger – the notion that we have the issue 'sorted out' is always going to be dangerous. There is great value in joint exercises, which have worked well in the past, to maintain and/or heighten awareness, identify issues and provide for a more robust and effective response to problems. One of the main functions of Public Health England is to collate information; provide linkage between organisations; increase research capacity, co-ordination and utility; and provide education and training (principally for frontline staff but always with an eye to the needs of the public).

7. Background Papers used in the preparation of the Report

North East and North Central London Health Protection Unit – Annual Report 2012

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HEALTH AND WELLBEING BOARD

16 JULY 2013

Title:	**Health & Wellbeing Strategy Priority - Maternity Services**
Report of the Children and Maternity Sub-group	
Open	**For Information**
Wards Affected: ALL	**Key Decision:** YES
Report Author: Sharon Morrow, Chief Operating Officer, Barking and Dagenham Clinical Commissioning Group	**Contact Details:** Sharon.morrow@barkingdagenhamccg.nhs.uk
Sponsor: Conor Burke, Accountable Officer, Barking and Dagenham CCG	
Summary: This report provides an update for the Health and Wellbeing Board on the changes to maternity services in north east London, including the redistribution of births. It outlines the improvements made by Barking, Havering, Redbridge University Hospitals NHS Trust to maternity services and provides details of the governance and assurance processes in place to monitor quality.	
Recommendation(s) The Health & Wellbeing Board is asked to note the report.	
Reason(s) This report responds to a request to provide an update to the Board on maternity services.	

1. Introduction

This report is being made by the Children and Maternity Group, which reports jointly to the Children's Trust and the Health and Wellbeing Board. The report has been produced to respond to concerns raised at the meeting of the NHS Barking and Dagenham Clinical Commissioning Group (CCG) Governing Body on 29 January 2013 in relation to maternity services at Barking, Havering, Redbridge University Hospitals NHS Trust (BHRUT). The report provides an overview of recent changes to maternity services across north east London, an overview of current performance and safeguarding issues.

2. Background

At the time of writing, approximately 90% of residents of Barking and Dagenham access maternity care at Queen's Hospital, provided by BHRUT. From May 2013 around 1,000 bookings (800 births) per annum from the borough moved from BHRUT (Queens Maternity Unit) to Barts Health NHS Trust at Newham Maternity Unit and at the Barking Birthing Centre at Barking Community Hospital. This follows the closure of the intra-partum maternity service at King George's Hospital in March 2013. The background to the changes in services and to the concerns about quality of maternity services at BHRUT is set out in brief below.

2.1 Quality concerns

Around April 2011 concerns were raised about the standard of maternity care provided by BHRUT were providing, which ranged from very poor staffing levels, serious incidents reporting and delayed interventions leading to poor outcomes for women and babies. At this time BHRUT provided maternity services at both Queen's and King George's Hospitals. This appeared to be a long standing problem that was getting worse. CQC carried out inspections in April and September and informed BHRUT and the PCT commissioners that immediate actions were required. The commissioners and provider worked closely together to implement actions including a cap on the daily number of births at both sites and stringent monitoring.

BHRUT with support from the PCT and NHS London, carried out intensive work to improve the quality and safety of maternity services. The most recent report from the CQC (published 26 January 2013)[1] following an unannounced inspection in December 2012 showed that a range of improvements had been made and that the care of women had improved. The women spoken to during the inspection were unanimous in saying that the care they were receiving was of a high standard.

2.2 Redistribution of maternity care across north east London

To support the necessary improvements in the quality of maternity services at BHRUT and to improve choice and sustainability of maternity services across north

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1 http://www.cqc.org.uk/sites/default/files/media/reports/RF4_Barking_Havering_and_Redbridge_University_Hospitals_NHS_Trust_RF4QH_Queens_Hospital_20130126.pdf

east London, maternity care has been redistributed through a phased approach. The main changes that have been made are summarised below:

- Overall the BHRUT catchment area decreased to enable a reduction in births. BHRUT are on trajectory to deliver around 8000 babies in 2013/14. (circa 2,560 deliveries for Barking and Dagenham CCG)
- A reduction in births at BHRUT from c.9500 pa to c.8000 pa (7500 BHR CCGs / 500 Essex).
- The transfer of births to one site (King George Hospital labour ward and theatres closed in March 2013)
- The opening of a midwifery led birthing unit at the Queen's site. This opened in January 2013 and is providing an average of 80 births a month. Positive feedback from women and families has been received about this service.
- An expansion of the Newham Hospital (Barts Health) catchment area for maternity services to cover a part of Barking and Dagenham.
- Newham Hospital (Barts Health) now provide services (including births) at the Barking birthing centre at Barking Community Hospital. Barking birthing centre opened to antenatal care in May 2012, postnatal care in July 2012 and to births in December 2012. There have been approx 65 births to date. Under the Health for north east London planning assumptions, the plan is for there to be 287 births in 2013/14 at the Barking Birthing Centre (a run rate of 29 per month by March) and 360 (30 per month) in 2014/15.
- An expansion of the Whipps Cross Hospital catchment area to cover a part of Redbridge, but also to withdraw from some areas of Waltham Forest, therefore no increase in total births at this site.
- An expansion of the Homerton Hospital catchment area into a part Waltham Forest, thus increase in births from that area.

3. Governance

During 2012/13 the governance for the changes summarised above was held by the North East London Cluster Board on behalf of north east London PCTs. The maternity system readiness board (MSRB) chaired by Dr T C Mohan, Barking and Dagenham Clinical Director, provided clinical commissioning oversight of readiness for change on behalf of Barking and Dagenham shadow CCG. A provider forum was established as a sub-committee of the MSRB to coordinate changes required. An external clinical assurance process ("Gateway Reviews") was put in place to support safe and effective implementation of the changes and to provide assurance to NHS North East London and the City (NELC) PCTs and NHS London in making the final decision regarding system readiness to proceed.

Discussions are now underway as to how commissioners and providers can continue to work together to ensure oversight of maternity services across north east London moving forward.

Performance monitoring of maternity services takes place through established contracting processes. Of particular relevance to this paper is the Barking Havering and Redbridge CCGs monthly maternity Clinical Quality Review Meeting (CQRM) with BHRUT, which is a sub group of the main Clinical Quality Review Meeting (CQRM). This is chaired by Dr Mohan in his capacity as Barking and Dagenham Clinical Director maternity lead, with representation from Havering, Redbridge and Essex CCGs. This meeting provides the formal opportunity to review the maternity dashboard, audits and patient experience feedback. There is a route to escalate issues to the main CQRM.

There is also a Newham site specific maternity quality meeting which has Barking and Dagenham CCG representation. The first meeting was held in June, and is planned to be held monthly. Barking and Dagenham CCG will also be represented at the Barts Health maternity board which met in April and scheduled to meet again in June, and bi-monthly thereafter.

4. Current performance

BHRUT:

Following the Gateway Reviews two sets of recommendations were made in relation to BHRUT, those for final action and assurance prior to final closure of the King George Hospital intra-partum service (all 6 have now been completed) and recommendations relating to ongoing assurance and system engagement (7 recommendations), which relate to:

- Close monitoring of the quality of maternity and neonatal services;
- Close monitoring of activity levels and increasing the proportion of women receiving care through the Queen's Birthing Centre (QBC);
- Monitor and audit outcomes of unexpected maternity attendances at KGH site for a minimum of 12 months following service change;
- The progression of the business case to centralise the Special Care Baby Unit (SCBU) onto the Queen's site to the agreed timelines;
- Review strategy to increase the proportion of out of hospital births by both the Trust and Commissioners;
- Review of Serious Incidents (SIs) relating to Obstetric Theatres through CQRM.

There is a well established monthly Maternity Clinical Quality Review Meeting (CQRM), chaired by Dr Chandra Mohan (Barking and Dagenham CCG), which is attended by a range of CCG representatives, including Diane Jones, Deputy Nurse Director of BHR CCGs who was previously a PCT Maternity Commissioner.

The Trust produces on a monthly basis a "Maternity Performance Dashboard" which is presented at the Maternity CQRM meeting and any issues requiring escalation are then fed into the overall BHRUT CQRM. As an example, the last two matters to have been escalated to the CQRM related to a safeguarding audit (which was escalated positively for feedback) and unfunded High Dependency Unit (HDU) beds which is currently being progressed via the Technical Sub Group (TSG).

From the March 2013 Dashboard, out of the 57 KPIs there were 7 areas “red rated” (action required) in January, 4 in February and 6 in March 2013, with the vast majority of areas “green rated”. The latest information received for April 2013 highlights the following areas:

- Serious Incidents (SIs) and Governance issues - There are six SIs for the month of April, one has been de-escalated as it was a category 0 the remaining five have care and delivery problems that are being fully investigated. 83% of the reports have been submitted within the time frame.

- Home births - the homebirth rate remains low. There have been discussions about the possible implementation of a home birth team, however the priority has been to stabilise the Queens Birthing Centre.

- Queen’s Birth Centre - the birth centre did not reach its target for this month; there is a month on month increase in deliveries which will reach the proposed target by the end of the year. The birth centre midwives are going to work in triage to identify the low risk women and triage them to the birth centre.

- Triage - 90% of women were seen within 30 minutes of arriving in triage. There has been a marked improvement this month due to increased doctors presence.

- Midwife vacancies - the vacancy rate remained the same this month at 11%. There will not be notable change until the funded establishment is reviewed and reduced in the new financial year.

- Staff turnover - this is high due to the TUPE of staff at the end of 2012, it will take a year until this figure improves.

- Maternal morbidity - all cases are reviewed and investigated by the governance team. The NHS London audit tool is used to review cases and these have been exceedingly well managed with a large amount have established risks. The remaining incidents do not appear to have identified any re-occurring themes in relation to care and service delivery problems.

A range of key performance indicators (KPIs) have been agreed as part of the 2013/14 contract negotiations with the Trust and they will form part of the Maternity Performance Dashboard referred to above and as such will be focussed on as part of the monthly CQRM review.

<u>Barts Health NHS Trust</u>

Arrangements are still being finalised however the current proposed way forward is for a Barts Health wide Maternity Board, underpinned by local site specific maternity CQRMs. Initial meetings of all four meetings have now been held/scheduled and detailed scope and roles/responsibilities will be developing during Quarter 2 2013/14. The meetings relating to Newham Hospital will be chaired by Newham CCG on behalf of all CCGs with an interest in the services provided by Barts Health.

5. Safeguarding issues

There is a strong safeguarding framework across the provider organisations for both children and adults. Children's safeguarding is overseen by the Barking and Dagenham CCG designated nurse for safeguarding.

All the staff with a lead for safeguarding were made aware of the maternity services redistribution and the potential challenges with cross boundary working. A meeting was held 9th January 2013 with the safeguarding lead midwives from provider services (Barts Health, BHRUT and Homerton) to discuss safeguarding issues in relation to the redistribution changes. All parties confirmed that an effective named midwife network is in place for advice and support and that there is a mechanism for referral to the appropriate borough social care services. A report was presented to the Barking and Dagenham Local Safeguarding Childrens Board in February 2013 to provide assurance on the safeguarding arrangement in place.

Post redistribution, the safeguarding leads have not reported any serious incidents due to the changes that happened. However, this will continue to be monitored through the SI governance process in place.

5 Mandatory Implications

5.1 Joint Strategic Needs assessment

The Joint Strategic Needs Assessment (JSNA) has a strong overall maternity service analysis within it. Key recommendations to Commissioners are:

- Ensure all women have high quality local support and access to services during pregnancy, through a review of maternity pathways by the Clinical Commissioning Group.
- Ensure that commissioning plans for service provision across the partnership have taken into account the local growth in the population aged five years and under.

5.2 Health & Wellbeing Strategy

The Health and Wellbeing Board mapped the outcome frameworks for the NHS, public health, and adult social care with the children and young people's plan. The strategy is based on eight priority themes that cover the breadth of the frameworks in which maternity services is picked up as a theme and mapped across the priority areas: Care and Support, Protection and Safeguarding, Improvement and Integration of Services, and Prevention. Actions, outcomes and outcome measures for maternity services are mapped against the four priority areas.

5.3 Integration

Women with known safeguarding issues and particularly with previous children in care, it was agreed that they should remain within borough for maternity care where there is knowledge of the family history.

Each maternity unit has a designated social worker who liaises closely with the named midwife and is a process that continues to work well. Any concerns identified by hospitals are discussed with the named midwife and social care team. A referral is made to the local borough social care team. Within B&D the referral is named midwife and social worker.

5.4 Financial Implications

There are no financial implications arising from this report.

5.5 Legal Implications

There are no legal implications arising from this report.

5.6 Non-Mandatory Implications

None.

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HEALTH AND WELLBEING BOARD

16 JULY 2013

Title:	**Summary and Key Recommendations of the Joint Strategic Needs Assessment 2012/13**

Report of the Director of Public Health

Open	**For Information**
Wards Affected: ALL	**Key Decision:** YES
Report Author: Dawn Jenkin, Head of Public Health Intelligence	**Contact Details:** Tel: 020 8227 5344 E-mail: dawn.jenkin@lbbd.gov.uk

Sponsor:

Matthew Cole, Director of Public Health

Summary:

This paper provides the key strategic recommendations arising from the refresh of the Joint Strategic Needs Assessment (JSNA) for 2013.

The JSNA comprises a large number of small sections which will be made available from the JSNA website, and more specific recommendations can be found there. Additionally some recommendations remain unchanged since 2012. The main driver for most of the changes in recommendations are the changes in demography seen in the borough between the 2001 and 2011 censuses, as well as changes linked to the economic climate and benefits changes.

In particular the emerging population structure of the borough will have significant implications for the planning of services and health improvement initiatives. The wide population base and narrow top of the borough's population pyramid is more typical of a developing country with a high birth rate and poor life expectancy.

Recommendation(s)

The Health and Wellbeing Board is recommended to agree:

(i) To note the recommendations of the JSNA.

(ii) To discuss the recommendations and their implications for strategic and commissioning decisions.

(iii) To accept the recommendations of the JSNA as providing a sound evidence base on which future commissioning and strategic decisions of the board can be made.

Reason(s)

The Joint Strategic Needs Assessment provides the fundamental evidence base on which the commissioning and strategic decisions of the board are made. It directly informs the development of the Joint Health and Wellbeing Strategy. It is a statutory duty of the Health and Wellbeing Board to produce the JSNA.

1. Introduction and background

Process and timetable

1.1 The Joint Strategic Needs Assessment (JSNA) should be seen as an iterative process, whereby as new information becomes available during the year the JSNA website is updated. In the summer of each year a paper will be tabled at the Health and Wellbeing Board which pulls together all the commissioning recommendations that have arisen from the evidence collated through the JSNA process during the preceding year. The rationale for this is that new information becomes available at different times of the year, i.e. the Carers' Survey results will not be available for inclusion until April 2013, relevant information on crime and disorder and adult social care will also not be available until after April.

Structure

1.2 The JSNA will continue to be structured using the 'life course' approach. It will be made available via the JSNA website which is a micro site of LBBD internet. There will be clear indexing of the sections which will be available for download in Adobe PDF format. Additionally other documents such as specific needs assessments, equity audits, and key documents relating to local health and social care needs from sources such as the national Public Health Observatories and Health Atlas will be uploaded to the site.

2. A summary of the key recommendations

2.1 In keeping with the life course approach, key recommendations for each stage across the life course have been selected, as shown overleaf. The evidence of need, key issues and recommendations, are discussed in further detail in the rest of the paper.

LIFE COURSE STAGE	KEY RECOMMENDATIONS
Pre – birth and early years	Ensure that commissioning plans for service provision across the partnership have taken into account the local growth in the population aged five years and under, in particular assuring the appropriate health visitor capacity is commissioned, through the Healthy Child Programme, for the needs of a growing population. Build on local successes, with continued support for improving uptake of childhood immunisation and promoting breastfeeding continuation at 6 to 8 weeks, and effective cross partnership working between local and regional stakeholders.
Primary School	Accelerate the positive impact already achieved on foundation stage outcomes for disadvantaged children, by increasing the capacity for targeted parenting support in children's centres. Ensure an effective focus, within the whole system approach, on achieving and maintaining healthy weight for children, including the promotion of breastfeeding, child nutrition and physical activity.
Adolescence	Ensure integrated and effective support to children and young people living with or affected by illness, disability or learning disability, through partnership work with the Children's Trust, to review issues of transition of care from childhood to adulthood. Take a proactive approach to local sexual health needs, through an integrated programme across the life course, to support a reduction in teenage conceptions and sexually transmitted infections.
Early Adulthood	Create opportunities for local residents to gain employment skills and experience by requiring all providers of services to offer work experience (for young people, care leavers and disadvantaged adults) and apprenticeships. Improve the outcomes for people living with diabetes, through the board's commitment to better diabetic care and services.
Maternity	Ensure all women have high quality local support and access to services during pregnancy, through a review of maternity pathways. Ensure that commissioning plans for service provision across the partnership have taken into account the local growth in the population aged five years and under, including anticipated demands on maternity services.

LIFE COURSE STAGE	KEY RECOMMENDATIONS
Established Adults	Take action across the entire care pathway, to improve outcomes for people with chronic diseases, via the leadership of the board, including integration of primary, secondary, social and community care. Promote a system wide approach to early diagnosis and secondary prevention, through working with practices that perform poorly on active case finding, evidence based prescribing and uptake of influenza vaccinations.
Older Adults	Promote a multi-component and wide ranging affordable warmth strategy, aimed at reducing fuel poverty and excess cold winter deaths, through insulation programmes and initiatives such as the Big Energy Switch. Provide better access to choice and dignity for residents at end of life, through the development of systems and training across health settings, including in acute care and in nursing and residential homes, which support the individual's wish to die at home.
Vulnerable and Minority Groups	Prioritise the development of a supported employment pathway within the borough for people with a learning disability or mental illness. Ensure victims have access to integrated, inclusive domestic and sexual violence services, through the development of a joint Health and Social Care Commissioning framework. Prioritise the health of looked after children by ensuring 95% compliance with health checks by the end of 2013/14.
Priorities spanning the life course	Tackle the challenge of obesity through a co-ordinated industrial scale, whole-system approach, including a partnership Healthy Weight Strategy and action plan. Tackle the single largest cause of preventable death and ill-health, through a whole system approach to reducing smoking prevalence, which includes high quality, locally responsive stop smoking services, a focus on supporting young people not to take up smoking and robust tobacco control measures. Recognise residents and local community groups as 'experts' in understanding their own health needs, by involving them systematically in all delivery plans and developing a strategy to engage with all sections of the borough, in particular seldom heard groups.

3. Key issues

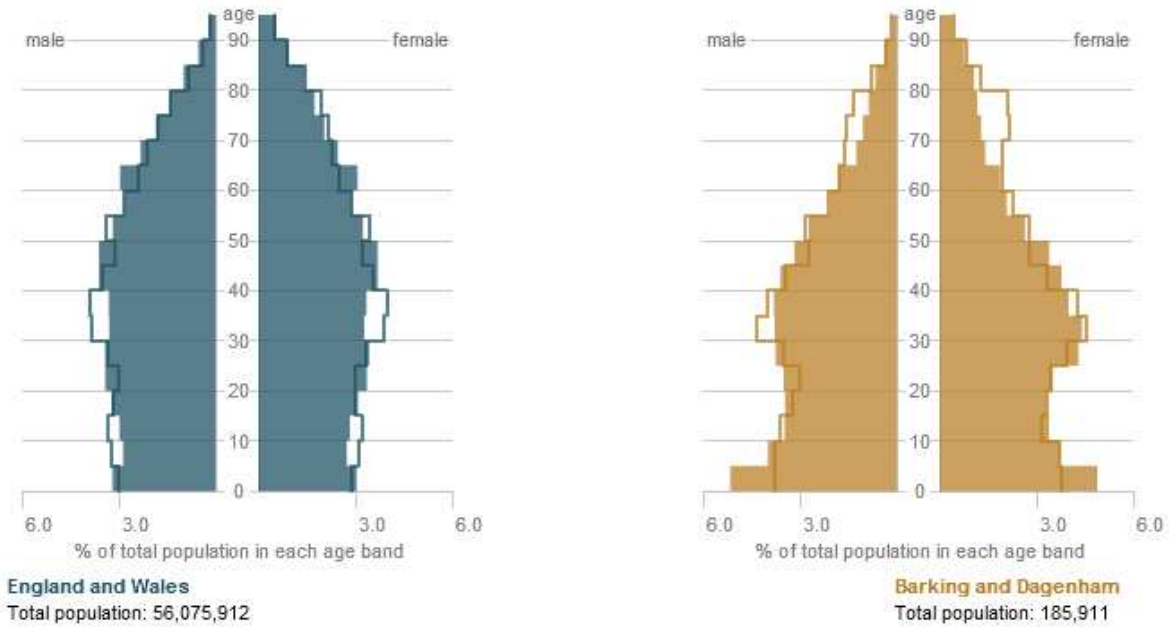
3.1 Demography

3.1.1 The 2011 Census showed that there were 185,911 people living in Barking and Dagenham. This was an increase in the overall population of 22,000 (13.4%) between 2001 and 2011, while the increase across England was 7%. The majority of this increase was amongst children and younger adults.

The population of 0 to 4 year olds rose by almost 50%, and one in four of the local population is now aged 15 or under. The proportion of the population aged 40+ is very similar in Barking and Dagenham (37.5%) to that in London (39.7%); however, Barking and Dagenham continues to have a lower proportion of elderly people (65+) when compared to the proportion in England as a whole, and this fell by 20% (4,800 people) between the two census dates. This was the largest decrease seen in this age group across London. The mean age of the population in 2011 was 33.4 compared to a London mean of 35.6 and an England mean age of 39.3.

3.1.2 The latest available Mid Year Estimate of population for the borough, published by the Office for National Statistics (ONS) was 187,029 at mid 2011, an increase of 1,118 since the 2011 census date.

Figure 1: 2011 Census Population Estimates (outlines show 2001)



Source: ONS 2001 mid-year population estimates, 2011 Census. ONS Data Visualisation Centre

3.1.3 Figure 1 shows the difference in the population structure of Barking and Dagenham compared to England and it further highlights the differences between the borough and the nation at last census.

3.1.4 The wide population base and narrow top of the borough's population pyramid is more typical of a developing country with a high birth rate and poor life

expectancy. This will have significant implications for planning of service provision, to meet the needs of a population which has both a very large proportion of children aged under 5, and an older population with a larger burden of ill health, leading to a reduction in healthy life expectancy and increased early mortality.

3.1.5 Another significant change has been a large increase in the proportion of the population from black and minority ethnic (BME) groups, predominantly the black African ethnic group, although other groups such as the Bangladeshi and 'white other' population have increased. The proportion of the population of white British origin fell from 80.86% in 2001 to 49.46% in 2011, which was the largest fall in any borough in the UK. This will impact on health and social care need as some diseases vary in prevalence across diverse groups.

3.1.6 The population is projected to continue growing in number with a predicted rise from 187,029 in 2011 to 226,471 in 2021 and to 249,063 by 2031.[(i)] The number of young people under 14 years of age and middle aged people between 25 years and 40 years of age is also projected to increase. Barking and Dagenham will continue to have a lower proportion of elderly people when compared to the proportion in England as a whole. This means the challenges associated with an increase in the ageing population may be less of an issue here compared to the rest of England. However the decreasing population size may be counter balanced by the relatively high deprivation and lower than average life expectancy experienced in the borough, which could be linked to poor health and co-morbidities at an earlier stage in life, driving up the need for health and social care support. This is supported by the Marmot Review, which indicates that the gap between life expectancy and disability free life expectancy is greatest in areas of greatest deprivation.[(ii)]

3.1.7 Given the clear pace of change in the demographic profile of the borough, analysis of demographic change and its impact on services will remain a critical aspect of the ongoing JSNA process.

3.2 Give every child the best start in life

- In 2011 there were 3,688 births to women resident in the borough. 60% of these births were to mothers born outside the UK, predominantly in Africa or Europe. There was also a fall in the proportion of younger mothers. This changing demographic is likely to result in an increasingly complex maternity caseload requiring significant co-ordination of local services to support families with young children.

- As well as the significant increase in births, there has been a 43% increase in the number of lone parent households. Of the 9,965 such households, 54% of parents were not in employment, despite a 91% increase in the number of parents in part-time or full-time employment. The 2011 Census also found that just under 5,000 households with dependent children also had at least one person in the household with a long term health problem or disability.

- Repeated United Kingdom confidential inquiries into maternal deaths have highlighted that a small number of women are murdered by their partner, ex-partner or someone known to them during or shortly after pregnancy. These reports have suggested that the incidence of domestic violence increases while women are pregnant. Between October 2012 and December 2012 the Independent Domestic and Sexual Violence Advocacy project, based within the maternity services at Queen's Hospital, supported 52 pregnant women from Barking and Dagenham.

- Teenage pregnancy rates remain amongst the highest in London. There is strong evidence that having children at a young age can damage young women's health and wellbeing and severely limit their education and career prospects, and that children born to teenagers are more likely to experience a range of negative outcomes later in life. There is a clear need for specific targeted interventions to support those women who choose to become teen parents to mitigate the impact on both mother and child.

- Immunisation uptake has improved significantly and moved substantially closer to the local target of 90% uptake but still remains below the national target of 95% across all childhood immunisations.

- Breast feeding rates at 6 to 8 weeks in Barking and Dagenham are substantially below the London average, but are above the England average. There has been a significant increase of between 8 and 12% in breastfeeding prevalence rates during 2011/12.

- There is growing evidence that targeted parenting support through children's centres is closing the gap in Foundation stage outcomes between disadvantaged children and the borough and national average (i.e. the principle of convergence).

KEY RECOMMENDATIONS

Ensure that commissioning plans for service provision across the partnership have taken into account the local growth in the population aged five years and under, in particular assuring the appropriate health visitor capacity is commissioned, through the Healthy Child Programme, for the needs of a growing population.

Ensure all women have high quality local support and access to services during pregnancy, through a review of maternity pathways.

Ensure that we support evidence based commissioning decisions about maternity through the use of robust data and information across the public health system.

Build on the local successes, with continued support for improving uptake of childhood immunisation and promoting breastfeeding continuation at 6 to 8 weeks, and effective cross partnership working between local and regional stakeholders.

Accelerate the positive impact already achieved on foundation stage outcomes for disadvantaged children, by increasing the capacity for targeted parenting support in children's centres.

3.3 Enabling children and young people

- The population of children and young people aged 5 to19 in Barking and Dagenham grew by 15% between the 2001 and 2011 census.

- The number of young people aged 16-17 in education increased by 66% between 2001 and 2011.

- There are about 2,000 children and young people living with a severe disability locally, and a further 4,700 with a mild disability/impairment.

- The proportion of children with special educational needs (SEN) is higher in Barking and Dagenham than the national average, although there has been a reduction since 2010, reflecting the work with schools to ensure inclusive practice and appropriate use of the special educational need processes and utilise the common assessment framework effectively to support children and young people at an earlier stage through Education Improvement Plans and School Action.

- The Children and Families Bill published on 5 February 2013 includes clauses on SEN and disability which aim to reform this system. They include a duty on all local authorities to draw up Education, Health and Care (EHC) plans, to replace statements and learning difficulty assessments. There is also a requirement to improve cooperation between all the services that support children and their families and particularly requiring local authorities and health authorities to work together.[iii]

- There is limited information on local prevalence of long term health conditions in children and young people; however published data on hospital admissions shows that Barking and Dagenham has significantly higher emergency admissions for asthma in childhood than London or England, although a shorter average length of stay which suggests these may be avoidable admissions.

- One in ten children and young people nationally has a clinically significant mental health condition. Applying this estimate to Barking and Dagenham would suggest that at least 4,500 children and young people in the borough are affected. Further work is needed to gather robust local information on the mental health and wellbeing of children and young people.

- Children living with domestic violence are likely to experience both physical and emotional impacts. Between 1 April 2012 and 31 July 2012, there were 668 child safeguarding referrals made in Barking and Dagenham, of which 132 had domestic violence as a stated issue, this equates to 19.8%.

- The Health and Wellbeing Strategy identified the importance of considering the needs of vulnerable groups. This JSNA has started to do limited exploration of the needs of children and young people from vulnerable groups but further work is needed to expand on this.

- Barking and Dagenham has the fifth highest proportion of overweight and obese children in Reception class (27%) and the fourth highest proportion in Year 6 (42%) in England. Further details and recommendations are provided under Section 3.7 Ill Health Prevention.

KEY RECOMMENDATIONS

Ensure that commissioning plans for service provision across the partnership have taken into account the local growth in the population aged five to 19 years

Support the partnership work to implement the statutory responsibilities of the Children and Families Bill, with regard to the development of Education, Health and Care plans.

Ensure integrated and effective support to children and young people living with or affected by illness, disability or learning disability, through partnership work with the Children's Trust, to review issues of transition of care from childhood to adulthood.

Enable improved care and support for children and young people living with long term conditions through a review of clinical care pathways.

Investigate further, within the next refresh of the JSNA, the underlying patterns and causes for high levels of emergency admissions for asthma.

Engage with secondary school children via the 'TellUs' health survey to improve understanding of health risk and need in adolescence.

Consider the re-establishment of specialist health improvement support to schools and educational settings.

Implement changes to the provision of specialist support for children and young people witnessing or experiencing domestic violence and intimate violence, following a review of existing pathways, in partnership with the Children's Trust.

Ensure that children and young people have the opportunities to live a healthier life through a comprehensive lifestyle approach to obesity, smoking, sexual health, alcohol misuse and physical activity.

3.4 Fair employment and good work for all

3.4.1 Dame Carol Black in 'Working for a Healthier Tomorrow' [(iv)] identified that the annual economic cost of sickness absence and worklessness associated with working age ill-health were estimated to be over £100 billion. Recent changes to benefits and the proposed changes to Remploy may increase this cost.

3.4.2 Additionally the Marmot report on health inequalities concluded "Being in good employment is protective of health. Conversely, unemployment contributes to poor health. Getting people into work is therefore of critical importance for reducing health inequalities" [(ii)].

3.4.3 13.8% of Barking and Dagenham residents have no qualifications, and only 65% of working age people were in employment in 2011. Of those who were in employment a number will be in part time work and in low paid jobs – the average weekly pay of a local resident is £551 compared to a London average of £613. Over 12,000 people (10.5% of working age population) had been claiming 'out of work' benefits for more than a year.

3.4.4 35% of households in Barking and Dagenham had no adults in employment in the household, and there were dependent children living in 30% of such households.

3.4.5 The latest figures (2012) show that a smaller proportion (37.5%) of people aged 16-64 with any disabilities in the borough are in employment, compared to 45.3% in London and 48.9% in England.

3.4.6 According to 2011/12 returns for National Indicator NI146 only 6.5% of adults with learning disabilities assessed or reviewed by adult social services were in paid employment. This ranked the borough 20th out of 31 London boroughs for which figures were available. Similarly the returns for National Indicator NI150 showed that only 5.9% of adults receiving secondary mental health services in the borough were in employment in 2011. This ranked the borough 18th from 31 London boroughs for which figures were available. These figures should be viewed in context of unemployment levels seen across the population in Barking and Dagenham, which may result in an increased difficulty in securing paid employment for those with learning disabilities or mental illness.

KEY RECOMMENDATIONS

Create opportunities for local residents to gain employment skills and experience by encouraging all providers of services to offer work experience (for young people, care leavers and disadvantaged adults) and apprenticeships.

Build on existing good practice by continuing to invest in programmes, such as apprenticeships, which increase the skills base and qualifications of residents.

Prioritise the development of a supported employment pathway within the borough for people with a learning disability or mental illness, including training and volunteering opportunities, in line with the Fulfilling Lives programme.

3.5 Health promotion

3.5.1 The health promotion section of the JSNA looks at the wider determinants of health and how they impact on life for local residents. From homelessness to overcrowding to fuel poverty to social housing and special housing needs, people's health and wellbeing will be improved or made worse by the support that society and communities provide. For example the fifth of the population with most exposure to green spaces during their lives have lower rates of mortality from

circulatory disease than the fifth with least exposure and whilst this is true across all social classes, the difference in rates is most stark in the least well off. A greater proportion of local residents live in fuel poverty here than in any other London borough (13.8%).

3.5.2 One of the greatest impacts on long term health is the type and quality of housing in which people are able to live. People in rented accommodation (both private rented and social housing) can experience higher rates of ill health than people who own their own homes. As a group, they can also experience higher rates of unemployment, ill health and disability than the average population.

3.5.3 During the last two years the Council has experienced a significant increase in housing pressure which has manifested itself in a rise in temporary accommodation placements and within that, an unwelcome major increase in bed and breakfast usage, which peaked in August 2012 at 226 households, 116 of which had at that time been in such accommodation in excess of 6 weeks, placing the Council in breach of legislation. The waiting list for housing has grown by 50% in the last five years to 15,200. Early local estimates have indicated that approximately 45 families will be affected by changes to housing benefits. Ongoing local analysis via the JSNA is required to further quantify the expected impacts on housing need and health. Barking and Dagenham is still seen as relatively affordable for private rented homes, and this may be attractive to housing benefit claimants and people on low incomes.

3.5.4 Leisure facilities are being expanded within the borough. Becontree Heath Leisure Centre has been completed, and a new centre is being built for Barking. The 2012 Olympics created additional investment into leisure facilities in the borough.

KEY RECOMMENDATIONS

Support the development of an updated Position Statement, on the Barking and Dagenham homelessness strategy, which focuses on solutions that take into account the health and wellbeing impact of housing issues. This will be integrated into the Barking and Dagenham Housing Strategy, and the Barking and Dagenham Joint Health and Wellbeing Strategy.

Explore and consider creative options to provide affordable high quality homes for local residents.

Promote a multi-component and wide ranging affordable warmth strategy, aimed at reducing fuel poverty and excess cold winter deaths, through insulation programmes and initiatives such as the Big Energy Switch.

Foster and build on the momentum created by the 2012 Olympics, by encouraging more people to be involved in sport and physical activity.

3.6 Community safety

3.6.1 Crime surveys have shown that Barking and Dagenham residents are more concerned about crime in their neighbourhoods than the London average. There are specific concerns about crimes involving gangs, guns and anti-social behaviour.

3.6.2 Meanwhile statistics on actual crimes show that within the borough:

- Barking and Dagenham continues to have the highest reported incidence of domestic violence in London. Nationally in 2011/12 domestic violence accounted for 15% of violent incidents and nearly half of assault with injury and common assault offences are related to domestic violence. Local police estimate that domestic violence accounts for 35% of violent crime with half of assault with injury and common assault offences in Barking and Dagenham related to domestic violence. There is also a link between excessive alcohol consumption and domestic violence.

- Barking and Dagenham has significantly reduced the number of first time entrants (FTEs) to the youth justice system over the last four years. This demonstrates that the approaches in the crime reduction and local Youth Offending Service (YOS) partnership are effective.

- In 2011/12 Barking and Dagenham had the highest number of young people (under 18yrs) in substance misuse treatment in London. The primary substances misused were alcohol and cannabis.

KEY RECOMMENDATIONS

Champion a multi-agency joint working approach to meeting victim's health and support needs, extending across criminal justice agencies, the health service, the Local Authority and the voluntary sector.

Secure resource for the implementation of the 2012-2015 Domestic and Sexual Violence Strategy.

Ensure victims have access to integrated, inclusive domestic and sexual violence services, through the development of a joint Health and Social Care Commissioning framework.

Raise the effectiveness of partnership agencies in detecting and responding to violence (including hate crime, female genital mutilation, honour based violence and forced marriage) through data recording systems which have alerts for domestic and sexual violence.

Develop a tailored approach to supporting young victims of crime (including hate crime), to allow early recognition and support for physical and mental health needs.

Act to tackle the predicted rise in gang activity, by promoting targeted strategies aimed at diverting young people from involvement in crime, gangs and gang-related activities.

3.7 Ill health prevention

- According to the London Health Observatory in February 2013, Barking and Dagenham still has the second highest overall smoking prevalence in London. Around a third of people on Primary Care Long Term Conditions Registers

continue to smoke and specifically on the Chronic Obstructive Pulmonary Disease (COPD) register almost 4 in 10 (37%) people are smokers.

- Smoking attributable deaths from lung cancer and chronic lung disease are also the second highest in London, second only to Tower Hamlets. New registrations for lung cancer are the highest in London. However proportional spend on lung cancer treatment appears low – Barking and Dagenham ranks 122nd out of 151 English PCTs for spend on this condition.

- Barking and Dagenham has the fifth highest proportion of overweight and obese children in Reception class (27%) and the fourth highest proportion in Year 6 (42%) in England. The adult obesity prevalence in the borough is estimated at 14%. Adult participation in physical activity was the second lowest in London.

- There is a higher rate of alcohol-attributable admissions to hospitals locally than the average for London or England. There are also higher rates of assault (both sexual assault and violent assault) linked to alcohol. In terms of mortality from chronic liver disease, local rates (2008/10) were 9th highest in London. Locally, comparative (per 100,000 population) spend on substance misuse is the second highest in England. It is unclear though if this includes spend on alcohol treatment.

- The NHS is often the first point of contact for victims of domestic violence. While it is difficult to quantify due to under-reporting, the health impacts may show as physical symptoms, injuries, chronic pain, neurological symptoms, gastrointestinal disorders, gynaecological problems, sexual health and increased cardiovascular risk. Domestic violence is also linked to increased risk of substance misuse, high blood pressure, smoking and obesity. Research indicates that domestic violence is also linked to both short and long term mental health problems including anxiety, post traumatic stress disorder, depression, suicidal ideation and self harm.

- Teenage pregnancy rates remain amongst the highest in London. There are higher rates of sexually transmitted infections in the population, increasing numbers of people affected by HIV, and a high proportion of women of all ages having terminations of pregnancy.

- NHS Health Check is a mechanism for diagnosing diabetes, high blood pressure and early kidney disease. They also identify adverse lifestyle issues that can be addressed before they have caused major illness. There are a small number of GP practices that remain unwilling or unable to provide the service.

- The borough has the second highest rate in London of hospital admissions from 'Ambulatory Care Sensitive Conditions' (ACS) – at 17% or 1 in 6. The conditions include heart failure, diabetes, asthma, angina, epilepsy and hypertension. Actively managing patients with ACS conditions – through vaccination; better self-management, disease-management or case-management; or lifestyle interventions – prevents acute exacerbations and reduces the need for emergency admissions.

- The information above about a high rate of admissions for ambulatory care sensitive conditions also links to information from the 2011/12 Adult Social Care Outcomes Framework suggesting that there is also a significantly higher proportion of council-supported permanent admissions of people aged 65+ to nursing and residential care. It should be noted however that since the 2011/12 ASCOF indicators were published the number of people aged 65 and over admitted into residential or nursing care has fallen significantly by 15.8% in 2012/13. Local social care data shows that the number in residential and nursing care has shown a net fall of 23 placements, whilst the number receiving care and support at home has increased by 100 in the year to March 2013. The early indications of trend show increasing use of care and support at home, which is contrary to national trends.

- COPD, diabetes and heart failure are three of the most important long term conditions locally in terms of prevalence and avoidable health care usage. There are areas for improvement throughout the care pathways for these conditions including:

    - Low levels of active case finding and diagnosis.

    - Variable and on occasions, poor, primary care management of the early stages of the disease (early secondary prevention) – this includes the use of some of the most evidence based interventions like stop smoking interventions, influenza vaccination, patient education in peer groups and graded exercise/rehabilitation programmes.

    - Community services not integrated effectively with primary care, to allow improved performance through training, skill sharing or complex case discussion.

    - Poor communication between secondary and primary care and community specialist services, so that patients who are admitted via A&E do not have their long term management in the community reassessed/optimised as a result of that interaction.

- People in this borough screened for diabetic retinopathy have exceptionally high rates of detected retinal disease (four times the England rate) and a large number need laser treatment.

- Very few people with established chronic heart, lung or neurological disease (including dementia) die in their own home or a nursing home, and the majority die in hospital. This is despite evidence that about two thirds of patients wish to die in their own home if sufficiently supported.

- Integration of care remains a vital component for improving the experience and care for people with long term conditions, disabilities, complex issues and at the end of their lives. Guidance emphasises that integration needs to be both at a direct care level but also at a strategic level. The Health and Wellbeing Board has specific responsibilities for coordinating commissioning and make best use of the combined resources of the NHS, social care and public health. This area needs a new and enhanced focus in 2013/14.

- Good primary care management and effective integration with community services are essential for achieving improved care and cost savings. The CCG needs to consider how to improve primary care access and performance to provide a bed rock on which to build integration of complex care which meets modern needs.

KEY RECOMMENDATIONS

Tackle the challenge of obesity through a co-ordinated industrial scale, whole-system approach, including a partnership Healthy Weight Strategy and action plan.

Ensure an effective focus, within the whole system approach, on achieving and maintaining healthy weight for children, including the promotion of breastfeeding, child nutrition and physical activity.

Tackle the single largest cause of preventable death and ill-health, through a whole system approach to reducing smoking prevalence, which includes high quality, locally responsive stop smoking services, a focus on supporting young people not to take up smoking and robust tobacco control measures.

Expand the opportunities for residents to get support by increasing smoking cessation advice in primary care.

Take a proactive approach to local sexual health needs, through an integrated programme across the life course, to support a reduction in teenage conceptions and in new HIV infections.

Promote the value of preventative care via the partnership, as being as important as prescribing drugs and specialist referrals, by improving lifestyle advice on smoking and weight management in primary care.

Promote the importance of healthier lifestyles as a key part of a multi-faceted approach to supporting people with long term conditions. Some lifestyle interventions will produce as much benefit as drug treatment.

Place the individual at the centre of their care, so that empowered individuals are the routine rather than the exception, through an emphasis on peer education and self help groups.

Reduce the impact of Ambulatory Care Sensitive conditions on the health of residents by improving vaccination, active case finding and disease management in primary care.

Ensure more equal access for all residents between 40 and 75 to NHS health checks, via in cluster primary care collaborations, allowing patients to be referred to better equipped practices for their health check.

Take action across the entire care pathway, to improve outcomes for people with chronic diseases, via the leadership of the board, including integration of primary, secondary, social and community care.

Promote a system wide approach to early diagnosis and secondary prevention, through working with practices that perform poorly on active case finding, evidence based prescribing and uptake of influenza vaccinations.

Improve the outcomes for people living with diabetes, through the board's commitment to better diabetic care and services.

Reduce the incidence of preventable complications, such as blindness and kidney failure by early diagnosis of diabetes, through active case finding.

Investigate, through the partnership between NHS England and the CCG, the reasons underlying high levels of diabetic retinal disease seen locally.

Ensure systematic delivery of all nine components of a basic annual diabetes check, through the work of the CCG with all practices.

Optimise drug treatment for people living with diabetes, to appropriately manage cholesterol, blood pressure and blood sugar.

Improve preventive care for older people at risk of hip fractures, through better primary care management of osteoporosis after a fragility fracture.

Provide better access to choice and dignity for residents at end of life, through the use of resources from the funding transfer from NHS England for the development of systems and training in nursing and residential homes, which support the individual's wish to die at home.

3.8 Safeguarding children and adults

Children and young people

- Barking and Dagenham has successfully implemented the Common Assessment Framework (CAF) across all partners. Analysis showed that only 4.9% of children going through this process ended up with a child protection plan, which suggests that process is providing an important early intervention to prevent children progressing to situations requiring child protection procedures.

- In 2012/13, there has been an increase in referrals to children's statutory social care services. In particular, this increase has been significant during January to March 2013, placing considerable pressure on children's social care. The number of children on child protection plans has declined to 200 (provisional 2012/13) in contrast to an increase in previous years. This could reflect the impact of the 12 -18 month panel which has removed children on plans for a long time safely and better triage and response systems.

- The largest proportion of child protection plans is among younger children. Analysis of the types of abuse which resulted in children being subject to child protection plans highlighted emotional abuse and neglect as the two most commonly identified abuse categories in the borough. This emphasises the

need for early intervention and prevention work in pregnancy and early year's settings.

- In 2012/13, the rate of looked after children per 10,000 0-17 year olds stands at 78, which is above the national and London rates but below the rates found in similar areas.

- As part of the statutory provision for looked after children, there is a responsibility to ensure that all looked after children have an annual medical and dental assessment and a sight test. This assessment should include review of physical and mental health and social wellbeing, development immunisation coverage, and health promotion interventions around health risk behaviours such as smoking and alcohol (where age appropriate). Performance on annual medicals for looked after children dropped in 2012/13 to a provisional figure 72% compared to 94% in 2011/12.

- A total of 27 children died between April 2011 and March 2012 who were resident in Barking and Dagenham. The demographics of the children that have died indicate, the largest proportion of deaths is amongst the under 1 year age group. There also appeared to be a disproportionately high number of deaths in African children.

Adults safeguarding

- There is limited research about abuse of adults but it is estimated that 140,000 adults in the UK who are frail, have a disability or are mentally ill, are abused or neglected each year. It is believed that abuse of adults is significantly under-reported. In a borough the size of Barking and Dagenham we would expect to see around 1,500 reports a year. In 2012/13 1,369 reports were received which is showing an upward trend compared to the 1,119 received in 2011/12 and the 720 received in 2010/11.

- Neglect (27%) and physical abuse (21%) are the most prominent types of abuse experienced by adults at risk in Barking and Dagenham. Of the cases which reached outcomes between April 2012 and December 2012, 58% were wholly or partly substantiated.

- Between September 2012 and February 2013 the partnership launched seven Safeguarding Adult Investigations into borough based care institutions.

- Deprivations of Liberty Safeguard (DoLS) requests continue to remain low, despite efforts to raise awareness with managing authorities, with 22 requests received between April 2012 and March 2013. Of these, just two were raised by hospitals, indicating that further work needs to happen to embed understanding of the Mental Capacity Act and DoLS within our hospital settings.

- Disabled adults are at increased risk of violence, and particularly those with mental illness or a learning disability[v].

- Younger people, those with learning disabilities, and substance misuse issues and mental health issues appear to be under-represented in the local statistics.

- The Barking and Dagenham Partnership has adopted the London-wide "Protecting Adults at Risk: London multi-agency policy and procedures to safeguard adults from abuse[vi]" The policy and procedures provide the framework for the Partnership to investigate and respond to allegations of abuse or neglect against or involving adults at risk in order to mitigate the risk of reoccurrence of escalation.

KEY RECOMMENDATIONS

Prioritise the health of looked after children by ensuring 95% compliance with health checks by the end of 2013/14.

Investigate, via the Child Death Overview Panel, why there appears to be disproportionately high representation of African children amongst child deaths in the borough.

Ensure adults at risk are at the centre of an effective multi-agency partnership, including adult social services, the NHS, and police, as part of a pan London approach to safeguarding.

Implement the recommendations of the Winterbourne View Concordat and note the implications of the Francis Report.

Promote the rights of the individual, through the implementation and awareness of the Mental Capacity Act requirements.

3.9 Adult social care

- Overall, Adult Social Care services continue to see increasing numbers of service users choosing self-directed support, through the provision of direct payments for their care, supported by a Personal Assistant. Services continue to see increases in demand, even though this is against a backdrop of slightly falling numbers of older people, which make up the largest single client group. The 2011 Office for National Statistics (ONS) mid-year population estimates show that Barking and Dagenham's 65+ population is 19,339. This is a 3.4% decrease compared to the 20,016 they reported for the previous year. Contrary to this information Barking and Dagenham are seeing an increase in the numbers of older people (65+) receiving care and support in the home. The favoured current explanation for this disparity is evidenced by recent data released by Public Health England, which placed Barking & Dagenham as 133rd out of 150 local authorities for premature mortality. This increased morbidity in the local population is thought to be introducing social care needs earlier than for other populations, and further research is planned in year to investigate this and other suggested causes.

- The number of all clients receiving services stands at 4,889 for 2012/13. This is a reduction on the reported figure of 5,993 but, crucially, is not a real-terms

reduction in substantive activity. In part, the reduction can be attributed to no longer supplying small items of equipment under £50, and the issuing of prescriptions to allow clients a better choice in the range of equipment they can purchase from their chosen supplier. In addition, we have carried out periodical reviews of information held on the social care database and closed down records that were no longer active: these were mainly small items of equipment which should have been closed after 4 to 6 weeks of being opened.

- Barking and Dagenham has seen a reduction in the number of people in residential care, from 420 on the last day of March 2012 to 362 on the same day in 2013. This figure includes all client groups in residential care. A substantial portion of the reduction is due to a detailed piece of work carried out by Adult Commissioning to convert learning disability residential homes in the borough to supported living accommodation. Those learning disability clients showing as in residential placements on the social care system were re-classified as being in supported living which has resulted in this year's figure being reduced.

- However, it is important to note that the figures include 23 fewer older people in long-term residential care at the end of 2012/13 than 2011/12. In 2011/12, the borough was reported to be the highest in its comparator group for the number of older people (65+) admitted permanently into either residential care or nursing care. For 2012/13, this indicator has seen a significant reduction of 15.8%, and we await further analysis on the final figures for the comparator group for the current year.

- The numbers of clients receiving a direct payment stands at 923 for 2012/13, which would give a percentage figure of 18.9% as a proportion of all clients receiving services. This will place us above the comparator group based on last year's figures, and we await this year's comparisons. In April 2012 the council introduced the scheme to allow clients to pay for major adaptations to their homes via a direct payment. Although the scheme was not fully operational until June it was a huge success and exceeded all targets set. Throughout the year a total of 143 major adaptations were financed via a direct payment totalling a cost in excess of £465,000, and we continue to explore further flexibilities with the funding that supports this budget for the coming year. We will continue to monitor the monthly spending on direct payments for adaptations.

- The numbers of clients with Learning Disabilities (LD) in employment fell from 30 in 2011/12 to 26 in 2012/13. This is an ASCOF indicator and this reduction means our percentage of LD clients in paid employment will reduce from 6.5% to 5.4% dropping us into the bottom quartile of the comparator group (comparing with other boroughs' 2011/12 figures).

- Issues have been raised regarding the number of carers known to social care being assessed or reviewed in the borough. 551 carers were recorded as being assessed or reviewed during the 2012/13 financial year, and investigations are currently underway to discover if this figure should be higher. This will include discussions between the Council and its contracted partner for the delivery of carers' social care assessments, Carers of Barking & Dagenham.

- According to the 2011 census information 49.5% of Barking and Dagenham's residents are of White British origin. This compares to a social care population ('all clients receiving social care services from the local authority') which is 82.2% White British. Further analysis will be undertaken in due course to compare the social care population with an age-adjusted borough population, so that a more representative comparison can be made.

- The Council has a range of programmes already underway, including Choice & Control (about homecare), Fulfilling Lives (Learning Disability services), Integrated Care (between primary care, social care and the hospital), and work to develop information and advice. These currently address the major priorities for improvement of social care provision.

- Detailed consideration of the impact of the Care Bill 2013 will be needed, including financial modelling, to inform the development of local systems and provision.

- Further consideration of the implications of the 2012/13 annual returns is underway and more detailed recommendations will arise out of that.

KEY RECOMMENDATIONS

Further explore the driving factors behind the rise in the number of older residents (aged 65 and over) who are receiving care and support in their own homes, relative to the reducing over-65 population that was described by the Census results;

Research, via a health equity audit, the alignment between ethnicity of the clients of Adult Social Care in the borough and that of the borough more widely and modelling of future trends and patterns.

Undertake a review of the arrangements with Carers of Barking & Dagenham for the assessment and review of carers, as well as the Council's own internal recording systems, to ensure that activity is being accurately accounted for and delivered.

4. Equality impact assessment

- An equalities impact assessment (EQIA) was undertaken to give more understanding on the impact of priorities set in the Joint Health and Wellbeing Strategy 2012-2015 (JHWBS) on local residents. This built on the findings of the 2012 EQIA of the JSNA. The EQIA found that overall the strategy has actions in place that should contribute to the reduction of existing barriers to equality and address potential inequalities.

- A series of consultations were undertaken to engage residents, voluntary and community groups from the nine protected equality characteristics to inform the development of the JHWBS. Time was taken to engage the various groups and jointly develop consultation approaches that best suited the target audience.

- Amongst the groups consulted with were Mencap, the BAD Youth Consultative group, the Older People's Forum and the Faith Forum. There is no recognised local forum for people from LGB communities or transgender communities. However, a new forum for the LGB community is being established with support from Barking and Dagenham CVS.

- The shift in population profile of the borough and the introduction of Gypsy, Irish Traveller and Roma in the 2011 census would suggest a need to widen future consultations to engage more specifically people from black and minority ethnic communities, the traveller community and 'white other' communities.

- Social class is not an equality characteristic protected under legislation; however, it is a significant factor in the health and wellbeing of local residents.

KEY RECOMMENDATIONS

Have regard to the issues identified by local groups as identified in the EQIA consultation, through the Joint Health and Wellbeing Strategy.

Improve equity in access to services and health outcomes through a focus on inclusive accessible information and support.

Recognise residents and local community groups as 'experts' in understanding their own health needs, by involving them systematically in all delivery plans and developing a strategy to engage with all sections of the borough, in particular seldom heard groups.

Consider the EQIA recommendations in commissioning decisions, and include consideration of social class/income as a factor in future Equality Impact Assessments.

5. Consultation

5.1 Details of local resident groups consulted as part of the Equality Impact Assessment have been given in the previous section.

5.2 Stakeholders from across the NHS, the CCG, the voluntary sector across the council were engaged in providing content, data and advice for their areas of expertise within the full JSNA document.

5.3 Comments and engagement on the recommendations of this paper were sought via prior consultation with stakeholders of the Health and Wellbeing Board.

6. Mandatory implications

6.1 Joint strategic needs assessment

This report provides an update on the most recent findings and recommendations of the JSNA.

6.2 Health and wellbeing strategy

The recommendations of this report align well with the strategic approach of the Joint Health and Wellbeing Strategy. The strategy continues to serve the borough well as a means to tackle the health and wellbeing needs of local people, as identified in the JSNA. The reader should note, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA. The purpose of the ongoing JSNA process is to continually improve our understanding of local need, and identify areas to be addressed in future strategies for the borough.

6.3 Integration

The report makes several recommendations related to the need for effective integration of services and partnership working.

6.4 Financial implications

London Borough of Barking and Dagenham

(Implications completed by: Dawn Calvert – Group Manager, Finance)

The London Borough of Barking and Dagenham have a Public Health Grant of £12,921,000 in 2013/14 which increases to £14,213,000 in 2014/15. The key recommendations within this report are intended to inform the development of the Health and Wellbeing Strategy and the subsequent commissioning plans. Once agreed the recommendations can be quantified and funding assigned.

Barking and Dagenham Clinical Commissioning Group

(Implications completed by: Finance, Barking and Dagenham CCG)

The CCG refresh of the CCG commissioning plan for 2014/15 will reflect the recommendations of the JSNA. It is expected that the CCG allocation for 2014/15 will be published in December 2013, as part of the operating plan framework. Through the planning process, resources available to the CCG will be aligned to the areas of greatest strategic and local need. Given the current financial environment the CCG is not expecting that there will be new funding for investment.

6.5 Legal implications

(Implications completed by: Lucinda Bell, Education and Adult Social Care Lawyer)

6.5.1 The Health and Social Care Act 2012 (HSCA 2012) imposes a legal duty on local authorities and PCTs to produce a Joint Strategic Needs Assessment (JSNA). In addition the local authority and the CCGs must prepare a joint health and wellbeing strategy (JHWS). In preparing the JSNA, consideration must be given to the extent to which the needs could be met more effectively by arrangements under section 75 of the National Health Service Act 2006, section 75, arrangements between local authorities and NHS bodies rather than in any other way.

6.5.2 The Equality Act 2010 imposes a duty on the Authority to have "due regard" to:

- The need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the EqA 2010 (*section 149(1)(a)*).

- The need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it (*section 149(1)(b)*).

- The need to foster good relations between persons who share a relevant protected characteristic and those who do not share it (*section 149(1)(c)*).

6.5.3 An Equality Impact Assessment has been undertaken.

6.6 Risk management

6.6.1 The recommendations of this paper are a product of the evidence based JSNA process, with an aim to improve health and wellbeing across the population. There are no risks anticipated, provided the commissioning and strategic decisions take into consideration equality and equity of access and provision.

7. Non-mandatory implications

The JSNA seeks to review the evidence of need for local residents across the breadth of health and wellbeing. Therefore the recommendations presented here and the full JSNA document will be of relevance to stakeholders across the health and social care economy.

8. Background papers used in the preparation of the report:

- GLA 2012 Trend Based Borough Projections
- The Marmot Review: Fair Society, Healthy Lives, 2010, Pages 17 and 20
- Children and Families Bill, 2013, Fact sheet
- www.dwp.gov.uk/docs/hwwb-working-for-a-healthier-tomorrow.pdf
- Hughes K, Bellis MA, Jones L, et al. Prevalence and risk of violence against adults with disabilities: a systematic review and and meta-analysis of observational studies (Lancet 2012; 379:1621-9)
- Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse, Adults Services SCIE Report 39, 2011

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HEALTH AND WELLBEING BOARD

16 JULY 2013

Title: Progress on Winterbourne View Concordat	
Report of the Corporate Director of Adult & Community Services	
Open	**For Decision**
Wards Affected: ALL	**Key Decision:** NO
Report Author: Pete Ellis, Strategic Commissioning Manager, Learning Disability	**Contact Details:** Tel: 020 8227 2875 / 2492 E-mail: pete.ellis@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director of Adult & Community Services	

Summary:

In December 2012 the government published its final report into the events at Winterbourne View Hospital and set out a programme of action to transform services so that vulnerable people no longer live inappropriately in hospitals and are cared for in line with best practice. Following the report all relevant statutory and non-statutory (50 in total) agencies / organisations designed and signed up to a 'concordat' which outlines key actions and their commitments in response to Winterbourne which will have an impact on Barking and Dagenham.

This report provides an update on the Borough's progress against the actions that we have had to have met by July 2013.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Note the progress that the Borough has made in achieving the actions set out in the Winterbourne View Concordat.

(ii) Note the Winterbourne View 'stocktake' document which has been produced for the Winterbourne View Joint Improvement Programme.

(iii) Agree the outline proposal for a local plan and commit to representatives from relevant organisations participating in local working group.

(iv) Note the identified risks and mitigation plans.

Reason(s)

To ensure an appropriate and 'whole systems' approach is taken to addressing the findings of the Winterbourne View Concordat by the Health and Wellbeing Board

1 Introduction

1.1 This report provides an overview of the findings of the government's Winterbourne View Report and distils the programme of actions set out in the accompanying Concordat. Copies of the full Report and Concordat can be accessed at: http://www.dh.gov.uk/health/2012/12/final-winterbourne/

1.2 The programme of action includes:

- by spring 2013, the Department of Health will set out proposals to strengthen accountability of boards of directors and senior managers for the safety and quality of care which their organisations provide;
- by June 2013, all current placements will be reviewed, everyone in hospital inappropriately will move to community-based support as quickly as possible, and no later than June 2014;
- by April 2014, each area will have a joint plan to ensure high quality care and support services for all people with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with best practice;
- as a consequence, there will be a dramatic reduction in hospital placements for this group of people;
- the Care Quality Commission will strengthen inspections and regulation of hospitals and care homes for this group of people, including unannounced inspections involving people who use services and their families;
- A new NHS and local government-led joint improvement team will be created to lead and support this transformation.

1.3 This programme is backed by a concordat signed by more than 50 partners, setting out what changes they will deliver and by when. These concordat's key actions and commitments have also been localised to what this will mean for Barking and Dagenham.

2 Findings of the Winterbourne View Report

2.1 The final report into the events at Winterbourne View Hospital states that staff routinely mistreated and abused patients, and management allowed a culture of abuse to flourish. The warning signs were not picked up by managers at the hospital, the parent company, by commissioners, regulators or adult safeguarding despite multiple opportunities. The report also reveals weaknesses in the system's ability to hold the leaders of care organisations to account.

2.2 The report highlighted that many people are in hospital who do not need to be, alongside a widespread failure to design, commission and provide services which give people the support they need close to home, and which are in line with well established best practice. In addition, it finds there was a failure to assess the quality of care or outcomes being delivered for the very high cost of places at Winterbourne View and other hospitals.

2.3 The report confirms that CQC's inspections of nearly 150 other hospitals and care homes have not found abuse and neglect like that at Winterbourne View. However, many of the people in Winterbourne View should not have been there in the first place, and in this regard the story is the same across England. Many people are in hospitals that do not need to be there, and many stay there for far too long – sometimes for years. The report also exposes that the main reason given for referrals to hospitals was 'management of a crisis', which suggests an intrinsic lack of planning for crises or local responsive services for people with this type of support need.

2.4 "The NHS Commissioning Board's objective is to ensure that Clinical Commissioning Groups work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people"

2.5 Whilst the organisational accountability for actions arising from the Winterbourne View Concordat is established in the concordat document, nonetheless it will be important at a local level to ensure that clear individual accountability on behalf of member agencies is established. With the safeguarding boards also having a role, it is important to ensure that there is clear governance around the action planning.

2.6 London Borough of Barking & Dagenham have established an action plan that identifies the issues to be addressed. At the discussion at the Safeguarding Adults Board, Sharon Morrow confirmed that a submission was being made to NHS London and that it would be handed over to CCG by the end of March 2013. The CCG planned regular reporting and monitoring through the Quality and Safety Committee.

2.7 Whilst the predominant concern in the Winterbourne View report concerns adults, it has important links with issues around transition of children into adult services, and therefore the Children's Trust and Local Safeguarding Children's Board will continue to have a role, and to input into the plans and commentaries on progress that are produced.

3 Progress Update

3.1 The borough has met the key actions required in Winterbourne View concordat. An outline of these key actions and how these have been met by the borough are set out below.

3.2 **Concordat Action**: "by the 1st June 2013 Reviews of all Barking and Dagenham residents placed in a inpatient setting".

3.3 **Update**: There are currently six Barking and Dagenham residents/ patients placed in a inpatient settings / Assessment Treatment Unit. We can confirm that all of six patients were reviewed by the Community Learning Disability Team by the June 1st deadline required in the Winterbourne View Concordat. In completing the reviews, and to ensure best practice was followed, local practioners followed the framework for reviews designed by the Winterbourne View Joint Improvement Programme (Local Government Association and NHS Commissioning Board). This also ensured that the patients and their families had the information, advice and advocacy support that was needed for them to understand and have the opportunity to express their views.

3.4 The outcome of the reviews showed that that four of the six patients were not yet suitable or ready to move back into the community. It is also important to note that these four individuals were placed in the inpatient settings due to serious offences that they had committed. The two patients assessed as being suitable to move back to a less secure setting have comprehensive plans in place to ensure that this is achieved safely by the 1st June 2014.

3.5 **Concordat Action**: Establishment of Lead Commissioner Responsibilities

3.6 **Update**: The concordat also required that a lead commissioner was named who would be responsible for individuals in inpatient services. The Clinical Commissioning Group is reviewing the register of patients transferred from the former PCT to ensure that commissioning responsibilities comply with the national guidance issued on this.

3.7 **Concordat Action**: *By the 1st April All CCGs to develop local registers of all people with challenging behaviour in NHS funded care.*

3.8 **Update**: As well as reviewing the care and support of all the patients in inpatient services, NHS Barking and Dagenham were required to develop and hand over to Barking and Dagenham Clinical Commissioning Group a local register of the people who are in an inpatient setting. This is now in place and is being used to track the progress and quality of the reviews of those patients. This tracker is 'live' and a local procedure has been put in place to ensure it is both updated and shared between the Local Authority, CCG and Commissioning Support Unit (CSU) to ensure everyone placed in a inpatient setting is tracked.

3.9 **Concordat Action**: *"From April 2013 Directors, management and leaders of organisations providing NHS or local authority funded services to ensure that*

systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care."

3.10 **Update**: The borough has in place strong governance and monitoring arrangements that will ensure we meet all the actions set out in the concordat. Responsibility for ensuring the delivery of the plans, informed by the Winterbourne View concordat, has been delegated to the Learning Disability sub-group with responsibility for delivery resting with the lead Commissioners. The group's role is to ensure that the key actions set out in the concordat are met. Winterbourne View will remain a standing agenda item at each of the sub group meetings which will then inform updates to the Health and Wellbeing Board. The sub group has, as core members of the group, representation from Healthwatch, family carers, service users, provider representative and Carers of Barking and Dagenham.

3.11 **Concordat Action**: *"From the 1st April Health and care commissioners should use contracts to hold providers to account for the quality and safety of the services they provide"*

3.12 **Update**: When making placements individual placements our Community Learning Disability Team always make placements based on individuals outcomes and needs which form part of the contract. Local Authority Adult commissioning have robust and comprehensive contracts in place for all larger block commissioned providers where they are required to submit quarterly contract performance information. As part of the local authorities contract monitoring and service review processes, all providers are subject to announced and unannounced visits and we undertake a comprehensive annual review which involves, as part of the process, consulting with both service users and family carers.

4 Winterbourne View Stock take and Strategic Assessment Framework

4.1 The Winterbourne View Joint Improvement Programme asked local areas to complete a stock take of progress against the commitments made nationally that should lead to all individuals receiving personalised care and support in appropriate community settings by the 1st June 2014.

4.2 The purpose of the stocktake is to enable local areas to assess their progress and for that to be shared nationally. The stocktake is also intended to enable local areas to identify what help and assistance they require from the Joint Improvement Programme and to help identify where resources can best be targeted. A copy of our completed stocktake is found at Appendix 1.

4.3 While this stocktake is specific to Winterbourne View, it has been designed to also feed directly into the CCG Assurance requirements and the joint Health and Social Care Joint Strategic Assessment Framework (SAF) which the completion of has now begun.

5 Next Steps

5.1 Both the CCG and the Local Authority continue to be jointly committed to ensuring our responsibilities and the actions set out in the Concordat remain a high priority for the borough.

5.2 A key action is the development of our local joint strategic plan where the strong presumption is for this to be delivered through pooled budget arrangements. This plan should inform the CCGs commissioning intentions for 14/15 so will be progressed over the summer. It is intended that the plan will cover the following areas:

- Local Concordat
- Challenging behaviour – a definition
- Vision and Values
- Understanding Local population demands and needs
- Consultation
- Current Service provision / Market Position
- Current spend / costs to the borough on services for people with CB
- Workforce Skills
- Safeguarding
- Delivery Plan and Commissioning Intentions
- Governance Arrangements
- Monitoring, Evaluation and Review
- Equality and Diversity

5.3 There are a number of workstreams that will feed into the writing of the plan including workforce analysis, needs analysis, review of current provision, and consultation. To ensure the project is completed within both the agreed internal and external timescales it is proposed a small working group is set up which reports to the Learning Disability sub-group. If we go by the proposal in WV the plan is the responsibility of commissioners in Health and Care so these will need to project manage it and have specialists / subject matter experts in Challenging Behaviour who sit on the group. We will also aim to recruit a family carer of someone with challenging behaviour to sit on the group. We will ensure that they are a key member of the group and will oversee the completion of the plan along with being able to, if willing, support the group in completing the consultations / focus groups.

5.4 A draft proposal and outline for this plan is to be submitted at the next learning disability sub-group in August for agreement on its structure. Discussions will also be held, alongside the development of this local joint strategic plan, around S75 agreements and pooled budgets arrangements between the Local Authority and CCG. It is expected that Health and Wellbeing Board members will oversee the plan, whilst the delivery of it will be the responsibility of the learning Disability

Partnership Board. Updates on the implementation and delivery of this plan will be regularly brought to the health and wellbeing board.

6 Mandatory Implications

6.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) has a strong overall analysis of needs of people with a learning disability as well as a detailed safeguarding element within it. There is general agreement that cross-sector working in the borough with involvement from the NHS, employment, housing and other bodies, in addition to the Council's children's services and adult and community services is good

6.2 Health and Wellbeing Strategy

The Health and Wellbeing Board mapped the outcome frameworks for the NHS, public health, and adult social care with the children and young people's plan. The strategy is based on eight strategic themes that cover the breadth of the frameworks in which learning disability is picked up as a key issue. These are Care and Support, Protection and Safeguarding, Improvement and Integration of Services, and Prevention. Actions, outcomes and outcome measures for people with learning disabilities are mapped across the life course against the four priority areas.

6.3 Integration

Responsibility for ensuring the delivery of the things set out the concordat rests with both the NHS and the Local Authority and there is commitment on both sides to enable this to happen. The local action plan will be fully integrated and will include actions for both health and social care.

6.4 Financial

(Implications completed by Dawn Calvert, Group Manager Finance, Adult & Community Services and Children's Services)

There are no quantifiable costs attached to the programme of action identified in response to the Winterbourne View Concordat or the stocktake. The delivery of the both programmes, including any subsequent additions, must be accommodated within the current resources of the accountable bodies identified within the plan.

6.5 **Legal**

(Implications completed by Lucinda Bell, Solicitor Social Care and Education)

The Health and Wellbeing Board is under a duty[1] to encourage integrated working. This includes:

- a duty to encourage those arranging for the provision of health or social care services in their area to work in an integrated manner; and
- a duty in particular to provide advice, assistance, and so on, to encourage the making of arrangements under section 75 of the NHSA 2006.

7 Risk Management

7.1 The following potential risks and mitigations have been identified:

Identified Potential Risk	Mitigation / Action
Completion of joint local strategic plan by 1st deadline	Sign off the structure plan and work required to complete it will be presented at August's learning disability sub-group. The LD Sub-group will continue to monitor and review progress against the completion of the plan. LD sub-group will continue to report up to the HWBB on progress against all actions in the concordat.
S75 / Pooled budget arrangements	Discussions are due to begin shortly between the Local Authority and CCG Monitoring and progress will be reported to the LD sub-group and the HWBB.
Move of people back to the local community by 1st June 2014 deadline	Comprehensive plans are already in place by the CLDT to support the patients identified to less restrictive settings The LD sub group will continue to monitor progress and report up to the HWBB

[1] Section 195(1) and (2), Health and Social Care Act 2012

8 Non-mandatory Implications

8.1 Crime and disorder: Some of the individuals in our AT&U's may present a risk of offending so risk management will need to be considered as part of the review process

8.2 Safeguarding: Barking and Dagenham will be bringing back to borough vulnerable service users who may have spent significant periods in patient services;

8.3 Property/assets: Barking and Dagenham will need to ensure suitable accommodation is in place as a form of prevention and for people who are coming back from out of borough.

8.4 Service User and Carer impact: Barking and Dagenham will have to work in close partnership with the carers and five service users in Assessment and Treatment Units (AT&U's) as part of the review process, in particular those who have been identified as suitable to return back to borough.

8.5 Staffing issues: Barking and Dagenham will need to ensure, in preparation for bringing individuals back into borough and pas part of our local strategic plan, it has both a skilled and competent workforce in place to support and care for people with learning disabilities and who have behaviour which challenges.

9 Background Papers Used in the Preparation of the Report:

- Winterbourne View Final Report and Concordat
- Winterbourne View Review good practice examples
- Mansell Report – Services for people with learning disabilities and challenging behaviour or mental health needs (rev) 2007
- Challenging Behaviour: a unified approach
- South Gloucestershire Safeguarding Adults Board Serious Case Review

10 List of appendices

— APPENDIX 1: Winterbourne View Stocktake

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Winterbourne View Joint Improvement Programme

Initial Stocktake of Progress against key Winterbourne View Concordat Commitment

The Winterbourne View Joint Improvement Programme is asking local areas to complete a stocktake of progress against the commitments made nationally that should lead to all individuals receiving personalised care and support in appropriate community settings no later than 1 June 2014.

The purpose of the stocktake is to enable local areas to assess their progress and for that to be shared nationally. The stocktake is also intended to enable local areas to identify what help and assistance they require from the Joint Improvement Programme and to help identify where resources can best be targeted.

The sharing of good practice is also an expected outcome. Please mark on your return if you have good practice examples and attach further details.

This document follows the recent letter from Norman Lamb, Minister of State regarding the role of HWBB and the stocktake will provide a local assurance tool for your HWBB.

While this stocktake is specific to Winterbourne View, it will feed directly into the CCG Assurance requirements and the soon to be published joint
Strategic Assessment Framework (SAF). Information compiled here will support that process.

This stocktake can only successfully be delivered through local partnerships. The programme is asking local authorities to lead this process given their leadership role through Health and Well Being Boards but responses need to be developed with local partners, including CCGs, and shared with Health and Wellbeing Boards.

The deadline for this completed stocktake is Friday 5 July. Any queries or final responses should be sent to Sarah.Brown@local.gov.uk

An easy read version is available on the LGA website

May 2013

1. **Models of partnership**			
	Assessment of current position evidence of work and issues arising	**Good practice example (please tick and attach)**	Support Required
1.1 Are you establishing local arrangements for joint delivery of this programme between the Local Authority and the CCG(s).	**1.1 –** Yes, local arrangements for the joint delivery of the programme are in place between the local authority and the CCG. The delivery and monitoring of progress is the responsibility of our Health and Wellbeing Board (H&WBB) and this was discussed and agreed on the 1st April 2013. Progress is regularly monitored and on the Forward Plan. The next update is due on the at the H&WBB on the 16th July 2013. The Learning Disability sub-group of the H&WBB is responsible for driving the programme forward. This is a multi agency group whose members include service users, family carers, care and health commissioners, members of the Community Learning Disability Team, North East London NHS Foundation Trust (NELFT), Barking, Havering, and Redbridge University Hospitals NHS Trust (BHRUT), local service providers, Healthwatch, Housing, employment, a member of the Safeguarding Team and the Police.		
1.2 Are other key partners working with you to support this; if so, who. (Please comment on housing, specialist commissioning & providers).	**1.2 –** Yes, our programme is being delivered through the Learning Disability sub group of the H&WBB where it is on every agenda. Our muti-agency arrangements as part		

	of our learning disability sub-group ensures we are working closely with all key partners in the delivery of this programme. The key partners and work being done to support the partnership are: Housing – senior officers from the council attend the Learning Disability sub-group. Our 2012-2015 Housing Strategy includes a housing needs assessment for people with Learning Disability. Housing colleagues have also worked closely with Adult Social Care in our Transformation Programme for Learning Disability Services. Local Providers – we have engaged with local providers (for example, MCCH, Look Ahead, Mencap, Outlook Care and Carers of Barking and Dagenham) around local services for people with learning disabilities or Autism, who also have mental health conditions or behaviours described as challenging. Local provider representatives also attend our Learning Disability sub-group and the Learning Disability provider forum where these issues are also discussed. The Local Authority and CGG also work closely with our local NHS Foundation Trust NELFT, who host the health staff in our integrated Community Learning Disability Team (CLDT), mental health services, and inpatient & crisis provision for the borough. The borough also works closely with our local Acute Trust NHS BHRUT and other Allied Health Professionals in providing quality services for people with a learning disability. For example, we recently worked closely with local opticians to set up the *Bridge to Vision*		

	programme which provides specialist eye care in the borough for people with a learning disability. Specialist Commissioning arrangements – The CCG have commissioned North East & Central Clinical Commissioning Unit to manage the local register for service users currently placed in inpatient services or Assessment and Treatment Units and they work closely with colleagues responsible for specialist NHS commissioning. Family Carers and Service Users – the Council works closely with family carers and service users to ensure we engage with them to discuss the issues arising from and the delivery of the concordat and ensure we provide quality services for people with a learning disability and their carers. We have both Family Carers and Service user forums and representatives who sit on the Learning Disability sub group and a large number are actively involved through the service user and carer forums.		
1.3 Have you established a planning function that will support the development of the kind of services needed for those people that have been reviewed and for other people with complex needs.	**1.3 -** Yes, we can confirm that we have completed person centred reviews of the six service users who are currently in a Assessment & Treatment Unit (A&TU) or inpatient services by the 1st June 2013 deadline. For those who have been assessed as suitable to move back to the community, a "move on" plan is in place which will focus on them moving back to the borough where this in accordance with their wishes or to a home in the community. As stated in section 1.1 our Learning Disability sub-group has taken responsibility for delivery of this plan to ensure		

	there is a multi agency approach in the delivery of the concordat. As part of our planning functions our latest Joint Strategic Needs Assessment (JSNA) includes a needs analysis of people with a learning disability and Autism in the borough., The latest JSNA refresh was completed prior to the release of the final DH Transforming Care report and Winterbourne View concordat and as part of the next refresh there will be a deeper analysis around assessing the needs of people with complex needs in particular, including challenging behaviour. This will be part of our Health and Wellbeing Strategy and locally agreed joint plan to ensure high quality care and support services for all children, young people and adults with learning disabilities or autism and mental health conditions or behaviour described as challenging. The borough has recently set its vision for the transformation of day opportunities for people with a learning disability. As part of this vision setting and planning, the council looked at the needs of people with complex needs which has informed the types of day opportunities that we will provide for this group. Finally, discussions are underway with our neighbouring authorities, through East London Solutions, to identify potential joint commissioning arrangements for people with complex needs.		

1.4 Is the Learning disability Partnership Board (or alternate arrangement) monitoring and reporting on progress.	**1.4-** Yes, issues arising from Winterbourne View have been discussed and considered following the Panorama programme initially aired on the 31st May 2011. Both the Safeguarding Adults Board and the Learning Disability Partnership Board have considered the findings from the Serious Case Review (SCR) commissioned by South Gloucestershire Council Adult Safeguarding Board and the DH initial report into the scandal. Since the release of Transforming Care and Concordat in December 2012 this has been a main agenda item at meetings which were on the **14th January**, **18th March**, a Partnership Board Away Day on the **10th May** and the **17th June**. The Partnership Board, since becoming a sub-group to the H&WBB, has been given the responsibility to continue to monitor and review progress at all forthcoming meetings and report progress to the H&WBB.		
1.5 Is the Health and Wellbeing Board engaged with local arrangements for delivery and receiving reports on progress.	**1.5 –** Yes, Our H&WBB is responsible for strategic responsibility and setting the direction for ensuring delivery on the key actions in the Winterbourne View Concordat. Senior representatives from our local health and social care economy and elected Members are formal members of the H&WB. Members of the H&WBB include: 4 Council members, including the Chair of the Board who is the Cabinet member for health, the Cabinet Member for Adult Social Care, the Cabinet		

	Member for Children"s Services Director of Public Health Corporate Director, Adult and Community Services Corporate Director, Children"s Services Executives from NHS BHRUT (Acute provider) Executives from NHS NELFT A Local Area Team representative from NHS England Healthwatch CCG's Accountable Officer CCG's Chair CCG Clinical Director Local arrangements for the Winterbourne View Concordat were discussed and agreed by the H&WBB at the first statutory board meeting on the 23rd April, 2013 and again at the next meeting on the 16th July 2013.		
1.6 Does the partnership have arrangements in place to resolve differences should they arise.	**1.6 –** Yes, any disputes, around the delivery of the programme, will be discussed and resolved through our Learning Disability sub-group and any difficulties escalated to the H&WBB as a formal decision making committee of the Council. However, local arrangements and milestones are clear and there is no disagreement between the partnership with regard to our project plan.		
1.7 Are accountabilities to local, regional and national bodies clear and understood across the partnership – e.g. HWB Board, NHSE Local Area Teams / CCG for a, clinical partnerships &	**1.7 –** Yes, local accountability for the delivery of the Winterbourne View Concordat sits with our H&WBB which, as outlined in s1.5, includes senior representation		

Safeguarding Boards.	from three senior members of the CCG, Corporate Director of Adult Social Care and a representative from the local area team for NHS England which ensures that local accountability is in place. Through ADASS there are also strong links with the National Winterbourne View Joint Improvement Programme and which ensures regular communication is in place both through this route and the LGA. Additionally, members of the Winterbourne View Joint Improvement Programme team have attended ADASS London branch meetings allowing our DASS to engage with them.		
1.8 Do you have any current issues regarding Ordinary Residence and the potential financial risks associated with this?	**1.8 –T**he Local Authority is applying existing rules on Ordinary Residence and have taken responsibility for reviewing service users that were funded by the Council or the PCT prior to April 1st. Moving forward any issues arising with regard to Ordinary Residence will be resolved through the usual guidance. We do not foresee any issues with the people we have reviewed in the short term though we anticipate this may be an issue nationally or in areas where there are larger numbers, particularly with differing rules around local authority ordinary residence and the over complex NHS responsible commissioner guidance.		
1.9 Has consideration been given to key areas where you might be able to use further support to develop and deliver your plan.	**1.9 –** Yes**,** Barking and Dagenham have identified two areas where we might be able to use further support: **1)** We would welcome the opportunity for pan-London workshops around the Winterbourne View Concordat and		✓

	to build on the Pan London Market Position Statement that was completed by NHS London in 2012/2013. We believe that this would help identify collaborative opportunities across the region and to identify regional solutions that will help deliver the programme. 2) Secondly, we would welcome support to ensure both local and national involvement from the Care Quality Commission and for them to help define the relationship between themselves and our local safeguarding arrangements.		
2. Understanding the money			
	Assessment of current position evidence of work and issues arising	**Good practice example (please tick and attach)**	Support Required
2.1 Are the costs of current services understood across the partnership.	**2.1**- Yes, there is clarity around the costs of current services across the local authority and CCG for the existing service users that are placed in either an Assessment & Treatment Unit or other inpatient service.		
2.2 Is there clarity about sources of funds to meet current costs, including funding from specialist commissioning bodies, continuing Health Care and NHS and Social Care.	**2.2** – Yes, there is clarity around the sources of funds to meet the current costs for our six service users, including funding from specialist commissioning, Continuing Health Care and NHS and Social Care. Funding arrangements are reported and monitored as part of our local register.		

	The cost of any provision will be met by the NHS until the point that any patient is assessed not to need NHS CHC.		
2.3 Do you currently use S75 arrangements that are sufficient & robust.	**2.3**- The Local Authority and the CCG currently have in place a Memorandum of Understanding. Partners are discussing the scope of a s75 agreement and this will be in place to facilitate both pooled budget & lead commissioning arrangements as well as the delivery of our locally agreed joint plan by1st April 2014.		
2.4 Is there a pooled budget and / or clear arrangements to share financial risk.	**2.3**- These will be established as part of our s75 arrangements which will be in place by the 1st April 2014.		
2.5 Have you agreed individual contributions to any pool?	**2.5**- These will be established as part of our s75 arrangements that will be in place by 1st April 2014.		
2.6 Does it include potential costs of young people in transition and of children"s services.	**2.6**- Yes, the borough has an agreed comprehensive Transitions Strategy (2012-2015) in place. This identifies the potential costs of young people in transition from children"s services. These costs of young people in transition and children"s services were used to inform the vision for our transformation programme of day opportunities for people with a Learning Disability in the borough.		
2.7 Between the partners is there an emerging financial strategy in the medium term that is b u i l t on current cost, future investment and potential for savings.	**2.7**-Yes, a financial strategy is being formulated as part of our s75 arrangements with the CCG and our locally agreed joint plan.		

3. Case management for individuals			
	Assessment of current position evidence of work and issues arising	**Good practice example (please tick and attach)**	Support Required
3.1 Do you have a joint, integrated community team?	**3.1**-Yes, we have a multi-disciplinary Community Learning Disability Team (CLDT) which includes social workers, Occupational Therapists, Physiotherapists, Nursing, Speech and Language Therapists, Health Facilitators, Psychologists and a Consultant Psychiatrist. This team is hosted and managed by the Local Authority.		
3.2 Is there clarity about the role and function of the local community team.	**3.2** - Yes, our CLDT has a comprehensive operational policy and procedure which is regularly reviewed and updated to reflect any best practice or statutory changes. This has also been adopted across other North East London authorities. A copy of this operational policy and procedure is found as appendix 3.2.	✓	
3.3 Does it have capacity to deliver the review and re-provision programme.	**3.3** – Yes, our CLDT, in partnership with local, regional and national commissioners, have completed person centred reviews on the six service users that are currently placed in either an A&TU's or other inpatient services. As part of the person centred reviews which were developed in partnership with family carers (where appropriate), service users, advocates and service		

	providers; our CLDT have put in place comprehensive move on plans to support those who have been identified as being able to move into less secure settings by the 1st June 2014 deadline. The CLDT will continue to work closely with commissioners to ensure re-provision programmes are in place and we have recognised that ongoing plans need to be made to support those to move-on from A&TU's or inpatient services.		
3.4 Is there clarity about overall professional leadership of the review programme.	**3.4**- Yes, professional leadership for the review programme is undertaken jointly through the Divisional Director for Adult Social Care in the Local Authority and the Clinical Director for Nursing in the Clinical Commissioning Group.		
3.5 Are the interests of people who are being reviewed, and of family carers, supported by named workers and / or advocates.	**3.5** Yes, a face-to-face review was undertaken by a social worker and a nurse for each of the six service users that are currently placed in either an A&TU or other inpatient service. As part of our reviews, we ensured we considered the needs and views of informal family carers and they were supported through this process. Where appropriate or needed, family carers were also given information and access to an independent advocate.		
4. Current Review Programme			

	Assessment of current position evidence of work and issues arising	**Good practice example (please tick and attach)**	Support Required
4.1 Is there agreement about the numbers of people who will be affected by the programme and are arrangements being put in place to support them and their families through the process.	**4.1 –** Yes, both the Local Authority and CCG have jointly agreed the numbers of individuals who are affected by the review programme. When completing the reviews our CLDT ensured all service users and family carers were offered access to independent advocacy and information on carer support organisations who could support them through the process.		
4.2 Are arrangements for review of people funded through specialist commissioning clear.	**4.2** – Yes, arrangements to review the service users funded by specialist commissioning arrangements and who are in A&TU or other inpatient settings are clear.		
4.3 Are the necessary joint arrangements (including people with learning disability, carers, advocacy organisations, Local Healthwatch) agreed and in place.	**4.3** – Yes. There were six service users placed in either an A&TU or inpatient service and we have agreed and put in place comprehensive individual joint arrangements for each service user. In completing our person centred reviews, we ensured advocacy, family carers (where appropriate) and providers were fully engaged in this process. In completing the reviews the CLDT followed the Joint Improvement Partnerships „Framework for Individual		

	Care Reviews of People with Challenging Behaviour currently in Hospital Placements".		
4.4 Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed and are being used.	**4.4** Yes, NHS Barking and Dagenham (the PCT) handed over, by the 1st April 2013 deadline, a comprehensive local register to the CCG on patients who are currently placed in either an inpatient setting or A&TU. This local register is managed and updated, on behalf of the CCG, by the North East & Central London Commissioning Support Unit (see appendix 4.4). The local register is now a live document which is reviewed and regularly updated and a process has been put in place so that care and health commissioners jointly use and share the same local register.		
4.5 Is there clarity about ownership, maintenance and monitoring of local registers following transition to CCG, including identifying who should be the first point of contact for each individual	**4.5 –** Yes, our local register is owned by the CCG and updated/maintained by a named contact (Continuing Healthcare Manager) in the North East & Central London Commissioning Support Unit. Oversight of this process is undertaken by the Nurse Director who has responsibility for both Safeguarding and Quality on behalf of the CCG governing body. Each patient who is in an A&TU or inpatient service has a care coordinator who is their identified first point of contact.		
4.6 Is advocacy routinely available to people (and family) to support assessment, care planning and review processes	**4.6** - Yes, following a comprehensive review of current advocacy provision in the borough, we have recently launched a „Specialist Advocacy and Social Care Complaints" framework that gives service users increased choice over the independent advocacy support they	✓	

	receive in the borough. We can confirm that independent advocacy was discussed and offered to all six services users (other than those who have declined) and all service users (others than those declined) have an independent advocate. Barking and Dagenham are part of the pan London commission with Voiceability to deliver the NHS complaints advocacy service.		
4.7 How do you know about the quality of the reviews and how good practice in this area is being developed.	**4.7** The Divisional Director for Adult Social Care and Chief Operating Officer for the CCG personally reviewed the quality of reviews for the six service users to ensure they met the required statutory requirements and quality standards set out in the Joint Improvement Programme"s framework for completing the reviews. Best practice, and review quality, was also discussed as part of CLDT"s team meetings and clinical supervision delivered by the teams Psychiatrist. The quality of reviews is considered as part of the Council's case file audit programme.		
4.8 Do completed reviews give a good understanding of Behaviour support being offered in individual situations.	**4.8 –** Yes, in completing the face-to-face reviews our CLDT ensured that these were completed jointly by a social worker and a community learning disability nurse who had significant experience in supporting and caring for people with a Learning Disability and/or Autism who may have behaviour that challenges.		

	Further clinical support was offered by the CLDT‟s Psychologists and Psychiatrist through clinical supervision.		
4.9 Have all the required reviews been completed. Are you satisfied that there are clear plans for any outstanding reviews to be completed	**4.9** Yes, all the reviews were completed by the 1st June 2013 deadline. There are no outstanding reviews.		
5. Safeguarding			
	Assessment of current position evidence of work and issues arising	**Good practice example (please tick and attach)**	Support Required
5.1 Where people are placed out of your area, are you engaged with local safeguarding arrangements – e.g. in line with the ADASS protocol.	**5.1** Yes, the borough follows the Protecting Adults At Risk: London Multi-Agency Policy And Procedures To Safeguard Adults From Abuse (Jan 2011) or, if outside of London, the ADASS Guidance on Out of Area Safeguarding Adults is applied (June 2012).		
5.2 How are you working with care providers (including housing) to ensure sharing of information & develop risk assessments.	**5.2** Yes, the borough runs bi- monthly multi agency safeguarding training sessions, which are regularly attended by around 30 delegates,. We have strengthened our relationships with local providers by establishing a borough wide Provider‟s Forum, as part of our Learning Disability sub-group, which meets quarterly and attended by Safeguarding Adult Team representatives.		

5.3 Have you been fully briefed on whether inspection of units in your locality have taken place, and if so are issues that may have been identified being worked on.	5.3 We do not have any units in the borough. The local unit is in neighbouring Redbridge, which is provided by NHS NELFT, and no issues have been identified with this Unit. Clinical oversight for Barking & Dagenham patients is undertaken by the CLDT psychiatrist.		
5.4 Are you satisfied that your Children and Adults Safeguarding Boards are in touch with your Winterbourne View review and development programme.	**5.4 -** Yes, the Safeguarding Adult Board (SAB) has led a great deal of discussion in relation to Winterbourne View dating back to the initial expose in May 2011. At the October 2011 Business Planning Day we took members through a fictional case study based on the abuse which occurred (Appendix 5.4a & 5.4b). We revisited the issues at the October 2012 Business Planning Day (Appendix 5.4c) where members were called to offer assurance of the safeguards in place within their organisation to mitigate a similar concern arising. Similarly, the Local Safeguarding Children"s Board (LSCB) is represented at the SAB and has been asked to consider the implications of Winterbourne at the next meeting in October 2013. A report is scheduled to be presented by the chair of the Learning Disability sub-group at the next LSCB in October 2013 for the LSCBs consideration.	✓	
5.5 Have they agreed a clear role to ensure that all current placements take account of existing concerns/alerts, the requirements of DoLS and the monitoring of restraint.	**5.5** Yes, in light of Winterbourne View we introduced systems to aggregate intelligence that we receive in relation to providers (Complaints, Safeguarding Concerns, Serious Incident forms, Health Protection		

	Agency information and contract monitoring outcomes) to assist local commissioners in contract monitoring and placements. Managing Authorities attend DoLs training which is run by the local authority. Contract monitoring looks at safeguarding arrangements and compliance with the Mental Capacity Act and social workers are alert to the need to identify unauthorised DoLs when undertaking reviews.		
5.6 Are there agreed multi-agency programmes that support staff in all settings to share information and good practice regarding people with learning disability and behaviour that challenges who are currently placed in hospital settings.	**5.6** – Yes, all agencies operating in the borough are expected to work in accordance with the Protecting Adults At Risk: London Multi-Agency Policy And Procedures to safeguard adults from abuse (Jan 2011) which sets out clear expectations around whistle-blowing and raising safeguarding alerts. The multi-agency training we deliver twice monthly to local providers, along with our *'Icare'* campaign (Appendix 5.6a,b&c), is very clear about the need for everyone to raise safeguarding concerns and locally we think this is working as we continue to report very high levels of alerts.	✓	
5.7 Is your Community Safety Partnership considering any of the issues that might impact on people with learning disability living in less restrictive environments.	**5.7-** Yes, we have made steady progress in ensuring that our community safety response more adequately addresses the needs of people with learning disabilities and that our learning disability arrangements consider community safety issues. This has been achieved through a number of mechanisms.	✓	

	Leadership – The Learning Disability sub-group is chaired by the Divisional Director of Community Safety and Public Protection, and our DASS chairs the Community Safety Strategic Partnership. Strategy – The Community Safety Partnership includes a Hate Crime Strategic Group and a Domestic and Sexual Violence Strategic Group. Service user engagement – The Metropolitan Police regularly engages with service users and family carers through our Learning Disability sub-group and local community events that ensure they are considering issues that might impact on people with learning disability in the community. This has led some exciting projects to ensure that services users are given a voice in community safety. Examples of achievements include:- Development of a voluntary adult at risk contact list so that community safety messages can be targeted to them via the safer neighborhood teams and the roll out of the „safe card" scheme (Appendix 5.7c); Disability Harassment training in schools (Appendix 5.7d), Training for police officers on disability awareness		

	(Appendix 5.7e) Training for carers on managing challenging behaviour and the easy read „Say No to Abuse" leaflet (Appendix 5.7f) and DVD. We have a person with a learning disability who volunteers with the Metropolitan Police and who does work at the schools with the Police on hate crime.		
5.8 Has your Safeguarding Board got working links between CQC, contracts management, safeguarding staff and care/case managers to maintain alertness to concerns.	**5.8** - Yes, and as set out in 5.5, we introduced systems to aggregate intelligence that we receive in relation to providers (Complaints, Safeguarding Concerns, Serious Incident forms, Health Protection Agency information and contract monitoring outcomes) to assist local commissioners in contract monitoring and placement decisions. This is overseen by a sub-group of the Safeguarding Adults Board who have an overview of local services. The Care Quality Commission are members of the SAB and are also routinely invited to attend strategy meetings and case conferences where safeguarding concerns relate to institutions. In practice CQC attendance is limited and unfortunately they have rarely engaged with our Safeguarding Adult Board. Engagement of CQC is an area of support that we have identified and stated earlier in section 1.9 of this stocktake.		✓

6. Commissioning arrangements			
	Assessment of current position evidence of work and issues arising	**Good practice example (please tick and attach)**	Support Required
6.1 Are you completing an initial assessment of commissioning requirements to support peoples‟ move from assessment and treatment/in-patient settings.	**6.1–** Yes, move-on plans were considered as part of the boroughs review programme and individual placements, which included individual commissioning requirements, have been considered for those who are moving back to the community. Wider commissioning requirements are in the process of being developed as part of our local strategic plan.		
6.2 Are these being jointly reviewed, developed and delivered.	**6.2 –** Yes, an initial assessment of commissioning requirements was reviewed and discussed jointly between both health and care commissioners for the service user who is able to move back to the borough in the short term. Another service user and their family have requested not to move back to the borough and we are working closely with them, and the relevant local authority, to ensure plans are in place to support them move back to the community in this area.		
6.3 Is there a shared understanding of how many people are placed out of area and of the proportion of this to total numbers of people fully funded by NHS CHC and those jointly supported by health and care services.	**6.3 -** Yes, the borough has a firm grasp on the numbers of Adults placed outside of the region. As of 15.06.2013 the borough has: 1. 6 x Service users in AT&U‟s or inpatient services		

	2. 29 x Service Users in Residential Care Homes placements 3. 8 x Service users in CHC Placements 4. 2 x Service Users in Nursing Home placements 5. 30 x Service Users in Supported Living There is a clear and shared understanding across the partnership of the current funding arrangements for people who are funded through either NHS CHC, social care and jointly.		
6.4 Do commissioning intentions reflect both the need deliver a re-provision programme for existing people and the need to substantially reduce future hospital placements for new people.	**6.4 –** Not currently. The Council"s commissioning intentions were put in place prior to the release of the Winterbourne View Concordat and Transforming Care report. When they are reviewed later this year, as part of our commissioning cycle, we will ensure it reflects the requirements set out in the Winterbourne View concordat. As part of our local joint strategic plan we will be reviewing our current service provision across health and social care to identify how we will reduce hospital placements in the future.		
6.5 Have joint reviewing and (de)commissioning arrangements been agreed with specialist commissioning teams.	**6.5 –** Given the small numbers/activity and dispersed locations of services users (6) that we have in either an A&TU or inpatient setting we are not planning any joint		

	reviews and (de)commissioning arrangements with specialist commissioning teams at this stage. As stated in 1.9 we would, however, welcome the opportunity to engage any regional or pan-London workshops to explore regional joint planning and commissioning opportunities.		
6.6 Have the potential costs and source(s) of funds of future commissioning arrangements been assessed.	**6.6 –** Yes, initial scoping is underway to review the potential costs and source of funds for future commissioning arrangements. This will need to be developed further to inform our local joint strategic plan which will be in place by 1st April 2014.		
6.7 Are local arrangements for the commissioning of advocacy support sufficient, if not, are changes being developed.	**6.7-** Yes, we have recently launched a new specialist advocacy and social care complaints framework where people with learning disability have increased choice and access to independent advocacy in the borough. In addition, we have IMCA, IMHA services and family carer advocacy services in place. Barking and Dagenham are part of the pan London commission with Voiceability to deliver the NHS complaints advocacy service.		
6.8 Is your local delivery plan in the process of being developed, resourced and agreed	**6.8 -** Yes, we are in the process of agreeing a structure and project plan for our local delivery plan. The proposed structure for our plan is due to be discussed and approved at the next H&WBB on the 16th July 2013.		
6.9 Are you confident that the 1 June 2014 target will be achieved (the commitment is for all people currently in in-patient	**6.9 –** Yes, we are confident that the service users who, as part of our review programme, have been identified as		

settings to be placed nearer home and in a less restrictive environment).	able to move to a less secure setting will be achieved by the 1st June 2014.		
6.10 If no, what are the obstacles, to delivery (e.g. organisational, financial, legal).	**6.10 –** Of the remaining service users a major obstacle for them to move back to the community is due to them being detained following hospital orders with MoJ restrictions. Given the level of risk, together with their challenging behavior, it would not be realistic to consider a move into a community setting by the 1st June 2014. Any medium term plans would be dependent on the availability of more forensic places regionally to manage a stepped approach to them moving to less restrictive settings and ultimately their own independent accommodation. Work across London has identified a shortfall in regional forensic facilities that would enable this approach to be considered.		
7. Developing local teams and services			
	Assessment of current position evidence of work and issues arising	**Good practice example (please tick and attach)**	Support Required
7.1 Are you completing an initial assessment of commissioning requirements to support peoples" move from assessment and treatment/in-patient settings.	**7.1 –**Yes, an initial assessment of the service users who were part of the review programme and who were able to move back to the community has been completed.		

	The wider commissioning strategic requirements, to support move on from A&TU"s or inpatient services, will also be part of the joint local strategic plan.		
7.2 Do you have ways of knowing about the quality and effectiveness of advocacy arrangements.	**7.2-** Yes, to improve choice and quality of our local advocacy provision in the borough in 2012 we reviewed previous services which resulted in us launching a specialist advocacy and social care complaints framework in April 2013 which gives our service users greater choice over the independent advocacy they receive in the borough. To ensure quality the local authority has in place a well established and comprehensive contract monitoring systems which includes: Comprehensive contracts and service specifications that include clear outcomes, quality standards (based on the advocacy charter) and key performance indicators. Quarterly contract meetings with advocacy providers to discuss performance / quality issues. A requirement for advocacy providers to submit a comprehensive contract monitoring information bespoke to our advocacy contracts. Comprehensive annual reviews which include	**X**	

	seeking feedback from service users. Unannounced spot checks and mystery shopping. Regular meetings with all framework providers to discuss best practice. The local authority, CCG, and IMCA providers also meet quarterly for an IMCA steering group which follows the Public Health England"s best practice guidance on commissioning IMCA services (see appendix 7.2 for the groups Terms of Reference).		
7.3 Do you have plans to ensure that there is capacity to ensure that Best Interests assessors are involved in care planning.	**7.3-**Yes, the local authority currently has trained and supported 22 best interest assessors which is sufficient to meet current demand across the borough. There are more social workers currently being trained to undertake this work to ensure there is flexibility in deployment.		
8. Prevention and crisis response capacity - Local/shared capacity to manage emergencies			
	Assessment of current position evidence of work and issues arising	**Good practice example (please tick and attach)**	Support Required
8.1 Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally.	8.1– As part of our joint local strategic plan we are completing a review of the capacity to manage crises locally.		

	The outcomes of the assessment will link into our joint strategic plan, and its commissioning intentions, where will be looking at developing appropriate emergency responses for people with challenging behaviour.		
8.2 Do you have / are you working on developing emergency responses that would avoid hospital admission (including under section of MHA.)	8.2 - Yes, emergency responses are currently provided by our local CLDT which includes a Consultant Psychiatrist. We will consider the capacity of this provision and look to develop our emergency responses to avoid hospital admission as part of local strategic plan.		
8.3 Do commissioning intentions include a workforce and skills assessment development.	8.3 - Yes, a workforce and skills assessment has recently taken place across our current social care workforce as. The needs of our local workforce, especially on supporting and caring for people with challenging behaviour, is to be considered with our partners in the NHS as part of future workforce planning. As part of the autism action plan we have also commissioned a independent organisation to complete a mapping of local autism services where part of this project includes a workforce and skills assessment.		
9. Understanding the population who need/receive services			
	Assessment of current position evidence of work and issues arising	**Good practice example (please tick and**	Support Required

		attach)	
9.1 Do your local planning functions and market assessments support the development of support for all people with complex needs, including people with behaviour that challenges.	**9.1 –** Yes, the development of our integrated CLDT in 2010 was an outcome of local planning to ensure we had a community team that could provide support to people with a learning disability which included people with complex needs and those with challenging behaviour. Since the publishing of the Winterbourne View Concordat in 2012 the borough has also supported NHS London (pre 1st April 2013) in the development of a London wide Market Position Statement (MPS) on both Health and Social Care learning disability services. The borough is also developing its own a local MPS through the support of the Department of Health's 'Developing Care Markets for Quality and Choice' (DCMQC) programme. Both Market Position Statements will be used in the development of our local joint strategic plan which will be in place by 1st April, 2014. As part of the boroughs autism action plan we have recently commissioned an independent organisation to complete a mapping exercise of our Autism specialist and mainstream services in the borough. This work will include a market assessment and understanding future demand for autism services which will also be used to inform our joint local strategic plan.		
9.2 From the current people who need to be reviewed, are you taking account of ethnicity, age profile and gender issues in planning and understanding future care services.	**9.2 –** Yes, demographic information is collated and monitored through both our local register and electronic recording system.		

10. Children and adults – transition planning			
10.1Do commissioning arrangements take account of the needs of children and young people in transition as well as of adults.	**10.1 –** Yes, through the development of our comprehensive Transition Strategy the borough has a clear understanding of the needs of young people coming through transition and this takes into account of the emerging requirements set out in the Children and Families Bill. Transition planning was also taken into account in the development of the transformation programme for day opportunities in the borough.		
10.2 Have you developed ways of understanding future demand in terms of numbers of people and likely services.	**10.2 -** Yes, the borough has in place a number of established approaches to enable us to understand the future demand on our service through: Reviewing Disabled Children Services and Special Educational Needs (SEN) Prevalence Data to understand demand. As part of our JSNA we look at future demand, in terms of numbers, on the needs and number of people with a learning disability, autism and transition. Using reliable tools on national prevalence data, namely the Improving Health and Lives website, PANSI and NASCIS. Analysing local population data. Through consultation with, for example, family		

	carers. Through the completion of learning disability Self Assessment Framework.		
11. Current and future market requirements and capacity			
11.1 Is an assessment of local market capacity in progress	**11.1-** Yes, through the support of the Department of Health's 'Developing Care Markets for Quality and Choice' (DCMQC) programme, the council is drafting an Adult Social Care MPS which will include data on the availability of current social care services , support available in the borough, analysis of gaps and opportunities in the market. This will be completed by the autumn.		
11.2 Does this include an updated gap analysis.	11.2Yes, the assessments of local market capacity and gap analysis completed by the council will also feed into and support the development of our local joint strategic plan on challenging behaviour.		
11.3 Are there local examples of innovative practice that can be shared more widely, e.g. the development of local fora to share/learn and develop best practice	11.3 The Council recently held a „market place event". New and existing service providers were given the opportunity to describe and market their services to frontline staff who assist in the development of support plans. This event will be followed up with a larger market event where people that use services, and family and carers will meet providers and learn about the services and support they offer. Planning is also underway for a series of smaller events based around localities in the borough focused on the support and services available in a particular local area.		

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HEALTH AND WELLBEING BOARD

16 JULY 2013

Title:	**A Review of Services for Those Affected by Domestic Violence**
Report of the Director of Public Health	
Open	**For Decision**
Wards Affected: ALL	**Key Decision:** YES
Report Author: Matthew Cole, Director of Public Health	**Contact Details:** Tel: 020 8227 3657 Email: matthew.cole@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	

Summary:

Reducing domestic violence is a responsibility shared by all the partner organisations and there are also various statutory duties to fulfil. For services the main priority for intervention is to increase the safety and protection of women and children.

The aim of undertaking a service review of domestic violence services is to evaluate the current impact and value for money of the services available in Barking and Dagenham. Commissioned services for 2013-14 which directly address domestic violence total £823,500 funded through various partner agencies. Services have evolved over time and this review provides the opportunity to ensure our provision is in line with current and future needs.

Recommendation(s)

The Health and Wellbeing Board is asked to:

(1) Consider the recommendations of the review of services relating to domestic violence and discuss the implications for Barking and Dagenham. These are that:

- Commissioners should prioritise the funding of services which focus on identification and protection of those individuals (including children) at risk and experiencing domestic violence. These would include both Independent Domestic and Sexual Violence Advocate services and the Refuge and Sanctuary supported accommodation services.
- Commissioners should also prioritise for funding those services that target people across the life course who are most at risk, for both preventative action as well as early identification, including pregnant women and people with disability or long term illness. Services that address prevention as well as early identification are important.

- Commissioners should ensure that preventative services targeted at perpetrators or potential perpetrators are targeted at those with known higher risk factors, e.g. those with alcohol or substance misuse, history of offending, or severe depression.
- Commissioners should review the counselling services provided by the Women's Trust with a view to decommissioning them. More cost effective options for delivery may be available through existing commissioned mental health services, including Improving Access to Psychological Therapy (IAPT) services.
- Commissioners should further review local services in 2014/15 following the publication by the National Institute for Health and Care Excellence (NICE) its guidance on domestic violence: how social care, health services and those they work with can identify, prevent and reduce domestic violence. This publication is expected in February 2014.

(2) The Health and Wellbeing Board should invite NHS England to present its plans to introduce important changes to the arrangements for commissioning sexual assault services and for those people who experience sexual violence.

(3) Commissioners should following the recent reorganisation of local maternity services and the introduction in 2013/14 of a new funding system which brings all maternity care into Payment by Results, consider the impact and opportunities presented by the new funding arrangements for maternity services.

In respect of the level of need it would be prudent for NHS Barking and Dagenham Clinical Commissioning Group to extend the existing contract with the Refuge for a further six months whilst these issues are considered and the appropriate provision is agreed by commissioners for 2014-15.

Reason(s):

Under the Health and Social Care Act 2012 the statutory Health and Wellbeing Board has a duty to consider and comment on service reviews into health and social care and make commissioning recommendations to improve the quality of care and value for money.

1. Background to review

The Health and Wellbeing Board of Barking and Dagenham received a report on domestic violence in April 2013, and agreed a recommendation that:

"The Public Health Programme Sub-Group be asked to review the provision of services in the borough and make recommendations to the Board's July meeting as to which services should be commissioned and how these should be funded".

The recommendations of this review are in section 5. The services are described in Appendix 1.

2. Definition of domestic violence

The Government published an update definition of domestic violence on 14 February 2013:

"*Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:*

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

*Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."**

* This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Whilst this is not a legislative change, the definition is intended to send a clear message to victims about what does constitute domestic violence and abuse.

3. Legal context

There are a range of civil remedies and criminal offences which are relevant in cases of domestic violence. Legislation has been developed to offer protection to victims and to children who witness domestic violence. Appendix 1 details the legal context. Two important points of note:

- The Crime and Disorder Act 1998 places a statutory requirement on local authorities to monitor the level of domestic abuse in their communities and establish partnerships in order to reduce the problem as well as to pressurise more reluctant agencies. The Community Safety Partnership brings together the representatives of statutory, voluntary and private organisations which deal with crime reduction including domestic violence.
- The legislation applied in respect of civil or criminal proceedings depends on the circumstances and offence of the domestic violence.

4. The role of the health service commissioners

Locally there is a need to clarify the commissioning responsibilities that NHS Barking and Dagenham Clinical Commissioning Group has in respect of safeguarding vulnerable women and children on the issue of domestic violence. Department of Health policy and guidance is well developed in this area.

The Department of Health recognises that the National Health Service is the service that the victims of domestic abuse are more likely to come into contact with at some point in their lives. Domestic violence has long been recognised as an important public health issue with significant implications for health service delivery in accident and emergency units, primary care, maternity services and mental health services (The Annual Report of the Chief Medical Officer for England and Wales *On the*

State of the Public Health 1996). The Department of Health in response to *Responding to violence against women and children – the role of the NHS*: *The report of the Taskforce on the Health Aspects of Violence Against Women and Children* (2010) offered further recommendations to improve health responses.

In the new commissioning landscape clinical commissioning groups (CCGs) will be responsible for commissioning health services for most of the population. In relation to children and young people, CCGs are under a statutory duty (Crime and Disorder Act 1998) to co-operate in the provision of multi-agency Youth Offending Teams. CCGs will also be responsible for the commissioning of emergency care services for 'every person present in its area,' as well as mental health services, including primary mental health, psychological therapies and child and adolescent mental health services.

The current priorities for NHS England, CCGs and Public Health England have four distinct foci: awareness raising of domestic violence as a public health issue; training and developing the health service workforce to offer an improved standard of service to those experiencing domestic violence (e.g. training for health visitors to provide support to families when they suspect violence against women or children may be a factor); improving the quality of service provision and finally developing information and research frameworks.

Further clarity will be available in February 2014, when the National Institute for Health and Care Excellence (NICE) publishes guidance on domestic violence: how social care, health services and those they work with can identify, prevent and reduce domestic violence. This would be the ideal point for health and social care commissioners to further review service provision for this vulnerable group.

5. Information about domestic violence

5.1 Analysis of the British Crime Surveys 2007/8[i] and 2011/12[ii] gives an insight into the national picture about who is most affected by domestic violence:

- In 2011/12, 7.3% of women and 5.0% of men reported having experienced domestic abuse during the year, equivalent to an estimated 1.2 million female victims and 800,000 male victims.
- The 2010/11 British Crime Survey estimated that 30% of women and 17% of men had experienced domestic abuse since the age of 16.
- The likelihood of being a victim of any domestic abuse tended to increase with decreasing household income. Women living in households with an income of less than £10,000 were at particularly high risk of any domestic abuse (13%).
- Women who were killed by current of former partners significantly outnumber men – around three quarters of the people killed by current or former partners are women.
- While men are more likely than women to be the victim of a homicide, women are more likely than men to be killed by a partner, ex-partner or other family member. 51% of all female victims of homicide and 5% of male victims were killed by a current or ex-partner.

- There is little variation in risk of any domestic abuse by ethnic group (between white and non-white groups).
- Both women and men with a long-term illness or disability (including learning disability) were more likely to be victims of any domestic abuse in 2011/12 (12.8% and 7.3% respectively), compared with those without a long-term illness or disability (4.6% and 6.1%).

Other research[iii] suggests that in 73% of cases of domestic violence, alcohol had been consumed prior to the incident and 48% of those convicted of domestic violence had a history of alcohol abuse, while 19% had a history of substance misuse.

5.2 In respect of uptake of Refuge facilities, the National Domestic Violence Helpline do not hold figures by borough. The Women's Aid Annual Survey 2011/12 confirms the following for England and Wales:

- around **19,510 women** and **19,440 children** stayed in refuge accommodation during the year 2011/2012;
- **27,900** women who sought emergency refuge during the year were – at least initially - unable to find a refuge space;
- around **139,100 women** and **19,145 children and young people** were directly supported by outreach and other non-refuge services provided by domestic violence organisations during the year 2011/12, and a further **107,700 children** received indirect support by virtue of the support given to their mothers;
- direct support from **all specialist domestic and sexual violence services** was provided for a total of **158,610 women** and **38,585 children and young people** during the year 2011/12; and
- an increasing number of service users had **additional support needs**, making it difficult for some services to provide the support needed.

5.3 Profile of the needs of service users

It must be noted that the profile of needs of service users has been become increasingly complex over time. Service providers have stated that there is a notable increase in management issues within the refuges, highlighting the difficulties for some in terms of communal living and the need for greater housing and support options. The service types and solutions have been considered in Barking and Dagenham and in the context of more specific needs, such as:

- Substance misuse
- Mental health
- Learning disabilities
- Minority ethnic groups (particularly travellers, Asian women and Eastern European migrant communities)
- Lesbian, gay, bisexual and transgender people
- Single people without children (including older people)

- Female and male victims and survivors of domestic abuse
- Children and young victims and survivors of domestic abuse

5.4 Domestic violence and pregnancy

Successive reports have suggested that the incidence of domestic violence increases while women are pregnant. Some reports suggest that between 30% and 40% of domestic violence starts while a woman is pregnant.

Repeated United Kingdom confidential inquiries into maternal deaths[iv] [v] have highlighted that a small number of women are murdered by their partner, ex-partner or someone known to them during or shortly after pregnancy. The most recent report of the Centre for Maternal and Child Enquiries (2011) provides a review of all maternal deaths between 2006 and 2008. During this time 11 women died in this manner. All but three were killed while still pregnant. A further 23 women, whose death was attributed to other causes, had features of domestic abuse. These 34 deaths represent 13% of the total number of maternal deaths reported. The report authors suggest that this was probably an underestimate. This proportion is consistent with previous years' reports.

The 34 UK women whose deaths were reported shared some common features including:

- they were more likely to be late bookers (after 22 weeks);
- their partner was reported as overbearing or disruptive and was present at all maternity appointments;
- they had a history of poor attendance at appointments;
- they had a history of severe depression or other mental illness;
- they or their children were already known to Social Services;
- they had a history of recurrent sexually transmitted infections.

5.5 The local situation

Barking and Dagenham has the highest reported rate of domestic abuse offences across the area covered by the Metropolitan Police Service. The Crown Prosecution Service estimates that nationally domestic abuse accounts for about 18% of violent crime; in Barking and Dagenham that figure is estimated to be about 35%. These figures imply that this would be equal to around 8/9 per 1000 population rate for domestic violence compared with 4/5 per 1000 for London as a whole. However, just because the proportion of violent crime attributed to domestic violence is high in Barking and Dagenham it doesn't mean the issue is necessarily more common than elsewhere. The Community Mental Health Profile 2013 identifies overall rates of violent crime are significantly worse in the borough than the England and London average as identified in the episodes of violent crime, rate per 1,000 population, 2010/11 (England average: 14.6, London: 21.3, Barking and Dagenham: 24.9) and supports the view that these numbers are an accurate reflection rather than different proportions of different types of crime.

Between 1 April 2012 and 31 July 2012, there were 668 child safeguarding referrals made in Barking and Dagenham, of which **132 (19.8%)** have domestic violence as a stated issue.

It is important to recognise in service provision that domestic violence can occur in heterosexual and same-sex relationships, and the perpetrator may also be a household member other than a partner or ex-partner. Men may also be subject to violence in the home. However the monitoring figures available from currently commissioned services identify that locally it is predominantly women in heterosexual relationships who are accessing services.

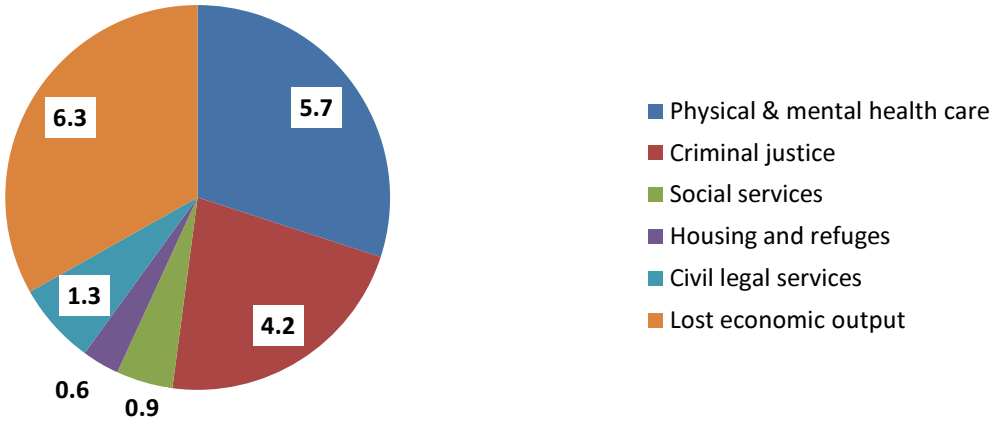
5.6 Economic analysis

The estimated cost of domestic violence in Barking and Dagenham is shown in Figure 1. This is based on work done at Lancaster University[vi] looking at costs in seven areas:

- The criminal justice system includes police, prosecution services, courts, probation and prisons.
- Health care (both physical and mental health), including costs to primary care and hospitals.
- Social services – only the costs linked to children and safeguarding are included.
- Housing and refuges: includes the cost of emergency Local Authority housing and refuges.
- Civil legal services: the cost of solicitors and injunctions are included.
- The cost of lost economic output due to time off work for injuries.

Figure1

Cost* of domestic violence in Barking and Dagenham 2009
(cost in £ millions - total £19.1 million)



* Based on 2009 population estimate (93,000 16–59 year olds, males and females). The estimated cost of lost economic output was limited solely to that due to time off work due to injuries. The chart excludes human and emotional costs.

With acknowledgment to the Trust for London and the Henry Smith Charity

The figure shows the majority of the £19.1 million is spent on direct health care (£5.7 million) or lost economic output (£6.3 million) due to time off work with injuries sustained. Investment in identification and preventative services should be a priority for health service commissioners in order to reduce the impact on use of hospital and primary care services and save money in the longer term.

6. Service quality

The Community Safety Partnership has undertaken a number of policy reviews, and developed strategy to ensure that the organisations providing the direct support services meet the minimum standards set by central government and work towards continually improving their services. This involved collating the views of current and ex-clients, staff, management and stakeholders or referrers. Some organisations did not meet the standards or decided to terminate their contract to provide the services, others had action plans to ensure that:

- There are policies and procedures in place for staff.
- There is information for applicants - such as leaflets advertising the service, how to apply, who is eligible, how people would be prioritised to ensure fair access to the services, what the service is like and what support can be provided.
- There is information for service users about how the service operates - including everyone having an assessment of their needs (i.e. what support is required) and a plan of how these needs will be met, and ensuring that people's health and safety are maintained, that they are aware that they have the right to live free from abuse and that if they wish to make a compliment, suggestion or complaint that they are empowered and enabled to state their views and these are actioned when required.

Nationally, a charity 'Co-ordinated Action Against Domestic Abuse' (CAADA) has been identified to support and improve the multi-agency response to domestic violence, focusing particularly on those most at risk of harm. Prevention activity in Barking and Dagenham is based on the model developed by CAADA. CAADA organises training for the Independent Domestic Violence Advisors (and other staff), and provides tools such as risk assessment tools to enable workers at a local level to work more effectively. CAADA also supports and develops the work of Multi-Agency Risk Assessment Conferences (MARAC). These are multi-agency meetings where information about high risk domestic abuse victims is shared. Analysis shows that following intervention by a MARAC and an Independent Domestic Violence Advisors service, up to 60% of domestic abuse victims report no further violence.

This now means that all services provided within Barking and Dagenham meet or exceed the minimum standards set by central government. There has been a recognised commitment from the agencies represented on the Community Safety Partnership to be the best and continually improve and develop their services. Additionally there are National Service Standards for domestic (and sexual) violence developed by Women's Aid at the request of central government.

7. Current service provision in Barking and Dagenham

In Barking and Dagenham there are a number of commissioned services which seek to support victims of domestic violence in the borough. The services work together to ensure a co-ordinated community response model. The service review has been driven by consideration of the following three categories that the services fall into:

- Core – a service which is essential for the protection of individuals.
- Supporting – a service which is necessary to support one of the core services.
- Supplementary – a service that while valuable is not essential to protecting individuals or preventing immediate harm.

7.1 Core Services

7.1.1 Refuge Independent Domestic and Sexual Violence Advocacy (IDSVA) community based service

The service provides specialist advocacy to high risk victims of domestic violence and ensures that victims access services, e.g. education for children, housing, benefits, criminal justice services and health services. This Independent Domestic and Sexual Violence Advocate service combines the roles of:

- The Independent Sexual Violence Advisors (ISVAs) provide independent support to victims of sexual abuse through the criminal justice process. ISVAs help victims to live without fear of violence and access the services they need in the aftermath of the abuse and violence they have experienced.
- The Independent Domestic Violence Advisors (IDVA) provide specialist support to victims of domestic violence. Their role is defined as follows: Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans. They are pro-active in implementing the plans, which address immediate safety, including practical steps to protect themselves and their children, as well as longer-term solutions.

7.1.2 Barking Havering and Redbridge University Hospitals NHS Trust Maternity Domestic and Sexual Violence Advocacy service (provided by the Refuge)

In December 2010 Barking and Dagenham PCT commissioned the Refuge to provide Independent Domestic and Sexual Violence Advisors at the maternity services based at Barking Havering and Redbridge University Hospitals NHS Trust. This is a two year funded project to establish a new domestic violence service as part of the ante natal and post natal care pathway. In addition to being based in the maternity service at King George Hospital the Maternity Domestic and Sexual Violence Advocacy service holds regular drop in sessions at the following booking clinics:

- First Monday of every month - Fanshawe Clinic, Dagenham
- Fourth Monday of every month - Loxford Polyclinic, Ilford
- Third Tuesday of every month - Ingrebourne Children's Centre, Romford
- Every Tuesday and Wednesday - King George Hospital, Ilford
- First Wednesday every month - St Kildas Children's Centre Romford
- Every Thursday - Queens Hospital maternity unit, Romford

The service works to identify and increase the safety of pregnant women experiencing domestic violence and any children exposed (including the unborn child) whilst also supporting the development and implementation of Trust procedures. Midwives are now routinely enquiring about domestic violence on around **90% of bookings** undertaken on the E3 maternity booking system. The service is one of only three services in London that provides this important service and has just been awarded the CAADA Leading Lights accreditation status having passed the entire 27 assessment criterion over a 12 month process.

The whole service at Queen's Hospital, regardless of residence, was funded by Barking and Dagenham PCT and since 1 April by NHS Barking and Dagenham Clinical Commissioning Group (NHSBD). This project comes to end in October 2013. It is important to note that the current payment arrangements for maternity services are set to change in 2013 and a **new system which brings all maternity care into Payment by Results (PbR)** is now being tested. It will pay for maternity services as a complete pathway upfront. The aim is to create incentives for providers to deliver the best, proactive care to prevent avoidable complications and interventions. NHS Trusts and NHS Foundation Trusts will receive enhanced PbR payments to recognise more complex care which is outlined in Appendix 2. This would apply in particular for women with complex social factors, including domestic violence.

The service needs to be reviewed by NHSBD and considered for mainstreaming as part of the care pathway in line with changes to funding arrangements for maternity services. For NHSBD, following the reorganisation of local maternity services, a significant number of women resident in Barking now receive their maternity care from Barts Health NHS Trust. From May 2012 around a 1000 bookings (800 births) per annum from the borough will move from Barking Havering Redbridge University Hospitals NHS Trust (Queens Maternity Unit) to Barts Health NHS Trust (Newham Maternity Unit). For those pregnant women identified as having complex social factors referral is made to the dedicated ACORN service based at the maternity service in Barking Community Hospital. This service is not separately commissioned and forms part of mainstream maternity services at Barts Health NHS Trust.

7.1.3 Sexual assault referral centres (often referred to as Havens)

Sexual assault referral centres are safe locations where victims of sexual assault can receive an integrated service of medical help, legal advice and counselling from professionally trained staff. This is a multi-agency approach that brings together various legal, medical agencies and departments in one place which helps both the

victims and those investigating the crimes. At present there are three sexual assault referral centres in London based in an acute hospital setting:

- St. Mary's Hospital – Paddington
- The Royal London Hospital – Whitechapel
- King's College Hospital - Camberwell

On 13 June 2013, NHS England announced its intention to introduce important changes for the arrangements for commissioning sexual assault services and for those people who experience sexual violence. In the context of this review it would be advisable for the Health and Wellbeing Board to invite NHS England to inform the Board of their commissioning intentions.

7.1.4 Refuge supported accommodation for women and children fleeing domestic abuse

Refuge places for women and their children are co-ordinated through the National Domestic Violence Helpline (which is run by Women's Aid and Refuge). The general premise is that women are placed outside of their borough to avoid the risk of future victimisation by the perpetrator or extended family and friends. This means that boroughs fund provision in their own borough on the assumption that their residents will be able to access other boroughs' provisions. Women's Aid and Refuge were not able to provide us with a breakdown of Barking and Dagenham residents housed elsewhere in the country. Their annual report identifies that in 2011/12 around 19,510 women and 19,440 children stayed in refuge accommodation nationally.

7.1.5 Victim support domestic violence case worker

This worker provides support to victims who would not meet the threshold for IDSVA support (i.e. those assessed as medium risk). The worker receives referrals automatically from the police and via the IDSVA service.

7.2 Supporting services

7.2.1 Multi-agency risk assessment conferences (MARAC)

Multi-agency risk assessment conferences (MARAC) are multi-agency meetings where statutory and voluntary agency representatives share information about high-risk victims of domestic abuse in order to produce a co-ordinated action plan to increase victim safety. The agencies that attend MARAC include: police, probation, IDSVAs, children's services, NHS and housing.

In 2011 a Home Office review into the effectiveness and cost effectiveness of MARACs found the following.

- Existing research indicates that MARACs (and IDVAs) have the potential to improve victim safety and reduce re-victimisation and therefore may be a highly cost-effective measure. However, as the available evidence on MARAC outcomes is relatively weak, a more robust evaluation would be required to strengthen these findings.

- Factors which were seen as supporting effective practice included having: strong partnership links (including a commitment from agencies to tackle domestic violence in general); strong leadership (through the MARAC chair); good co-ordination (through a MARAC co-ordinator); and the availability of training and induction.

7.2.2 MARAC co-ordinator - the multi agency risk assessment

The post holder co-ordinates and administers the multi-agency risk assessment conferences.

7.2.3 Domestic violence and hate crime manager

Provides strategic co-ordination to the partnership and leads work around awareness raising (includes White Ribbon Campaign UK) and multi agency training.

7.2.4 Sanctuary project

Sanctuary is a service for domestic violence survivors who wish to remain in their own homes. Sanctuary is one aspect of the borough's safer homes project which provides more secure homes. Referrals for Sanctuary are co-ordinated by the MARAC co-ordinator.

7.2.5 East London Rape Crisis Centre

The service comprises telephone support and counseling. There are four service outcomes set for this service which is shared across all the boroughs in east London.

The importance of awareness raising and the helpline is two-fold: firstly to promote an understanding of the impact of domestic violence and sexual assault and that it is not acceptable behaviour. Secondly, to ensure that victims had knowledge of support services and how to access help. This was due to a realisation that some victims initially required a 'listening ear' in terms of hearing and understanding their experiences of abuse. The process of seeking help was very rarely, in most cases, about immediately accessing refuge accommodation and in many instances a victim wanted to talk about and consider what options of support could be made available to her and her children.

7.3 Supplementary services

7.3.1 'Finding the Words' project

This is a project to work with young people around healthy relationships and sexual exploitation.

7.3.2 White Ribbon day

The Community Safety Partnership is an active supporter of the White Ribbon Campaign UK working to involve men in opposing violence against women and is set up to co-operate with work done by Womankind Worldwide.

7.3.3 Woman's Trust

The Woman's Trust is a specialist counselling and support service/mental health agency providing support to women to address the emotional and psychological impacts of domestic violence. The commissioned service provides up to 18 weeks of specialist counselling provision so that they can rebuild their lives.

8 Gaps in service provision

8.1 Improved provision of services for children affected by domestic abuse.

There is a longstanding recognition of the need to improve services for children and young people affected by this concern. One of the pressing needs, for children/young people identified by non-abusing parents is the provision of emotional support and counselling. Traditionally and until the present day, the option of access to the Child and Adolescent Mental Health Services (CAMHS) appeared to be the only viable option. The obstacle of a long waiting time was a significant off-putting factor and frustration, meaning that children did not access help.

Up until April 2013, there were no direct services commissioned for children affected by domestic violence. However, this financial year the Council has commissioned service provision for this group of children. This funding will enable therapeutic support to those children affected and will also place a domestic violence advocate in the Multi Agency Safeguarding Hubs (MASH) to ensure victims receive the support they require to protect their children. The Council has also invested in a community treatment programme funded by AVA (Against Violence and Abuse) and this will commence in September 2013. The programme will work with children and the victims of abuse.

8.2 Refuge provision

Nationally, the demand upon places is high with 27,900 women who sought emergency refuges during the year unable, at least initially, to find a refuge space. Refuges also report that there are an increasing number of service users who have additional support needs (substance misuse, disabilities) making it difficult for some services to provide the support needed.

8.3 Domestic violence intervention programme:

There are two types of perpetrator programme, those run by the probation service (IDAP) for convicted offenders, and community-based programmes run by the voluntary sector. The benefit of having a community-based programme is that it includes perpetrators who have not been convicted. In 2007 Barking and Dagenham commissioned the Domestic Violence Intervention Project (DVIP) to provide a community-based programme for £34k per annum. Initially this was commissioned in Stratford as part of an innovative east London arrangement with neighbouring boroughs. Five years on, while neighbouring boroughs decommissioned the service, we continued to run the service from a satellite venue in Barking and Dagenham. While it was recognised that the service worked effectively to address perpetrators behaviour, the numbers of individuals completing the 26 week course was only16 in 2011/12. The service was therefore not deemed to be cost effective and was decommissioned to contribute to the Council's cost

savings requirements. This has left a gap in provision, particularly for those perpetrators who cannot afford to access the service independently although it was generally felt that the programme was potentially unrealistic for some service users who could not commit to the 26 weekly sessions. Any plans to retender would need to consider what model of intervention would be most cost effective.

9. Review of domestic violence services

The new (2012–2015) Domestic and Sexual Violence strategy for the borough has four objectives:

- prevent domestic and sexual violence from happening in the first place;
- provide support to victims where violence does occur;
- reduce the risk of harm to victims and bring perpetrators to justice; and
- work better as a partnership locally to achieve the best outcomes for victims.

The review is timely as key contracts are up for re-procurement in 2014 these are:

- The two IDSVA services (Community Based IDSVA and Maternity based IDSVA) were commissioned in 2010 for three years as one contract. The current contract expires in January 2014. In April 2013 NHSBD agreed to fund the Maternity based project until September 2013. Funding has been secured from the Mayor's Office for Policing and Crime (MOPAC) to increase the offer to young people through the appointment of a young person's IDSVA in 2013/14 and an additional £40k for both 2014/15 and 2015/16.
- The Refuge Supported Accommodation was commissioned as a three year contract by the Council comes to an end in March 2014.

Services commissioned to address the issue of domestic violence in the borough should be aligned to at least one of the above objectives, but it may be necessary to prioritise the objectives above in order to inform commissioning decisions in the context of affordability.

A brief description of each of the services that are currently funded is contained in Appendix 3 of this report. The cost of each service is also provided as well as some information about outputs. Currently, the single largest investment is on the provision of the IDSVA service in local hospitals and the community. This totals £250k.

10. Conclusion and recommendations

The review of services for those affected by domestic violence has identified that the borough has in place a range of services that meet or exceed the minimum standards set by central government. Relative to other London boroughs and other parts of the country there is a good comprehensive level of provision to support and safeguard vulnerable women and children who experience domestic violence.

The high incidence and prevalence of domestic violence in this borough means that the application of increasingly scarce resources needs to optimise the effectiveness

and value for money achieved by services commissioned to address this important issue. The following recommendations should be considered:

10.1 Commissioners should prioritise the funding of services which focus on identification and protection of those individuals (including children) at risk and experiencing domestic violence. These would include both Independent Domestic and Sexual Violence Advocate services and the Refuge and Sanctuary supported accommodation services.

10.2 Commissioners should also prioritise for funding those services that target people across the life course who are most at risk, for both preventative action as well as early identification, including pregnant women and people with disability or long term illness. Services that address prevention as well as early identification are important.

10.3 Commissioners should ensure that preventative services targeted at perpetrators or potential perpetrators are targeted at those with known higher risk factors, e.g. those with alcohol or substance misuse, history of offending, or severe depression.

10.4 Commissioners should review the counselling services provided by the Woman's Trust with a view to decommissioning them. More cost effective options for delivery may be available through existing commissioned mental health services, including Improving Access to Psychological Therapy (IAPT) services.

10.5 Commissioners should further review local services in 2014/15 following the publication by the National Institute for Health and Care Excellence (NICE) its guidance on domestic violence: how social care, health services and those they work with can identify, prevent and reduce domestic violence. This publication is expected in February 2014.

10.6 The Health and Wellbeing Board should invite NHS England to present its plans to introduce important changes to the arrangements for commissioning sexual assault services and for those people who experience sexual violence.

10.7 Commissioners should following the recent reorganisation of local maternity services and the introduction in 2013/14 of a new funding system which brings all maternity care into Payment by Results, consider the impact and opportunities presented by the new funding arrangements for maternity services.

In respect of the level of need it would be prudent for NHS Barking and Dagenham Clinical Commissioning Group to extend the existing contract with the Refuge for a further six months whilst these issues are considered and the appropriate provision is agreed by commissioners for 2014/15.

11. Mandatory implications

11.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) has a strong overall domestic violence analysis as well as a detailed safeguarding element within it. There is general agreement that cross-sector working in the borough with involvement from

the NHS, employment, housing, police and other bodies, in addition to the Council's children's services and adult and community services is good.

11.2 Health and Wellbeing strategy

The Health and Wellbeing Board mapped the outcome frameworks for the NHS, public health, and adult social care with the children and young people's plan. The strategy is based on eight strategic themes that cover the breadth of the frameworks in which domestic violence is picked up as a key issue. These are Care and Support, Protection and Safeguarding, Improvement and Integration of Services, and Prevention. Actions, outcomes and outcome measures for domestic violence are mapped across the life course against the four priority areas.

11.3 Integration

The development of a multi-agency response to domestic violence is now widely acknowledged as the most effective way both to support and protect women and children who have experienced domestic violence, and to challenge male perpetrators. This does not mean just the setting up of inter-agency domestic violence forums. Rather it refers to the co-ordination or even, in some instances, the integration of service provision so that agencies work to the same brief and adopt a consistent approach

One of the outcomes we want to achieve for our joint Health and Wellbeing Strategy is to improve health and social care outcomes through integrated services.

11.4 Financial implications

(Implications completed by: Dawn Calvert, Group Manager, Finance)

In 2013/14 funding of £823,500 is being invested in domestic violence services from multiple sources which are summarised below:

Barking and Dagenham	£204,500
Public Health Grant	£368,000
Housing Revenue Account	£72,000
CCG	£120,000
Metropolitan Police	£39,000
MOPAC	£20,000
Total	**£823,500**

Appendix 3 details the allocation of the 2013/14 investment in more depth.

If any of the services detailed in Appendix 3 are decommissioned this could potentially release funding to be either re-invested within domestic violence services or within the contributing organisation.

(Implications completed by: Sharon Morrow, Chief Operating Officer NHS Barking & Dagenham CCG)

NHS Barking and Dagenham CCG is reviewing a number of contracts that have been novated from the former PCT and has committed funding up until October 2013, to enable a service review to be undertaken.

A NHSBD decision on continued investment in this service beyond 2014 would be informed by the following:

- The local need for a service and the health benefits
- The effectiveness of the service
- National guidance on commissioning for domestic violence services
- How much of the project to establish a service is now "business as usual" for the provider
- The change in maternity pathways – ensuring that resources are prioritised for Barking and Dagenham residents

Any decision to stop the service before the end of the contract term would require a 6 month notice period. The CCG would be required to procure a service if it was to be continued beyond April 2014.

11.5 Legal implications

(Implications completed by Lucinda Bell, Solicitor, Social Care & Education)

- **Procurement**

  If services are commissioned by way of a service contract between the Council and an outside organisation, the Council will need to ensure that the provisions for awarding contracts are adhered to as set out in the EU procurement regulations. Likewise, if the Council is to grant fund such organisations in order to commission aspects of delivery, State Aid rules may apply, dependent upon the nature of the organisation being funded and other considerations. Legal Services is available to provide advice on these matters once further information is forthcoming.

- **Equalities**

  Section 149 of the Equality Act 2010 imposes the Public Sector Equality Duty on the Council.

- **Health and Wellbeing Board Duties**

  The Heath and Wellbeing Board has the power to encourage commissioners of health-related services to work closely with it and a power to encourage providers of health or social care services to work closely together (*Section 195(3) and (4), Health and Social Care Act 2012*). The Board is under a duty to encourage integrated working this includes:

- a duty to encourage those arranging for the provision of health or social care services in their area to work in an integrated manner; and
- a duty in particular to provide advice, assistance, and so on, to encourage the making of arrangements under section 75 of the National Health Service Act 2006. (*Section 195(1) and (2),* Health and Social Care Act 2012).

11.6 Risk management

There is no legal obligation upon the Council or its partners to provide services to support the victims of domestic violence; however, the work that the partner organisations undertake serves to prevent serious injury and homicides. Therefore, the primary risk of not having appropriate needs based commissioned services on domestic violence is to the reputation of the Council and its partners. Domestic violence is a widespread problem and it is appropriate that the Health and Wellbeing Board should be clear about its commissioning priorities in addressing it.

11.7 Section 17 of the Crime and Disorder Act

Under section 17 of the Crime and Disorder Act 1998 all statutory agencies within the Health and Wellbeing Board have a duty to integrate consideration of the impact on crime and disorder of any decision, policy, activity or strategy that it performs. The statutory agencies are required to ensure that there is no negative impact on crime and disorder of any such decisions. Domestic violence is the biggest crime of violence in Barking and Dagenham and impacts adversely on individuals and on children as witnesses to violence. While an effective commissioned programme of services is not a statutory requirement, it will improve community safety and support victims.

12. Non-mandatory implications

12.1 Safeguarding

Addressing domestic violence and abuse is a key priority for the Local Safeguarding Children's Board and the Safeguarding Adults Board.

Research indicates that adults at risk are twice as likely to experience domestic violence and are also likely to endure it for longer and so the level of violence is likely to be more severe. In 2011/12 **15%** of all allegations of abuse or neglect against adults at risk were allegedly perpetrated by partners and **22%** perpetrated by other family members. This indicates that approximately **37%** of safeguarding adult alerts are domestic violence in nature. Adults at risk are likely to remain in abusive relationships because they face greater barriers in leaving. For example victims who misuse substances or have mental health issues may face greater stigma in seeking help or feel that they are excluded from mainstream services. Equally those with learning disabilities and/or those who lack capacity may not understand how to seek help. Equally while most services do provide some access for disabled individuals, those with more complex care needs may not be able to access some services.

The numbers of children suffering abuse relating to domestic violence continues to increase. The rate of referrals from the Police in particular relating to domestic violence incidents where children are present has seen a steep increase over the last 3 years. Currently 80% of the children on a child protection plan have been involved in or at least witnessed domestic violence and the increase of this issue in the teenage population is also cause for concern. In addition there are over 430 Looked after children many of whom have suffered such abuse and over 60% of all contacts received in social care have some form of domestic violence related issues. This is likely to continue with the demographic changes and the impact of the government's welfare reforms begins to have an impact.

These issues need to be considered when we commission services to ensure that services do not discriminate against adults and children at risk.

13. Background papers used in the preparation of the report:

Domestic Violence and Sexual Violence Strategy
http://moderngov.lbbd.gov.uk/documents/s64161/DSV%20Report.pdf

Joint strategic Needs assessment
http://www.barkinganddagenhamjsna.org.uk/Pages/jsnahome.aspx

Joint Health and Wellbeing Strategy
http://www.lbbd.gov.uk/AboutBarkingandDagenham/PlansandStrategies/Documents/HealthandWellbeingStrategy.pdf

Home Office circular 003/2013: new government domestic violence and abuse definition https://www.gov.uk/government/publications/new-government-domestic-violence-and-abuse-definition

The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom http://onlinelibrary.wiley.com/doi/10.1111/bjo.2011.118.issue-s1/issuetoc

The Annual Report of the Chief Medical Officer for England and Wales *On the State of the Public Health*, 1996

Securing excellence in commissioning sexual assault services
http://www.england.nhs.uk/2013/06/13/commis-sex-ass-serv/

Community Mental Health Profile 2013
http://www.nepho.org.uk/cmhp/index.php?pdf=E09000002

Supporting high-risk victims of domestic violence: a review of Multi-Agency Risk Assessment

Conferences (MARACs)

https://www.gov.uk/government/publications/supporting-high-risk-victims-of-domestic-violence

14. Glossary

BHRUT	Barking, Havering and Redbridge University Hospitals NHS Trust
CAADA	Co-ordinated Action Against Domestic Abuse (charity)
IAPT	Improving Access to Psychological Therapies
IDVA	Independent Domestic Violence Advisor
LBBD	London Borough of Barking and Dagenham
MARAC	Multi-Agency Risk Assessment Conference
MOPAC	Mayor's Office for Policing and Crime

15. References

[i] Povey, D (Ed.), Coleman K., Kaiza P., Roe S. "Homicides, Firearm Offences and Intimate Violence 2007/08 (Supplementary Volume 2 to Crime in England and Wales 2007/08)" 22/01/09.

[ii] Office of National Statistics "The Crime Survey: focus on: Violent Crime and Sexual Offences, 2011/12" London February 2013.

[iii] Gilchrist, E., Johnson, R., Takriti, R., Weston, S., Beech, A. & Kebbell, M. (2003) "Domestic violence offenders: characteristics and offending related needs" Home Office Findings 217, London.

[iv] Lewis, G. (ed.) "Why Mothers Die: The sixth report of the confidential inquiries into maternal deaths in the United Kingdom" Confidential Inquiry into maternal and child health (CEMACH)" Royal College of Obstetricians and Gynaecologists, London 2004.

[v] 2011 Centre for Maternal and Child Enquiries (CMACE), BJOG 118 (Suppl. 1), 1–203.

[vi] Walby, S. "The Cost of Domestic Violence: Up-date 2009" Project of the UNESCO Chair in Gender Research, Lancaster University.

Appendix 1

The following are some of the laws that are relevant to domestic abuse;

The Children Act 1989 and the Children Act 2004
This law establishes the legal framework for child protection and the key principle that the welfare of the child is the paramount consideration. It affirms that children should usually be cared for within their own home, but that children should also be safe and protected if they are at risk of significant harm. Section 17 makes provision for local authorities to provide support, care and services to safeguard and promote the welfare and development of the child and can be used, even if the mother has no recourse to public funds to support mothers and their children.

Adoption and Children Act 2002
Section 120 of the Adoption and Children Act 2002 extends the legal definition of 'significant harm' to children to include the harm caused by witnessing or overhearing abuse of another, especially in a context of domestic violence. It is important to remember that the responsibility for the harm lies with the abuser.

Female Genital Mutilation Act 2003
This Act came into force on 3 March 2004. It replaces the 1985 Act and makes it an offence for the first time for UK nationals or permanent UK residents to carry out Female Genital Mutilation (FGM) abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal.

Domestic Violence Crime and Victims Act 2004
The Domestic Violence, Crime and Victims Act 2004, introduces new powers for the police and courts to tackle offenders whilst ensuring that victims get the support and protection they need. The new Act creates a number of important provisions for example: there are new procedures to deal with multiple offending; breach of non-molestation orders becomes a criminal offence; and causing or allowing the death of a child or vulnerable adult becomes a new offence.

The Gender Equality Duty 2007
The Gender Equality Duty requires all public bodies to respond to the needs of women and men fairly and tailor their services accordingly. Domestic violence disproportionately affects women and their children. Apart from the physical injuries sustained by victims and their children, those experiencing domestic violence are twice as likely to experience high levels of depression. They are also more likely to self harm and attempt suicide.

The Housing Act (1996)
The Housing Act (1996) broadened the definition of homelessness for those who are eligible for accommodation, including victims of domestic violence and articulating this explicitly. This legislation provides for housing assistance to victims by engaging with their landlords (supported housing), who can take special measures to assure the accommodation.

The Homelessness Act (2002)
The Homelessness Act (2002) broadened the definition of violence to include all types of violence, not only domestic violence (Smith, 2003). Moreover, the provision of safe

accommodation for victims of domestic violence has become a priority for local authorities who have been obliged to generate the homeless prevention strategies for victims of domestic abuse.

Criminal Law Sanctions
Murder - Common law
Manslaughter Common law
Breaches of Bail - Bail Act 1976 s6(1) (2) and (7)
Criminal damage - Criminal Damage Act 1971 s1 (1)
Common assault - Criminal Justice Act 1988 s39
Threats to kill - Offences against the Persons Act 1861 s16
GBH with intent - Offences against the Persons Act 1861 s18
GBH/wounding - Offences against the Persons Act 1861 s20
ABH - Offences against the Persons Act 1861 s47
Other Offences against the Persons Act 1861
Harassment - Protection from Harassment Act s2(1) and (2), 4(1)
Affray - Public Order Act 1986 s3
Threatening behaviour - Public Order Act 1986 s4
Threatening behaviour with intent - Public Order Act 1986 s4(A)
Rape - Sexual Offences Act 1956 s1
Assault - by penetration Sexual Offences Act 2003 s2
Sexual assault - Sexual Offences Act 2003 s3
Theft - Theft Act 1968 s1
Blackmail - Theft Act 1968 s21
Witness intimidation - Criminal Justice and Public Order Act 1994 s51
Criminal trespass - Criminal Law Act 1977 s6(1)
Child cruelty - Children and Young Persons Act 1933 s1
Child abduction - Child Abduction Act 1984 ss1 and 2
Trafficking for exploitation - Asylum and Immigration (Treatment of Claimants, etc) Act 2004 s4, Serious Organised Crime and Police Act 2005
Trafficking for sexual exploitation - Sexual Offences Act 2003 ss57-60; Serious Organised Crime and Police Act 2005

The legislation applied depends on the circumstances and offence of the domestic violence. Annex E of the *Crown Prosecution Service's Policy for Prosecuting Cases of Domestic Violence* (2011) provides a detailed outline of types of behaviour that can occur in cases of domestic violence and that might amount to a criminal offence.
Available at: http://www.cps.gov.uk/publications/prosecution/domestic/domv_guidance.html#a17

Appendix 2

NHS funding of maternity services

The current payment arrangements for maternity services are set to change in 2013. CCGs will have little opportunity to control maternity spend through referral mechanisms so will need to be confident that providers are providing appropriate levels of care.

Current Arrangements: In most instances, maternity services are funded through two distinct mechanisms, firstly local contracts between PCTs and acute units for community antenatal care and postnatal care usually based on block contracts; whilst the national payment by results (PbR) system provides a series of tariffs for inpatient and some clinic activity and for intrapartum care. These tariffs have failed to capture in a coherent way the work that is undertaken in maternity care and have introduced an incentive for providers to intervene more often during pregnancy.

Proposed Pathway system for introduction 2013/14: A new system which brings all maternity care into PbR is now being tested. It will pay for maternity services as a pathway bundling together all the care needed for pregnancy and paid for upfront. The aim is to create incentives for providers to deliver the best, proactive care to prevent avoidable complications and interventions. The rationale is that the more proactive services are, the less interventions will be necessary and the fewer expensive interventions services undertake, the more money providers will save. Neonatal care will continue to be excluded from the pathway payment and will be commissioned and funded separate from maternity through the NHS Commissioning Board.

Intermediate		***Intensive***
Current factors	Complex social factors (including domestic violence) Obesity BMI >35 Physical Disabilities Underweight BMI <18 Substance/Alcohol Misuse	Twins or more
Medical factors	Mental Health Hepatitis B or C Generic/Inherited Disorder Epilepsy requiring convulsants Hypertension Previous uterine surgery (exc LSCS)	Cardio vascular disease HIV Malignant Disease Diabetes/other endocrine Rhesus isoimmunisation Renal disease Severe (brittle) asthma Autoimmune disease Venous thromboembolic disease Sickle cell/ thalassaemia Thrombophilia/clotting disorder
Previous Obstetric History	Pre-eclampsia, HELLP Puerperal psychosis Term baby ,21/2kg or 41/2kg Intrauterine growth restriction	Previous fetal congenital anomaly that required specialist fetal medicine

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APPENDIX 3

DOMESTIC VIOLENCE SERVICES 2013/14 – Total Contract Value £823,500

Name & cost of service	Aims/objectives	Outputs / outcomes	Discussion points	Recommendation
Children's Domestic Violence Service Contract value: £200,000 (funded from Public Health grant)	Commissioned 1 April 2013. Service commences August 2013	This is a new two year project to establish a best practice provision to support children and young people who are affected by domestic violence with a focus on improving health and wellbeing, in particular mental wellbeing.	At the time of writing the review Children's services are still working through its operating model and the service has not yet been established.	12 month evaluation
East London Rape Crisis Centre (NIA). Contract value: £20,000 (funded through LBBD community safety). Mayor's Office for Policing and Crime (MOPAC) arrangement with east London boroughs making an equal contribution.	The service comprises telephone support and counselling. There are four service outcomes set for this service which is shared across all the boroughs in east London. The outcomes are briefly: • service users have a better understanding of the consequences of rape/assault and of their rights in the justice and health sectors; • service users have improved self-esteem, confidence, emotional health and well-being and physical health and enhanced positive coping strategies; • increased access to a range of services; • equality for disadvantaged groups promoted through the service.	58 calls from local residents to the information and referral line for calendar year 2012, 10 clients referred for counseling, eight for advocacy, and four for workshops.	There is recognition and a need to promote the helpline as a first port of call for victims and consistent widespread promotion of the helpline is necessary to ensure that the information and opportunity is accessible to all residents This is essentially a counseling service and is a potential duplication with Woman's Trust counseling service	Continue service

Name & cost of service	Aims/objectives	Outputs / outcomes	Discussion points	Recommendation
'Finding the Words' Contract value: £15,000 (funded from Public Health grant)	A peer-based sexual exploitation education programme being delivered in partnership with Arc Theatre. Since April 2012 the programme has been rolled out to 2 of our 10 schools which has resulted in 1156 young people accessing the session. The project would therefore aim to reach young people in the remaining eight schools, the Pupil Referral Unit as well as youth settings such as youth clubs and the YOS when required	• Increase number of young people educated about sexual exploitation (500 young people partaking per year) • The majority of young people trained should rate the training as informative or above.	This is the key prevention arm of our strategy for working with young people	12 month evaluation
LBBD Domestic Violence and Hate Crime Manager. Service cost: £34,000 (funded from Public Health grant).	1 X 0.6 WTE post, provides strategic co-ordination to the partnership.	• To strategically lead the development and implementation of the domestic violence a hate crime objectives. • To work as part of a co-ordinated response to domestic violence in Barking and Dagenham • To manage the establishment and operation of the Barking and Dagenham domestic violence MARAC. • To assist in the establishment and development of a Specialist Domestic Violence Court in Barking and Dagenham		Continue funding

Name & cost of service	Aims/objectives	Outputs / outcomes	Discussion points	Recommendation
LBBD MARAC Co-ordinator. Service cost: £43,000 (funded from Public Health grant)	Co-ordinator of the MARAC (Multi Agency Risk Assessment Conference). This is a public protection mechanism which aims to reduce domestic homicide through co-ordinating interventions to support very high risk victims of domestic abuse and their children.	• There were 365 referrals to the Barking and Dagenham MARAC between April 2012 and March 2013. In total there were also 510 children in affected relationships. • Data shows that the current cessation rate is 77% with just 23% of clients reportedly experiencing repeat _victimization after an intervention. • MARACs enable the early identification of perpetrators and child victims of abuse.	CAADA estimates that for every £1 invested into MARAC £6 is saved[i].	Continue funding
Refuge – BHRUT Queens Hospital maternity unit based IDSVA service Contract value: £120,000 p.a. (funded by CCG)	The service consists of 3 x (WTE) Advocates and 0.5 x (WTE) Service Co-ordinator. The support includes risk assessment, support, advocacy and safety planning.	Of the 258 referrals received up until Jan 2013, 72% were Barking and Dagenham residents. • B&D – 187 • Havering – 34 • Redbridge – 37 Between the 1st April 2012 – 31st March 2013 the maternity IDVA service have referred 22 pregnant women to MARAC. Additional outcomes of the project until Jan 2013: • 231 risk assessments conducted • 321 children and 262 unborn children exposed to DV • 347 midwives trained • Average length of abuse 2.3 years, 65% reported to police and 15% attended A&E due to domestic violence, average visits to GP was 4	NHSBD are commissioning the whole service regardless of residence and need to agree with Havering and Redbridge CCGs that this will move from a block contract to cost per case contract NHSBD as part of their commissioning intentions need to consider the services available to those women who's maternity care is now provided by Barts Health NHS Trust	Continue funding whilst Commissioners review service model as the service may be more cost-effectively provided to all women in pregnancy

Name & cost of service	Aims/objectives	Outputs / outcomes	Discussion points	Recommendation
Refuge – Community based IDSVA service. Contract value: £130,000 p.a. (funded £40k from Housing Revenue Account, £51k from Public Health Grant, £39k from Metropolitan Police)	The service provides specialist advocacy to high risk victims of domestic violence. Support includes risk assessment, support, advocacy and safety planning. The service consists of 2.6 x Full Time Equivalent (FTE) Advocates and 0.5 x (FTE) Service Co-ordinator. Part of single contract commissioned in 2010 which includes BHRUT IDSVA service. Expires January 2014.	158 new clients accessed the service between April 2012 and March 2013 and 333 exit forms were completed. With the exception of one person who was transgender, all new clients were female. The largest cohort (86 people) was aged between 21 and 30, with another 37 being aged between 31 and 40. 86 were white British/Irish/other. The average length of abuse reported by clients was three years. 86 clients reported they had children and a total of 142 children lived in affected households. Refuge estimated an average reduction in the risk of serious harm or homicide of 32.8% for clients.	On average the service costs £823.00 per person accessing the service.	Continue funding
Victim Support Domestic Violence caseworker. Contract value: £31,500 (funded by LBBD Community Safety)	This worker provides support to victims who would not meet the threshold for IDSVA support (i.e. those assessed as medium risk). The worker receives referrals automatically from the police and also via the IDSVA service.	This year the project has received 1,697 domestic violence referrals resulting in 1,588 phone calls, 708 emails to survivors and partner agencies, 85 attendances at court, 20 MARAC and DV forum meetings. 982 cases of advocacy support, 61 cases were escalated back up to IDSVA high risk services and 166 referrals were made for target hardening.	The service costs about £18.50 per referral.	Continue funding

Name & cost of service	Aims/objectives	Outputs / outcomes	Discussion points	Recommendation
Sanctuary project. Contract value: £50,000 (funded £18,000 from LBBD anti-social behaviour and £32,000 Housing Revenue Account anti-social behaviour).	Sanctuary is a service for domestic violence survivors who wish to remain in their own homes. Sanctuary is one aspect of the borough's safer homes project.	166 referrals were made to Sanctuary in the last year. This outcome of the service is that victims and their children are supported to feel safer in their own homes by reducing repeat victimisation and/or enabling them to have enough security in place to wait for the police to arrive.	Potential savings are achieved by reducing the cost associated with re-housing and homelessness applications.	Continue funding
Refuge – supported accommodation Contract value: £135,000 per annum (funded by LBBD Commissioning)	This service consists of 13 units across two sites in Barking and Dagenham. The service employs 0.7 x (FTE) Manager across two sites and 2.5 x (FTE) support workers. Most women are from out of borough as local residents are accommodated in other areas.	Barking and Dagenham residents usually go to refuges out of borough, and are housed in one of the 42 refuges across 19 local authority areas. 13/19 of the local authorities are in London. The total number of women using the facility over 2012-2013 is 32 with 29 accompanying children. A comparison of contract values of these services was made between London boroughs. This indicates that the annual contract value for Barking and Dagenham is better value for money as our unit costs are much lower than the second cheapest provision in Barnet. We have good throughput and utilisation with no void periods further supporting good value for money based on the unit cost	Age limit on male children going into accommodation can be as low as 12. Our provision is largely used by those fleeing violence from out of borough but this would be same as any of the other boroughs used as part of benchmarking. It is difficult to try and locate figures for numbers fleeing Barking and Dagenham.	Continue funding

Name & cost of service	Aims/objectives	Outputs / outcomes	Discussion points	Recommendation
Woman's Trust. Contract value: £25,000 p.a. (funded from Public Health Grant)	Woman's Trust (WT) is a counselling and support service/mental health agency, providing support to women to address the emotional and psychological impacts of domestic violence. The Trust aims to empower women to overcome the mental health effects of abuse, re-gain control, make positive choices, rebuild their lives and live free from violence and abuse, through provision of women-only, client-led, services. Aim is to enable women to build up the confidence to be part of the local community and the economy again.	Between 2009 and 2012 there was a 168% increase in the number of referrals received, 298 were referred in 2012/13. All women were offered an initial session in 2012/13; however, only 124 attended. 43.5% were of white British origin. 569/860 sessions were attended. Clients attended an average of 10.1 sessions each. 84/124 clients were in the 26 to 45 age group.	2012/13 report that the average waiting time from referral to appointment is 7.1 weeks. The average wait from initial appointment to first counselling session, 18.75 weeks. There is potential duplication of services with East London Rape Crisis Centre**,** although aspects of the service do differ. Women only service. Alternative service should be available to all from mainstream mental health services.	Consider for decommissioning after assessing alternatives.

[i] CAADA (2010) 'Saving Lives; Saving Money: MARAC and high risk domestic abuse'. Bristol: CAADA.

HEALTH AND WELLBEING BOARD

16 JULY 2013

Title:	Managing Performance of the Health & Wellbeing System
Report of the Corporate Director of Adult & Community Services	
Open	**For Decision**
Wards Affected: ALL	**Key Decision:** No
Report Author: Mark Tyson, Group Manager, Service Support & Improvement	**Contact Details:** Tel: 020 8227 2875 Email: mark.tyson@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director of Adult & Community Services	

Summary:

The Council's Constitution, Part C Section D, sets out the role of the Health & Wellbeing Board to 'To promote and advance the health and wellbeing of the people of Barking & Dagenham, and work to secure improvements in the health, social care and health-related services available to them.' There is also a requirement that the Board report annually to Assembly on its work. Both of these requirements imply the need for the Board to take a rounded view of the performance of the health and social care system, across both preventive activity and the direct delivery of health and social care services.

This report presents a structure and process through which the Board might achieve this aim, including example documentation and a draft list of indicators for inclusion in the Board's own reporting. The Board is invited to approve the system or make amendments, with a view to it commencing in September.

Recommendation(s)

To approve the performance system as proposed, with any amendments, and note the intention to bring the first report to the Board's September meeting.

Reason(s)

The Health & Wellbeing Board is intended to have the widest view across the whole health and social care economy and to secure improvements on behalf of local people. This implies a need to have a rounded awareness of the performance of the system, and any remedial action that is required to ensure that health and social care services are of the standard local people are entitled to expect.

1 Introduction

1.1 The Health & Wellbeing Board is established to ensure that an integrated approach is taken to securing improvements in the health and wellbeing of the local population, as well as the necessary improvements in the services that they access to help them stay healthy and independent. It is convened as a committee of the Council to ensure that this activity takes place in an open and transparent way, as part of the local democratic process.

1.2 The Shadow Board had previously agreed (12 March 2013, minute 285) that it would receive the first full performance report in September 2013, and a 'mock-up' earlier than that so that Board members had opportunity to comment on the proposed approach. This report provides that opportunity for comment.

1.3 It is essential, therefore, that Board members have a system by which they can receive and review a broad-based performance report on key areas of this work. It is for partners to ensure that delivery takes place, but Board should challenge and enable where there are areas of underperformance, and therefore the purpose of the Board receiving a performance overview will be to:

- Highlight areas where further work is needed to ensure adequate delivery, particularly where this might require the participation of more than one partner agency;
- Ensure a focus is maintained on those areas that have been collectively established by the Board as a priority;
- Ensure that an opportunity is provided to place on the public record discussions and decisions relating to performance issues (including exemplary performance) for parts of the health and social care economy.

1.4 This report provides an example of the format that will be used to provide the Health & Wellbeing Board with this performance review. It is intended that the first performance report will be provided to the Board in September, when sufficient time has elapsed in the 2012/13 year to gather a reasonable tranche of data. Thereafter reports will be scheduled to pick up performance quarterly as a minimum, fitting in with the timings of the Health & Wellbeing Board meetings.

1.5 Section 3 provides an overview of the proposed indicators to be reviewed for the first year; Section 3 presents the proposed overall structure for the performance reporting system.

2 Indicators to be included in the performance report

2.1 Appendix 1 provides the list of indicators that are proposed to be included in the performance report. They are extracted from the full Outcomes Framework that was agreed by the Shadow Board at its meetings on 27 November 2012 (minute 253) and 12 March 2013 (minute 285).

2.2 The Board cannot, of course, scrutinise every indicator at every meeting. The focus of this selection is therefore on:

- Indicators which are seen as critical to the core priorities for improvement of the local health and social care system;
- Indicators which are seen as critical to the core priorities for improvement of the health of the local population;
- Indicators on which the allocation of the Public Health Grant and Health Premium will be assessed (NHS Health Checks, National Child Measurement Programme, Community Contraceptive Services, Stop Smoking Services and premature mortality from all causes)
- A reasonable spread across the very wide sphere of business for the Board;
- Those indicators on which there can be demonstrable shift in-year (or proxies in place of those that would only see change, or be available to report, at year end);
- Indicators which need to be reviewed because performance is significantly below that which would be expected or desired.

2.3 Where annual indicators have been included within the framework, these represent critical outcomes to be reported annually, for which suitable proxy indicators or more frequent data collections will need to be developed.

2.4 A small number of indicators have been proposed which are not included in the current Health and Wellbeing Performance Framework. These are included due to a developing need being identified within the borough, or a statutory responsibility to monitor the indicator, as part of the public health grant review.

3 Proposed Board Performance System

3.1 It is proposed that the performance system for the Health & Wellbeing Board comprise three parts:

- The covering report will provide context and overview, and draw Board members' attention to what is specifically covered in the attachments;
- A 'dashboard' will present the overview across the range of selected indicators. It will include trend, benchmarking and the allocation of indicators to groups within the substructure. It is based on a format employed successfully by the Children's Trust.
- For areas of concern, or which simply need to be highlighted in more detail, indicator sheets are being prepared which have fuller narrative, background on the performance trends and information on remedial actions or actions being taken to sustain positive performance. These are currently used in Adult & Community Services for performance reporting.

3.2 Appendix 2 provides an example of the dashboard to be used for the reporting.

3.3 Appendix 3 provides examples of the indicator templates, based on public health and social care information as currently used within Adult & Community Services.

4 Care Quality Commission reports on local providers and services

4.1 To sit alongside the regular performance monitoring arrangements detailed in this paper, it is also proposed that a periodic round-up is provided to the Board of Care Quality Commission reports on local providers. This will ensure that the Health & Wellbeing Board is aware of local inspection activity and can consider an overall summary on health and social care service quality, as viewed through CQC's reporting.

4.2 An example of the kind of information that might be reported, taken from CQC's weekly report for the 24 June 2013, is shown below. The column on 'outcome' has been added, based on the CQC website entry for the service under inspection.

Provider	Location	Publ'n date	Link	Org type	Outcome
Concordia Specialist Care Services Limited	Porters Avenue Doctors Surgery	22 June 2013	http://www.cqc.org.uk/directory/1-408717547	Independent Healthcare Org	Met all standards
Inspire Dental Dagenham Limited	Inspire Dental Dagenham	18 June 2013	http://www.cqc.org.uk/directory/1-199667941	Primary Dental Care	Met all standards

5 Discussion

5.1 The Board is invited to consider the example information provided in the appendices, and provide comments. Officers in Public Health, Adult & Community Services and Children's Services will then work with partners to ensure that the first performance report is prepared for the September meeting of the Board.

6 Mandatory Implications

Joint Strategic Needs Assessment

6.1 Maintaining a current log of performance throughout the year will ensure that areas of concern are readily flagged for further analysis through the Joint Strategic Needs Assessment during its yearly refresh. More fundamentally, having identified areas in need of sustained improvement through the JSNA process, it is essential that continued scrutiny is applied to ensure that performance is improving and that identified or recommended actions are on track to deliver.

Health and Wellbeing Strategy

6.2 As above, where JSNA recommendations are accepted by the Health & Wellbeing Board as being priorities for action, they are then transferred into the Health & Wellbeing Strategy. It is essential that the Board has the information on which to base its assessment of whether the Strategy is being delivered, and the performance system as proposed seeks to do this.

Integration

6.3 By taking a wide view of health and social care, and ensuring that the measures chosen in the performance framework cover the full span of the Board's business, the Board is supported to maintain a view on the functioning of the whole system, as well as to be supported in decision-making on integrated service planning. It is

also for Board members to consider indicators and programmes that are not specifically in their area of responsibility, but to which they can bring a broader viewpoint.

6.4 Some of the indicators proposed, such as delayed transfers of care, are specifically descriptive of the performance of multiple agencies within the Health & Wellbeing Board, and so provide direct indications as to the effectiveness of the system's integrated activity.

Legal Implications

(Implications completed by: Lucinda Bell, Solicitor Social Care and Education)

6.5 The Local Authority is required to establish its Health and Welfare Board under the Health and Social Care Act 2012. It has functions in relation to the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy. It has a duty to encourage integrated working. The proposed structure is intended to aid reporting and assessing performance, as required by the Constitution and The Health and Social Care Act.

Finance Implications

(Implications completed by: Dawn Calvert, Group Manager, Finance)

6.6 There are no financial implications to this paper

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APPENDIX 1

Suggested Indicators for a Health and Wellbeing Dashboard

Lifecourse	Suggested indicator - Health and Wellbeing Board	Part of the HWB Performance Framework?	Lead	Data Source	Frequency
early years	Percentage of children achieving national standard for school readiness aged 5 years.	yes	Children's Services	Department for Education	Annual
early years	Rate of infant mortality under the age of 1 year	No	public health	HSCIC	Annual
early years	Percentage Uptake of Diphtheria, Tetanus and Pertussis (DTaP) Immunisation at 5 years old	yes	NHS England	PHE COVER Data	Quarterly
early years	Percentage Uptake of Measles, Mumps and Rubella (MMR2) Immunisation at 5 years old	yes	NHS England	PHE COVER Data	Quarterly
early years	Percentage Prevalence of Breastfeeding at 6-8 Week Check	yes	NHS England	Department of Health	Quarterly
primary school	Percentage Prevalence of children in reception year that are obese or overweight	yes	public health	NCMP	Annual
primary school	Percentage Prevalence of children in year 6 that are obese or overweight	yes	public health	NCMP	Annual
primary school	Percentage of school children eligible for Free School Meals	yes	Children's Services	School Census	Bi-annual
primary school	Of those eligible, the percentage of children who take up Free School Meals	yes	Children's Services	School Census	Bi-annual
adolescence	Alcohol specific admissions aged under 18	yes	Children's Services	Local Alcohol Profiles for England	Annual
adolescence	Under 18 rate of terminations of pregnancy	yes	LBBD	ONS	Annual
adolescence	Annual health check Looked After Children	yes	Children's Services	..	Quarterly
adolescence	Emotional Wellbeing of Looked after children	yes	Children's Services	..	Quarterly
adolescence	Number of children and young people accessing Tier 3/4 CAMHS services	yes	CCG	..	Quarterly
early adulthood	Number of positive Chlamydia screening results	yes	Public Health	Local Chlamydia Screening Programme	Monthly
early adulthood	Number of four week smoking quitters	yes	Public Health	Local Smoking Cessation Service	Monthly
early adulthood	Cervical Screening - Coverage of women aged 25 -64 years - Percentage women who have been adequately tested within the last five years	yes	NHS England	HSCIC	Quarterly
Maternity	Percentage Women seen by a maternity professional by 12 weeks and 6 days of pregnancy	yes	CCG	Department of Health	Quarterly
Maternity	Percentage of women who are smoking at time of delivery	yes	CCG	HSCIC	Quarterly

Lifecourse	Suggested indicator - Health and Wellbeing Board	Part of the HWB Performance Framework?	Lead	Data Source	Frequency
established adults	Percentage of eligible population that received a health check in last five years	yes	Public Health	Local Health Checks Team	Quarterly
established adults	Breast Screening - Coverage of women aged 53-70 years – Percentage women whose last test was less than three years ago	yes	NHS England	HSCIC	Annual
older adults	Number of people accessing homecare via managed budgets compared to direct payments	yes	ACS	ACS	Monthly
older adults	Older people in residential/nursing care admissions/discharges	yes	ACS	ACS	Monthly
older adults	Rates of emergency admissions for COPD per 100,000 population	yes	CCG	HSCIC	Annual
older adults	Percentage of terminally ill patients who die at home if they chose to	yes	CCG	Public Health Deaths file (PCMD)	Quarterly
vulnerable	Number of cases discussed at MARAC meetings per quarter.	yes	ACS	MARAC	Quarterly
vulnerable	Percentage households in temporary accommodation	NO	ACS	Department for Communities and Local Government	Quarterly
vulnerable	Percentage of individuals with Learning Difficulties or Disability with annual health check	yes	CCG	..	Quarterly
all ages	Alcohol related recorded crimes	yes	ACS	Local Alcohol Profiles for England	Annual
all ages	KT31 community contraceptive services - statutory return	NO	public health	HSCIC	Annual
all ages	Emergency readmissions within 30 days of discharge from hospital	No	CCG	HSCIC	Annual
all ages	Rate of premature mortality under the age of 75 from all causes	No	public health	HSCIC	Annual
all ages	Percentage successful completion of drug treatment - opiate users	No	ACS	Substance Misuse Strategy Team	Monthly
all ages	Rate of emergency admissions due to ambulatory care sensitive conditions	yes	CCG	NHS Better Care, Better Value	Quarterly
all ages	Percentage of A&E attendances without treatment, intervention or admission	yes	CCG	SUS extract	Quarterly
all ages	Improving Access to Psychological Therapies: People who have entered treatment as a proportion of people with anxiety or depression (Percentage)	yes	CCG	HSCIC	Quarterly
all ages	Percentage of eligible diabetic population receiving screening for early detection of diabetic retinopathy	yes	NHS England	Department of Health	Quarterly
all ages	Delayed Transfers of Care, including those that are due to the local authority	yes	ACS	NHS England	Quarterly

Public Health Indicator Summary

Key

	Data unavailable due to irrelevance, reporting frequency or the performance indicator being new for the period
..	Data unavailable as not yet due.
	Data missing and requires updating
	Provisional end of year figure
DoT	Each indicator is denoted with a colour coded arrow to show whether performance has improved (green) or worsened (red).
NC	No Colour

INDICATOR DESCRIPTION	PERFORMANCE AND R/A/G STATUS																BENCHMARKING		TARGET
Title	2011/12				2012/13												DoT	Traffic light	England Average	London Average	2012/13
	Q1	Q2	Q3	Q4	Q1			Q2			Q3			Q4							
1					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar					
Four Week Smoking Quitters	..	..	..	..	173	315	426	530	614	721	876	975	1044	1222	1366	1480	↗	G			1479
Numerator: The number of smokers setting an agreed quit date and, when assessed, self-reporting as not having smoked in the previous two weeks. Denominator: the target number of self reported quitters per month.																					
2																					
NHS Health Checks Received	3.6%	2.7%	3.0%	3.1%	2.1%			2.0%			2.9%			3.0%			↗	R	8.1%	9.3%	15.0%
Numerator: Number of people aged 40-74 eligible for an NHS Health Check who have received an NHS Health Check in the financial year. Denominator: Number of people aged 40-74 eligible for an NHS Health Check who																					
3																					
Chlamydia Screening Programme	..	..	..	..	59	64	59	51	40	49	48	47	33	45	46	44	→	R			60
Number of positive tests for chlamydia for people aged 15-24 years.																					
4i																					
Childhood Obesity (Reception Coverage)	95.4%				..												↗	G			
Percentage of children in reception year that have had their height and weight measured during the school year. Numerator: Number of children in reception year that have had their height and weight measured during the																					
4ii																					
Childhood Obesity (Reception Prevalence)	13.7%				..												↘	G			
Percentage of children in reception year whose weight is above the 95th centile of the population. Numerator: children in or reception year whose weight is above the 95th centile of the population. Denominator: Number of																					
4iii																					
Childhood Obesity (Year 6 Coverage)	93.4%				..												↗	G			
Percentage of children in year 6 that have had their height and weight measured during the school year. Numerator: Number of children in year 6 that have had their height and weight measured during the school year. De																					
4iv																					
Childhood Obesity (Year 6 Prevalence)	26.9%				..												↗	R			
Percentage of children in or year 6 whose weight is above the 95th centile of the population. Numerator: children in or year 6 whose weight is above the 95th centile of the population. Denominator: Number of children in ye																					
5																					
Teenage Conceptions	50.7	46.6	..	..	..			..			..			..			↘	A			
Conceptions in women aged under 18 per 1,000 females aged 15-17. Numerator: Number of live births to women aged under 18 years. Denominator: Resident population aged 15-17																					
6																					
Ambulatory Care Sensitive Admissions	1136.2				..												↗	R			
Numerator: number of persons aged over 18 with chronic conditions admitted to hospital as an emergency admission. Denominator: populatioin aged 28 years and over.																					
7i																					
DTaP	..	..	..	..	91.2%			91.0%			91.9%			..			↗	R			92%
Percentage of children immunised with DTaP vaccination. Number of children vaccinated with DTaP at any time up to their 1st birthday. Denominator: Total number of children for whom the PCT is responsible on 31/03/13																					
7ii																					
MMR 2	..	..	..	..	85.5%			83.8%			85.6%			..			↗	R			95%
Percentage of children given two doses of MMR vaccination. Numerator : Number of children vaccinated with two doses of MMR at any time up to their 5th birthday. Denominator: Total number of children for whom the PCT																					
8i																					
Breastfeeding Status at 6-8 Weeks (Coverage)	95.2%				95.1%			95.8%			95.4%			91.9%			↘	R	95.5%	92.4%	95%
Percentage of infants in the quarter who are due for a 6 to 8 week check who attend. Numerator: Number of infants due a 6-8 week check that attend check. Denominator: Total number of infants due a 6-8 week check.																					
8ii																					
Breastfeeding Status at 6-8 Weeks (Prevalence)	53.5%				55.4%			54.2%			54.8%			48.3%			↘	R	47.2%	65.1%	58%
Percentage of infants being breastfed at the 6-8 week check (number of infants partially or totally breastfeeding). Numerator: Number of infants who are totally or partially breastfed at 6-8 week check. Denominator: Total																					
9																					
Early Access to Maternity	..	..	..	..	..			76.8%			77.1%			..			↗	R			
Numerator - Number of women in the relevant PCT population who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks and 6 days of p																					
10																					
Cancer Screening (Breast)	68.6%				..												↘	R	77.0%	69.3%	
Numerator: coverage of women aged 53-70 – % women whose last test was less than three years ago. Denominator: Women aged 53-70 years.																					
11																					
Cancer Screening (Cervical)	75.0%				..												↘	A	78.6%	74.1%	
Numerator: Coverage of women aged 25 -64 years - % women who have been adequately tested within the last five years. Denominator: Women aged 25-64 years.																					
12																					
Diabetic Retinopathy - Retinal Eye Checks	..	..	..	..	..			88.5%			83.6%			..			↘	G			
Numerator - Number of people with diabetes receiving screening for the early detection (and treatment if needed) of diabetic retinopathy in the last 12 months. Denominator - Number of patients with diabetes identified by																					

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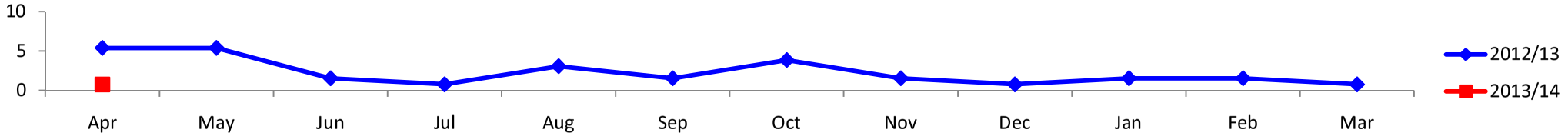
Delayed Transfers of Care (DTOC) Adult Social Care – Indicator 1				May 2013 Source: http://www.england.nhs.uk/statistics/
Definition	The national definition of a delayed transfer of care is when a patient is ready for transfer from acute care, but is still occupying an acute bed.	**How this indicator works**	This indicator measures the number of patients with a Delayed Transfer of Care (DTOC) at midnight on the last Thursday of the reporting period, who were solely the responsibility of Social Care. The figures shown below are per 100,000 18+ residents. (18+ population of 133,215)	
What good looks like	Good performance would be to remain under the 2012/13 England average of 2.66 DTOC's per 100,000 population.	**Why this indicator is important**	This indicator is important to measure as the authority is fined for delayed discharges that are found to be solely its responsibility.	
History with this indicator	The 2012/13 yearly average for the number of people delayed at midnight on the last Thursday of the month was 1.60 (the yearly average is an ASCOF indicator)	**Any issues to consider**	Please note that these figures are taken from the Department of Health website and have **not** been verified by Barking and Dagenham Social care, these figures will also include patients from Mental Health. Also the borough's 18+ population has increased by 3,000 compared with the previous year.	

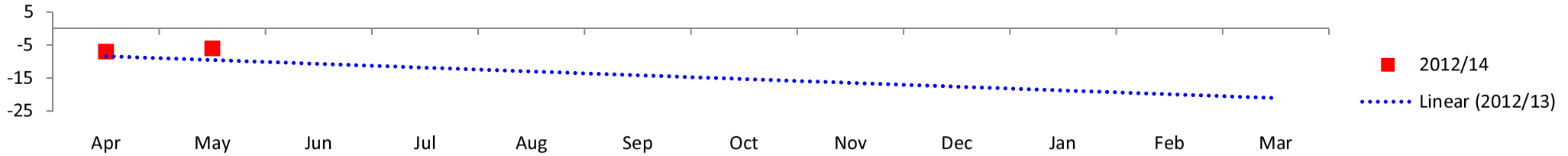
	Apr-13	May-13	June-13	July-13	Aug-13	Sept-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Marc-14
DTOC per 100,000	0.75	TBC										



Performance Overview **RAG**	• At midnight of the last Thursday in April a total of 11 Barking and Dagenham residents were reported as being a delayed discharge, only 1 of these people are reported to be the responsibility of adult social care. • When this one person is converted to a per 100,000 population ratio it becomes 0.75. • A total of 30 delayed days were reported throughout April for people whom are the responsibility of social care. For all of these days the responsible organisation was NELFT.	**Actions to sustain or improve performance**	Performance has been sustained any the only delayed days reported in April were the responsibility of NELFT. Plans are currently underway to develop a joint assessment and discharge service which will help to further improve the DTOC situation.
Benchmarking	• The England average for social care responsible DTOC's in April was 2.5		

Residential/ Nursing OPS Placement Admission/ Discharges Adult Social Care – Indicator 2													May 2013 Source: Susanne Knoerr/ Faysal Maruf
Definition	The number of Admissions and Discharges into Residential and Nursing Placements for people over the age of 65.						**How this indicator works**	This indicator looks at external residential and nursing OPS placements and the number of admissions and discharges throughout the financial year. It also shows the monthly net admission/discharge figure.					
What good looks like	Work is currently being undertaken to establish the current average length of stay in residential/ nursing placements. Once this has been completed discussion around a sensible target can be had.						**Why this indicator is important**	Both residential and nursing placements carry great financial costs to the council; therefore it is vital these are closely monitored in order to remain within budget.					
History with this indicator	In the 2011/12 financial year there were a total of 132 admissions and 125 discharges. This equates to a plus 7 net admissions for the year.						**Any issues to consider**						

	Apr-13	May-13	June-13	July-13	Aug-13	Sept-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Marc-14
Admissions	8	10										
Discharges	15	9										
Monthly Net	-7	+1										
YTD Net	-7	-6										

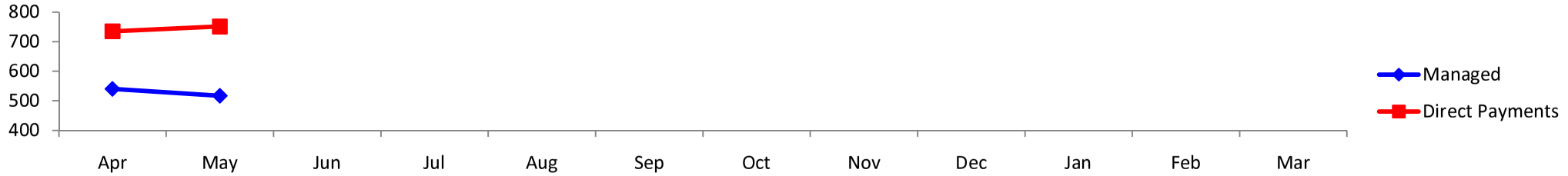


Performance Overview **RAG**	• Throughout May 2013 a total of 10 clients were admitted into external residential and nursing placements. • In the same period we have been notified of 9 client discharges, therefore the monthly net total is 1 admission. • This takes the year to date net total to 6 net discharges from residential/ nursing placements. • The above graph has changed from last month to show last year's trend line instead of the monthly figures, this is because it is the yearly trend which is important and not the individual month's performance.	**Actions to sustain or improve performance**	With this particular indicator it is the yearly trend which should be focused on and not the individual month's performance. Admissions are the only aspect which we have any control over and ideally these should be between 8 & 10 a month.
Benchmarking	N/A		

The Number of People Accessing Home Care Via Managed Budgets Compared to Direct Payments (18+)	May 2013
Adult Social Care – Indicator 4	Source: Business Objects

Definition	The number of people accessing home care via a managed personal budget compared to the number receiving direct payments	**How this indicator works**	Below are the numbers of people (18+) who are receiving home based services via a managed personal budget compared to those receiving home based services via direct payments. These are monthly figures and are **not** accumulative.
What good looks like	A higher proportion of people accessing care and support in the home via Direct Payments.	**Why this indicator is important**	It is important to increase the use of Direct Payments amongst service users as they help to personalisation by enabling clients a greater choice and control over their care and support.
History with this indicator	In March 2012 a total of 1,158 people were recorded as receiving home care, 597 (51.6%) of which were doing so via a direct payment.	**Any issues to consider**	These figures do **not** include crisis intervention.

	Apr-13	May-13	June-13	July-13	Aug-13	Sept-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Marc-14
Managed	540	517										
Direct Pay	735	751										
Total	1,359	1,347										



Performance Overview	• In May 2013 517 people were in receipt of a managed personal budget, this is a 4.3% decrease when compared to the 540 who were in receipt throughout the previous month. • 751 people were accessing direct payments in May 2013, this is a slight increase when compared to the 745 in the previous month. • In comparison in May 2012 504 people were receiving direct payments, therefore the number of people receiving direct payments has increased by 49% in the last year.	**Actions to sustain or improve performance**	Good performance overall and the Choice and Control programme will help to further promote the use of personal assistants in the borough.
RAG			
Benchmarking	N/A		

HEALTH AND WELLBEING BOARD

16 JULY 2013

Title:	**Longer Lives - A Summary For Barking & Dagenham**
Report of the Director of Public Health	
Open	**For Information**
Wards Affected: ALL	**Key Decision:** NO
Report Author: Dawn Jenkin, Health of Health Intelligence	**Contact Details:** Tel: 020 8227 5344 E-mail: dawn.jenkin@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	

Summary:

On Tuesday 11 June 2013, one of Public Health England's first major initiatives, *Longer Lives,* was launched. This is an online tool, giving information about premature mortality for all 150 local authorities in England, including a breakdown of early deaths due to cancer, liver disease, heart disease and stroke and lung disease. The tool allows national ranking of local authorities based on rates of mortality, as well as ranking within groups of local authorities that have similar levels of deprivation. It has attracted considerable attention and comment in the media and from professional bodies.

This tool highlights that Barking and Dagenham has disproportionately high rates of early deaths, under the age of 75, even when taking into account the level of deprivation locally.

The mortality figures used as the basis for the tool are expected to form part of the allocation formula for the Public Health Grant and the Health Premium, according to early indications from the Advisory Committee on Resource Allocation (ACRA).

This document provides an overview of the tool, and its intended uses. It further provides headline findings for the London Borough of Barking and Dagenham.

From 2009 to 2011, there were 1,411 premature deaths in Barking and Dagenham. The borough ranks 133rd out of 150 boroughs in England, where 1 ranks best and 150 ranks worst for premature deaths. For all the major conditions highlighted, the borough ranks near the bottom, when compared with national rates. The four main disease groups account for nearly 80% (1,113 deaths) of early mortality in the borough. Cancer accounted for 545 early deaths.

For overall premature deaths Barking and Dagenham ranks 9th out of 15 similarly deprived boroughs, where 15th indicates the worst mortality. In particular, the borough ranks very poorly and worst in London for premature deaths due to cancer and due to lung disease.

This report goes on to identify key approaches to reducing premature mortality, which include reducing smoking prevalence and obesity and increasing physical activity, early diagnosis and management of long term conditions and increasing uptake of cancer

screening services.

Recommendation(s)

The Health and Wellbeing Board is recommended to agree:

(i) To note the contents of the report.

(ii) To discuss the implications of this tool with regard to health outcomes in Barking and Dagenham.

Reason(s)

Early mortality is reflected in lower life expectancy for residents of the borough, and implies not only years of life lost for individuals, but also poor health outcomes during life, greater proportion of life spent living with disability and long term conditions and lost productivity resulting in economic loss at a personal and whole health economy level.

Approaches and interventions exist which can tackle early preventable mortality, these need to be prioritised within the framework of the Joint Health and Wellbeing Strategy.

Early indications are that premature mortality rates for local authorities will form a key aspect of the allocation formula for both the core element of the Public Health Grant and the future Health Premium.

1. Introduction

1.1 On Tuesday 11 June 2013, one of Public Health England's first major initiatives, *Longer Lives,* was launched.

1.2 *Longer Lives* makes information about the health of the nation available to everyone and connects people with the knowledge and resources they need to help the country work together towards better health.

1.3 Making England's premature mortality data transparent and accessible is a significant step forward for the new health and care system and likely to generate considerable interest.

1.4 Available as a web tool, *Longer Lives* shows how premature mortality varies by upper tier local authority (county, unitary authority or metropolitan borough) across England. It displays premature mortality from all causes, and also from some of the most common causes including: cancer, heart disease and stroke, lung disease and liver disease.

1.5 The data provided in Longer Lives is from the Public Health Outcomes Framework (PHOF). This is not the first time it has been published, but the first time it has been published in this form, making the information easy to access, view and compare. It is also the first time it has been published alongside relevant supporting information, such as the intervention guidance provided by the National Institute of Health and Care Excellence (NICE).

1.6 One of the most important factors affecting premature mortality is socioeconomic status, and on the whole, more deprived local authorities have worse premature mortality than more affluent authorities. This tool enables local authorities to compare themselves with other local authorities that have lower premature mortality to discover whether there are any other actions they could be taking. It is possible

to identify the most important causes of premature mortality locally and find other local authorities that may have particularly good premature mortality despite similar socioeconomic status. This should make it easier to obtain examples of good practice, and decide which might be useful locally.

1.7 The Longer Lives tool can now be accessed online at the Public Health England website. http://longerlives.phe.org.uk/

2. Highlights for Barking and Dagenham

2.1 This tool highlights that Barking and Dagenham has disproportionately high rates of early deaths, under the age of 75, even when taking into account the level of deprivation locally.

2.2 The Longer Lives tool provides ready access to information about the number of premature deaths (those occurring before the age of 75) in Barking and Dagenham between 2009 and 2011. The tool then highlights death rates for all causes, and four specific disease groups which are the most common causes of death in England: heart disease and stroke, lung disease, liver disease and cancer. Appendix 1 provides a graphical overview of the findings for Barking and Dagenham compared to national, and compared to local authorities with similar deprivation.

2.3 Over the course of three years, there were 1,411 premature deaths in Barking and Dagenham (a directly standardised mortality rate of 337 per 100,000 population). This ranks the borough 133rd out of 150 boroughs in England, where 1 ranks best and 150 ranks worst for premature deaths.

2.4 For all the major conditions highlighted in the tool, Barking and Dagenham has early death rates that are significantly worse than the national picture. Appendix 2 provides a comparison of Barking and Dagenham, Redbridge and Havering with national rates. Of the 1,411 deaths, nearly 80% were due to the four main disease groups considered here (1,113 in total)

i) **342** were due to heart disease and stroke

ii) **148** were due to lung disease

iii) **78** were due to liver disease

iv) **545** were due to cancer

2.5 When reviewing these figures, it is important to consider them in the context of the underlying deprivation which exists in a local area. As shown in The Marmot Review higher deprivation is linked to shorter life expectancies and greater premature mortality. For this reason the tool also looks at groups of comparator local authorities with similar levels of deprivation.

2.6 Within its comparator group of 15 local authorities, for overall premature deaths Barking and Dagenham ranks 9th, where 15th indicates the worst mortality. In particular, the borough ranks very poorly for premature deaths due to cancer and due to lung disease.

2.7 Early death rates due to cancer in Barking and Dagenham are significantly higher than those seen in other local authorities with similar deprivation levels.

2.8 Further information on the local authorities within the Barking and Dagenham comparator group and ranking for causes of mortality can be found in Appendix 3. For overall premature mortality in this group, Salford is the worst performing and Brent is the best performing.

2.9 Looking at early death rates across London, Barking and Dagenham had the worst rates for premature mortality due to cancer and due to lung disease, and the second worst for overall mortality, following Tower Hamlets. Appendix 4 provides colour coded maps of London, which show the variety of mortality rates within the city. London boroughs have amongst the best and the worst rates in England for early deaths.

3. Evidence for the causes of early mortality and the ways to tackle it

3.1 The key way to reduce premature mortality in the longer term is to prevent the development of cancer, heart disease and stroke, lung disease and liver disease. This primary prevention is achieved by addressing some of the underlying causes of these diseases, including smoking, alcohol consumption and obesity.

3.2 Smoking is the most significant cause of preventable mortality due to cancer. It is responsible for one in four cancer deaths in the UK (Public Health England Longer Lives tool). At least 90% of deaths from lung cancer are caused by smoking.

3.3 While the number of people aged less than 75 years who die from cancer is falling nationally, in Barking and Dagenham it is continuing to rise (Barking and Dagenham JSNA, 2011). Previous mortality figures from 2008 to 2010 show that Barking and Dagenham has amongst the highest rates in London for deaths that can be attributed to smoking. Smoking prevalence in the borough in 2010 was estimated to be 29%, which is significantly higher than the London average.

3.4 Poor diet, alcohol and obesity have also been linked to cancers such as bowel, breast and liver cancer.

3.5 Lung disease consists of a number of conditions, one of which is Chronic Obstructive Pulmonary Disease, known as COPD. This disease “is progressive, largely preventable and strongly linked to deprivation in England. It is the fifth largest cause of emergency hospital admissions and an estimated 85% of cases are caused by smoking”(National Clinical Guideline Centre, 2010, via the Longer Lives web tool) The JSNA has found that death rates due to COPD from 2008 to 2010 locally are significantly higher than London or national rates. Key approaches to reducing mortality include the provision of stop smoking services, targeted campaigns to help prevent those under the age of 18 from taking up smoking and improved tobacco control partnership working, including enforcement of underage sales. Air pollution can also cause breathing problems and aggravate existing lung conditions.

3.6 Improving diet and physical activity, as well as diagnosing and managing high blood pressure will help to reduce the risks of heart disease and stroke.

3.7 According to Public Health England (PHE), early deaths due to liver disease continue to rise in England, whilst rates are falling in the EU. Liver disease has been linked to alcohol consumption, obesity and infection with hepatitis B or C. The JSNA found that alcohol related hospital admissions locally show a rising trend up until the most recent data of 2010 to 2011, and alcohol-related disorder has been identified as a concern by residents of Barking and Dagenham through local and

national surveys. Campaigns such as change for life that advocate reducing alcohol consumption, healthy diet and physical activity will help to address these health risks.

3.8 More immediate approaches that will deliver reduction in early deaths, over the short and medium term include secondary prevention. That is, the early identification, treatment and management of existing long term conditions.

3.9 Early diagnosis, through the NHS health check programme, and breast, bowel and cervical screening, followed by effective management of the condition play a critical role in improving health outcomes and healthy life expectancy. The JSNA finds that one year survival rates for all major cancers have been poor in outer north east London boroughs.

3.10 Early diagnosis should also help to identify and manage diabetes, a condition linked with increasing prevalence of obesity, which when left untreated can result in severe complications and lead to development of other conditions such as heart disease. By 2025 it has been estimated that over 12,385 people in Barking and Dagenham will be living with diabetes (JSNA, 2011).

4. Initiatives in Barking and Dagenham to tackle early death rates

4.1 The Barking and Dagenham Joint Health and Wellbeing Strategy aims to increase life expectancy and close the gap between the borough and the London average for life expectancy. It tackles early death through prioritising healthy lifestyles, prevention, early diagnosis, good treatment and better services across the life course, from before birth to end of life.

4.2 A life course approach is critical to effectively improving outcomes across the whole population. As noted in the Marmot Review (2010) “the foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status.

4.3 A sustained approach, at scale, from birth onwards, to health promotion, primary prevention, early diagnosis and treatment is needed in order to impact on the mortality rates seen in Barking and Dagenham.

4.4 To take forward this strategy, collaborative initiatives and services have been commissioned across the partnership, funded through the public health grant, which include

i) The stop smoking service.

ii) A tobacco control coordinator to work with the Barking and Dagenham Tobacco Control Alliance, to lead on reducing smoking prevalence, improving tobacco control and promoting a smoke free agenda.

iii) The NHS health check programme delivered via primary care practices and pharmacies, to help identify those at risk of diabetes, heart disease and stroke.

iv) A range of healthy eating initiatives which will give an industrial scale healthy eating programme across the borough, and an ambitious programme to promote participation in regular physical activity in schools.

5. Early responses to the Public Health England Longer Lives tool

5.1 The early response to the publication of the Longer Lives tool has been mixed.

5.2 The Health Secretary Jeremy Hunt has said that the local variation in early deaths is "shocking" and must drive action to improve health (BBC News, 11 June 2013)

5.3 A statement from the Faculty of Public Health (Independent, 11 June 2013):

> "This new map from Public Health England may not contain many surprises but it is a useful tool for people working for councils who are now responsible for the public health of people in their areas. It is not acceptable that there is such a divide between the 'health haves' and 'have nots' in some parts of England.
>
> "The proof of this map's effectiveness will be in the proverbial pudding: time will tell if it is a useful addition to the tools used by public health professionals and others to help people get healthier and live longer. We need everyone – e.g. local authorities, the NHS – to work together and use this data to help improve people's health in their areas. Our members have the expertise and skills to help tackle the stark health problems shown by this map and they stand ready to help."

5.4 The Independent has highlighted a serious divide in health outcomes between the north and the south of England

5.5 A statement from the Local Government Association (11 June 2013):

> "The Longer Lives tool will provide some useful insight into the serious public health challenges facing councils and help us identify local priorities.
>
> But this data must be used with caution. Using it out of context to create any sort of national league table dangerously over simplifies matters and ignores the very complex socio-economic and cultural factors that affect the premature mortality rate.
>
> Attempts to measure performance and rank councils in this way are therefore deeply troubling. Not to mention that improving the public's health is not the sole responsibility of local government. We need to work with our partners in the NHS, PHE and central government to address a whole range of inequalities and issues in order to help everyone lead healthier lives.
>
> The reality is that in many cases it could take years before we see reductions in the number of those suffering with conditions like cancer or heart disease as a result of new public health initiatives.
>
> Government must take a long-term commitment to public health and provide councils with the right resources if we are going to have a real impact."

6. Implications

Financial Implications

(Implications completed by: Dawn Calvert – Group Manager, Finance)

6.1 In June 2012, the Department of Health published "Healthy Lives, Healthy People: Update on Public Health Funding", which set out early indications on local authority Public Health finance, including the detailed composition of an interim allocation formula, proposed for mandatory and non-mandatory elements of the Public Health Grant.

6.1 ACRA was commissioned by the Secretary of State to develop a formula for the allocation of the public health budget to local authorities relative to population health need, to enable action to improve population wide health and reduce health inequalities.

6.2 ACRA's interim recommendation is based on the standardised mortality ratio (SMR) for those aged under 75 years (SMR<75). The SMR<75 is a measure of how many more or fewer deaths there are in a local area compared with the national average, having adjusted for the differences between the age profile of the local areas compared with the national average.

6.4 Since the publication of the Department of Health's document in 2012 Barking and Dagenham has been allocated a Public Health Grant of £12.291m for 2013/14 and £14.213m for 2014/15. Grant allocations beyond 2014/15 are not known.

6.5 The data presented by the Longer Lives tool is expected to form a key element of future allocation decisions for the Public Health Grant and Health Premium.

Legal Implications

(Implications completed by: Lucinda Bell, Education and Adult Social Care)

6.6 The Board is asked to note the contents of this report, and discuss only.

7. References

- The Public Health England Longer Lives Tool
- The Barking and Dagenham Joint Strategic Needs Assessment 2011
- National Clinical Guideline Centre. (2010) Chronic obstructive pulmonary disease: management of chronic obstructive pulmonary disease in adults in primary and secondary care
- The Barking and Dagenham Health and Wellbeing Strategy 2012 – 2015
- Fair Society, Healthy Lives (The Marmot Review), Executive Summary p.16
- Healthy Lives, Healthy People: Update on Public Health Funding (Department of Health, June 2012)

8. List of appendices

— Appendix 1: Comparison of Barking & Dagenham to all Local Authorities

— Appendix 2: Comparison with England Average

— Appendix 3: Comparative Data with Similar Local Authorities

— Appendix 4: Maps of the London Area, showing Premature Mortality Outcomes

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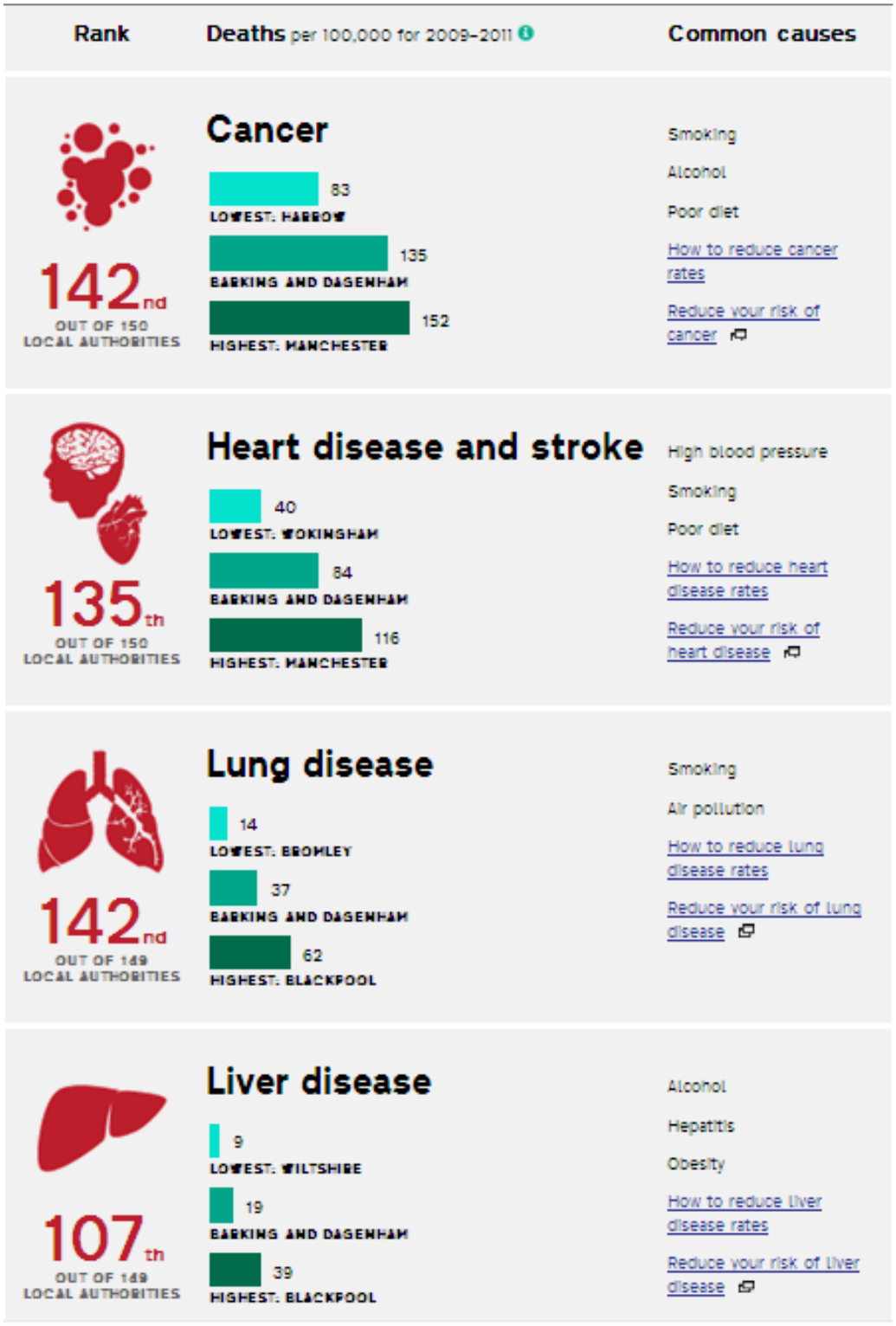
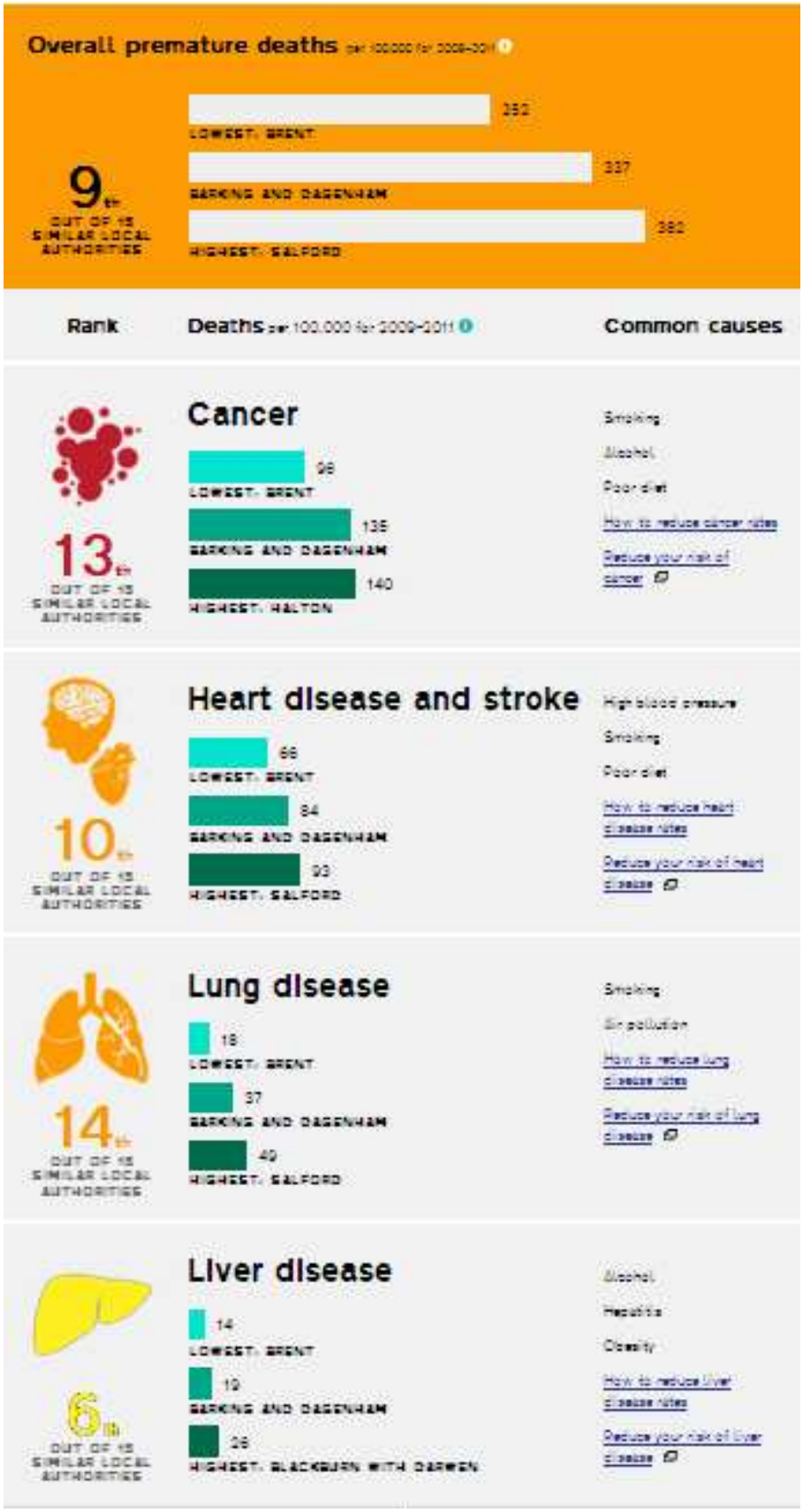
APPENDIX 1

Comparison of Barking & Dagenham to all Local Authorities



- Barking and Dagenham is rated red for all four of the main causes of premature deaths;
- Ranked particularly poorly for lung disease and cancer where it is in the bottom ten LAs in the country.

Comparison of Barking & Dagenham to Local Authorities With Similar Deprivation Levels.



- Barking and Dagenham also ranks quite poorly when compared to its statistical neighbours, only being ranked above average for liver disease; It is significantly worse than the average for cancer and below average for heart and lung disease.

APPENDIX 2

Comparison with England Average

All rates are per 100,000 directly standardised population	Barking & Dagenham		Redbridge		Havering	
	Rate	Rank	Rate	Rank	Rate	Rank
Overall Premature Mortality	337.2	133	244.3	40	247.2	45
Premature Mortality from Cancer	135.3	142	97.7	30	104.2	64
Premature Mortality from Heart Disease and Stroke	83.7	135	59.3	53	62.4	60
Premature Mortality from Lung Disease	36.9	142	19.7	44	18.5	37
Premature Mortality from Liver Disease	18.7	107	13.3	52	11.0	30

Significantly better than England average
Better than England average
Worse than England average
Significantly worse than England average

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APPENDIX 3

Comparative Data with Similar Local Authorities

Longer Lives also allows comparison with the other local authorities within the same socioeconomic deprivation bracket (socioeconomic decile 2 – 'most deprived').

Barking & Dagenham
Blackburn with Darwen
Bradford
Brent
Greenwich
Halton
Hartlepool
Lambeth
Leicester
Lewisham
Nottingham
Rochdale
Salford
Walsall
Wolverhampton

All rates are per 100,000 directly standardised population	Barking & Dagenham		Worst Performing		Best Performing	
	Rate	Rank	Rate	Name	Rate	Name
Overall Premature Mortality	337.2	9	382.0	Salford	251.8	Brent
Premature Mortality from Cancer	135.3	13	140.0	Halton	96.2	Brent
Premature Mortality from Heart Disease and Stroke	83.7	10	92.8	Salford	66.0	Brent
Premature Mortality from Lung Disease	36.9	14	49.1	Salford	17.8	Brent
Premature Mortality from Liver Disease	18.7	6	25.9	Blackburn with Darwen	14.5	Brent

Significantly better than socioeconomic decile average
Better than socioeconomic decile average
Worse than socioeconomic decile average
Significantly worse than socioeconomic decile average

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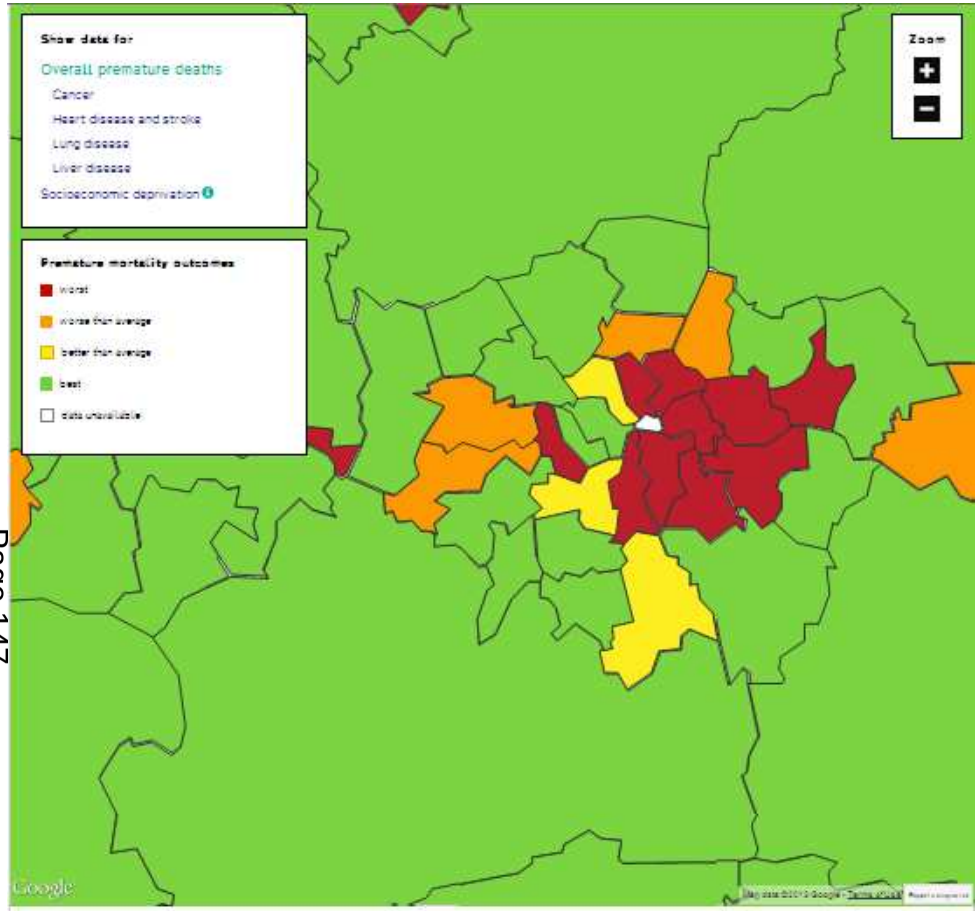
Overall Premature Deaths

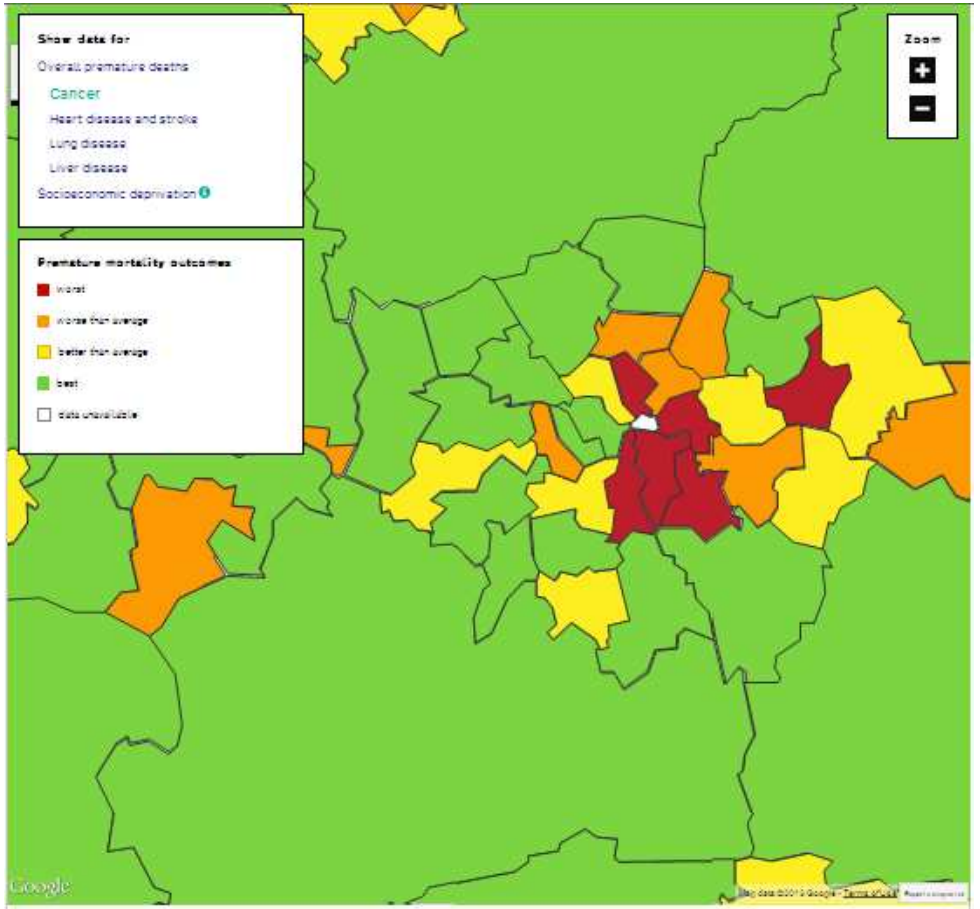


Peer group outcomes

Longer Lives provides peer grouping so local authorities can compare their premature mortality rates with others of a similar socioeconomic status. On the right are the authorities with the best rates in each of the five more deprived groups, and the authorities with the worst rates in each of the five less deprived groups.

Authorities with worst rates in the five less deprived groups	Authorities with best rates in the five more deprived groups
Bracknell Forest	Kensington & Chelsea
York	Enfield
Milton Keynes	Rotherham
Warrington	Brent
Lancashire cc	Waltham Forest

Premature Cancer Mortality



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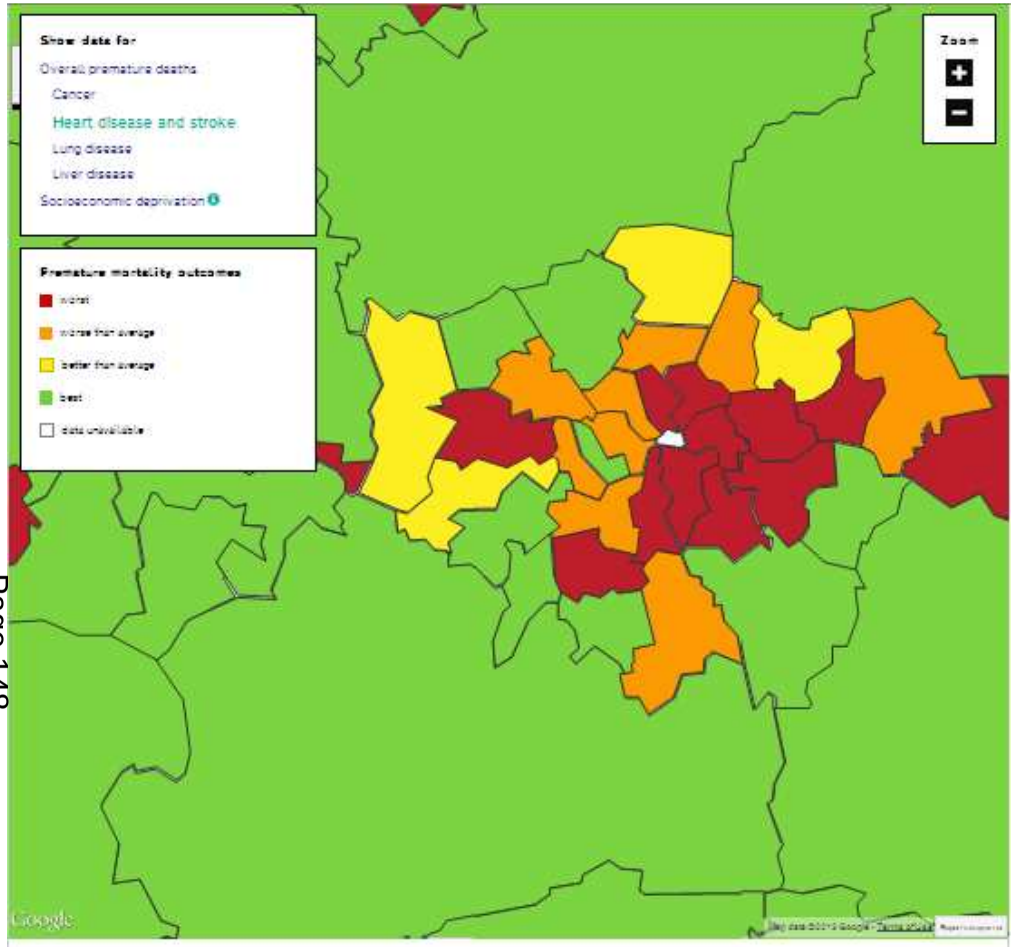
Bracknell Forest	Kensington & Chelsea
York	Enfield
Milton Keynes	Rotherham
Warrington	Brent
Lancashire cc	Waltham Forest

Premature Mortality from Heart Disease and Stroke



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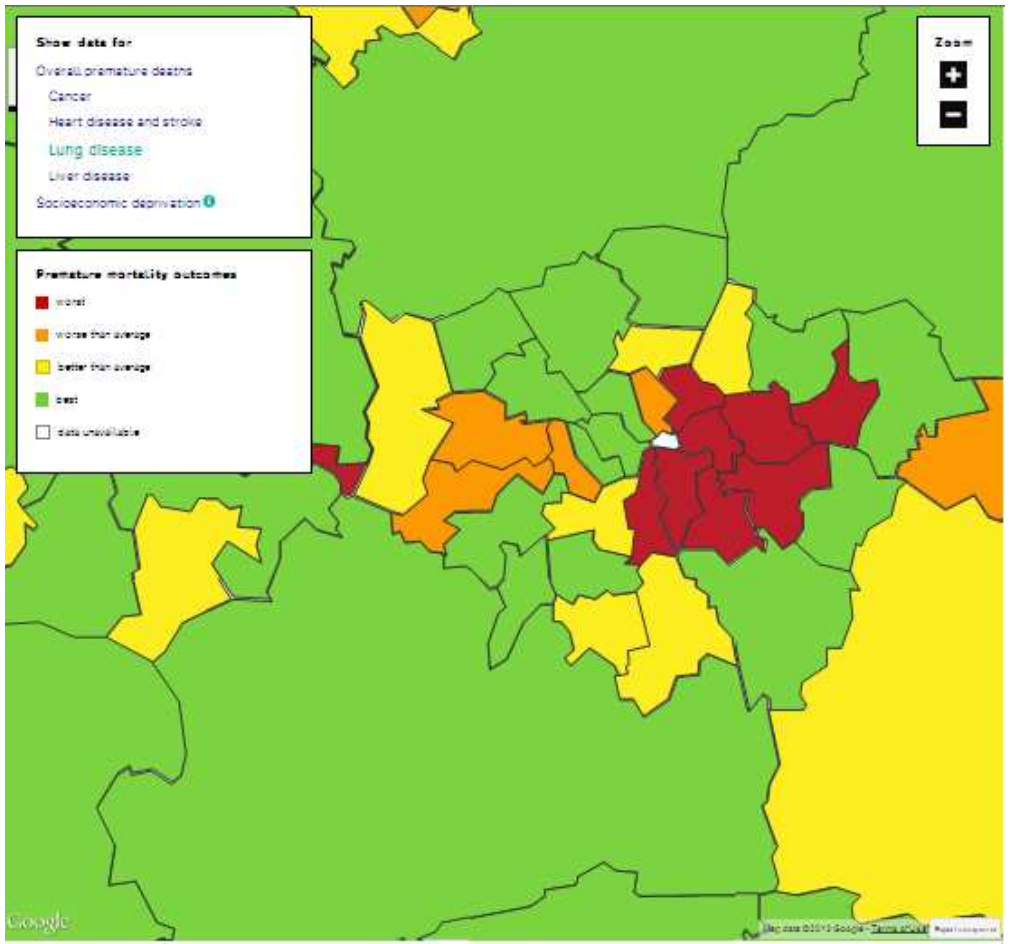
Authorities with worst rates in the five less deprived groups

Bracknell Forest
York
Milton Keynes
Warrington
Lancashire cc

Authorities with best rates in the five more deprived groups

Kensington & Chelsea
Enfield
Rotherham
Brent
Waltham Forest

Premature Mortality from Lung Disease



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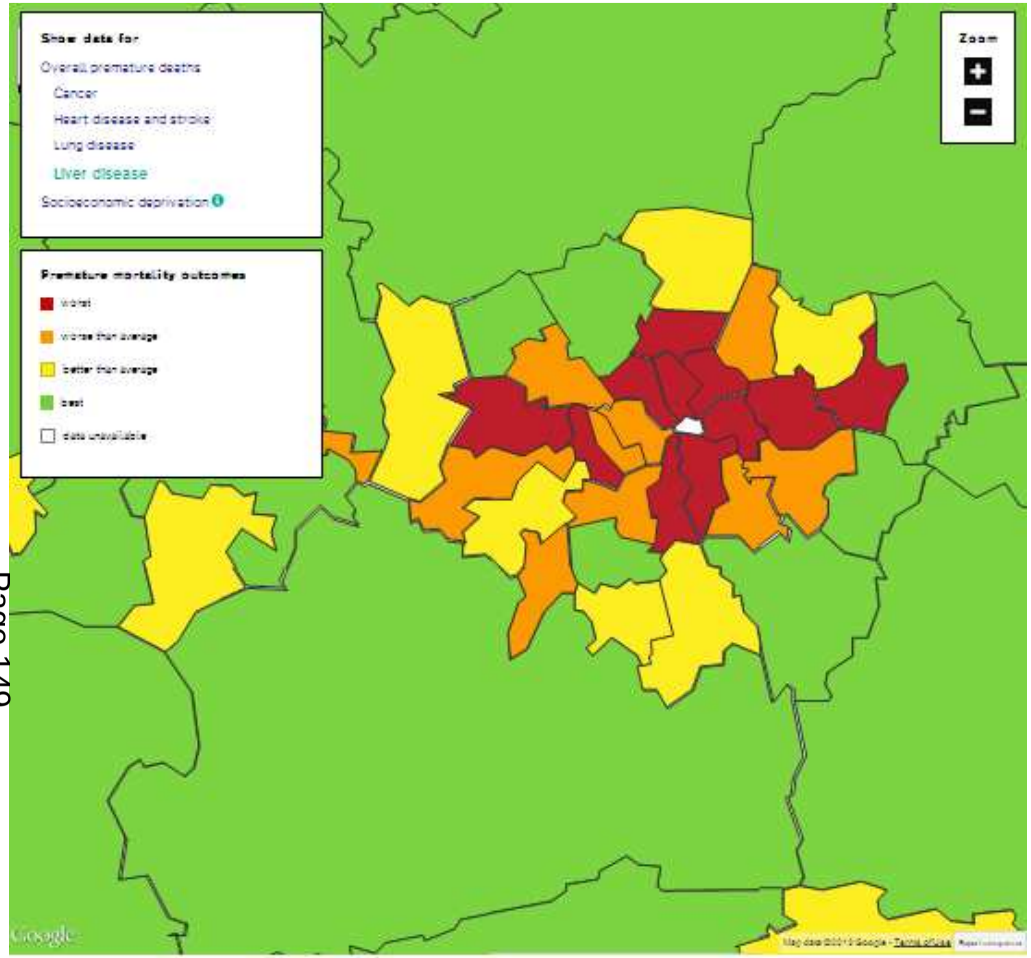
Authorities with worst rates in the five less deprived groups

Bracknell Forest
York
Milton Keynes
Warrington
Lancashire cc

Authorities with best rates in the five more deprived groups

Kensington & Chelsea
Enfield
Rotherham
Brent
Waltham Forest

Premature Mortality from Liver Disease



Peer group outcomes

Longer Lives provides peer grouping so local authorities can compare their premature mortality rates with others of similar socioeconomic status. On the right are the authorities with the best rates in each of the five more deprived groups, and the authorities with the worst rates in each of the five less deprived groups.

Authorities with worst rates in the five less deprived groups

Bracknell Forest
York
Milton Keynes
Warrington
Lancashire cc

Authorities with best rates in the five more deprived groups

Kensington & Chelsea
Enfield
Rotherham
Brent
Waltham Forest

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HEALTH AND WELLBEING BOARD

16 JULY 2013

Title:	Referral from Development Control Board
Report of the Chief Executive	
Open	**For Information**
Wards Affected: NONE	**Key Decision:** NO
Report Authors: Glen Oldfield, Clerk of the Board, Democratic Services	**Contact Details:** Telephone: 020 8227 5796 E-mail: glen.oldfield@lbbd.gov.uk
Sponsor: Cllr Worby, Chair of the Health and Wellbeing Board	

Summary:

On 28 May 2013, the Development Control Board (DCB - a quasi-judicial Committee of the Council that is responsible for taking decisions on large planning applications) considered a planning application from Dr Natalya Bila. The application sought permission for St Martin's Vicarage on Goresbrook Road, Dagenham to be converted from a five bedroom house into a GP practice with first floor living accommodation.

Whilst the Board approved the planning application, in doing so it raised the following concerns and asked that they be recorded in the minutes with a request for the Health & Wellbeing Board be made aware of those concerns. The specific concerns were as follows:

- **the apparent lack of involvement of the NHS in assisting the doctor to relocate**

  Dr Bila is currently situated at the Heathway Medical Centre (585 Heathway, Dagenham), however the lease expires in January 2014 prompting relocation to ensure business continuity. In light of this the DCB wishes to know:

  - What is the role of the NHS in ensuring that GP's find suitable premises for their practices? And;
  - What support is given to GP's to assist with relocation?

- **the upheaval for patients using the doctor's existing surgery**

  The DCB was concerned that Dr Bila's relocation was driven by the necessity to find accommodation because of the lease expiring at her current location. It appeared that that the relocation was not centred around the needs/desires of patients/residents or undertaken as part of the strategic planning of health services.

- **pressure on parking in the area**

  Two off street car parking spaces are proposed for the doctor's flat but there will be no off street car parking for the doctor's surgery. The DCB was concerned that demand for parking would outstrip capacity; putting pressure on provision in that locality and requiring increased enforcement. In reaching their decision the DCB received advice from Highways Officers who after assessing parking provision in the area judged the parking arrangements to be acceptable for the purposes of this application.

Recommendation(s)

The Health and Wellbeing Board is asked to:

- Note the concerns of the Development Control Board as described above and recorded in the minutes (Minute 5 - DCB, 6pm, 28 May 2013)
- Request that the CCG and NHS England jointly author a report that explains how, in areas where there is significant population growth or decline, decisions are reached with regard to primary care estates in order that the local provision of primary care services matches the needs of the population.

HEALTH AND WELLBEING BOARD

16 JULY 2013

Title:	**Chair's Report**
Report of the Chair of the Health and Wellbeing Board	
Open	**For Information**
Wards Affected: NONE	**Key Decision:** NO
Report Author: Mark Tyson, Group Manager Service Support & Improvement	**Contact Details:** Tel: 020 8227 2875 Email: Mark.Tyson@lbbd.gov.uk
Sponsor: Councillor Maureen Worby, Chair of the Health and Wellbeing Board	

Summary:

This report provides information on the mental health scrutiny review of the Health and Adult Services Select Committee. There are also updates on the Urgent Care Board, the Integrated Care Coalition, and the Fulfilling Lives programme for people with learning disabilities. A brief overview is given of the new GP profiles which are now publicly available, and finally there is an update on items from the last Chair's Report.

Recommendation(s)

The Health and Wellbeing Board is recommended to agree:

(i) To note the contents of the Chair's Report and comment on any item covered should they wish to do so

1 Scrutiny Review on the Impact of the Recession and Welfare Reforms on Mental Health

1.1 At their April meeting the Health and Adult Services Select Committee (HASSC) agreed to focus their scrutiny review for 2013/14 on the impact that the recession and welfare reforms are having on mental health in Barking and Dagenham and what the Council and other agencies can do locally to mitigate the impact.

1.2 There is a large amount of evidence that economic recession causes increases in mental health problems. The review will combine academic research, local and national data and information from service users. This review will help all organisations with an interest in the health and wellbeing of residents in Barking and Dagenham to respond more effectively to the mental health problems caused by recent and ongoing economic problems. As the topic is so broad the review will be focussed on the mental health of working age residents as they are likely to be most directly affected by the recession and welfare reforms.

1.3 The first draft of the report is due to be completed by November, with a final sign off and an action plan for the Health and Wellbeing Board to take forward ready by January 2014.

2 Update on the Urgent Care Board

2.1 The Integrated Care Coalition recommended the establishment of an Urgent Care Board following the workshop discussion on 24 May 2013, it takes the place of the Integrated Care Coalition which has been meeting since May 2012. The first formal meeting of the Board took place on 19 June 2013. The Board has been established as an advisory board to drive improvement in urgent care at a pace across the BHR system. It brings together senior leaders across health and social care and is accountable to the Integrated Care Coalition.

2.2 At its first meeting the Urgent Care Board agreed Terms of Reference, to which they added representatives from NHS England and from Healthwatch Havering to represent the overall patient voice. Current performance of Urgent Care was reviewed, and an above London average increase in ambulance use and waiting times for minors were raised as particular concerns.

2.3 The Urgent Care Board is also involved in some forward planning, and agreed that a £1.8m pot of uncommitted money from A&E should be used to target out of hospital initiatives in line with the Integrated Care Strategy. A framework will be developed to evaluate bids for this money which will assess whether the bid will have a measurable impact on urgent care demand and a clear methodology for evaluating performance. If initiatives fail to deliver funding will be stopped. Early discussions were also held over winter planning for 2013/14 and approval given to changes which should help NELFT to meet its bed productivity targets.

2.4 The next meeting of the Board will take place in Havering at the end of July, and it will continue to meet on a monthly basis.

3 London-wide event on Urgent Care

3.1 Chief Executives, Clinical Leaders and Directors of Social Services have been invited to join a one day regional event on 18 July 2013 to discuss emergency services across London. An update on Urgent Care will be given at the September meeting of the Health and Wellbeing Board by Sharon Morrow. If you have any questions in the meantime please contact Sharon at Sharon.Morrow@barkingdagenhamccg.nhs.uk

4 Update on Fulfilling Lives

4.1 The Council's vision for learning disability services, known as 'Fulfilling Lives' has been updated and presented to Council Members. The Fulfilling Lives vision responds to changes in social care legislation such as personalised budgets, and to consultation feedback which asked for greater flexibility and opportunity.

4.2 The key points of the Fulfilling Lives vision are that service users should be able to:

- live independently in the community, in their own home where this is possible;
- be able to live in safety without fear of crime and discrimination;
- be able to travel independently and enjoy the facilities the borough has to offer;
- be supported to access a wide range of mainstream activities, including leisure opportunities;
- have access to appropriate training and support which will lead to employment and volunteering opportunities, including micro-enterprise;
- to take advantage of the option of a Direct Payment because there will be a choice of services and activities available to meet their needs;
- access good quality and appropriate health care at all stages of their life course;
- receive care as close to home as possible.

4.3 To deliver this vision we will: continue to provide a high quality service, ensure clearer transition pathways for those leaving Trinity School, provide support for people to access mainstream services and normal daily activities, provide a safe supportive base where people with learning disabilities can meet which will be open in the evening and at weekends. We will also provide a programme of accredited training to help people with learning disabilities into work, and provide opportunities to try these skills in a supported environment as well as apprenticeship opportunities and some real jobs. To increase independence we will support the development of employment opportunities through user-led micro-enterprises and expect people to travel independently on public transport where possible.

4.4 The way that our specialist centres operate will see some changes to meet this vision. A Resource Centre model will be developed at the Maples with an accredited training programme leading to work opportunities, a community based programme which supports people in engaging in mainstream activities, and provision of services in the evenings and at weekends. The possibility of remodelling Healthlands' schedules and transport arrangements to increase capacity and flexibility is also being explored as we continue to explore ways of helping people with learning disabilities to lead 'ordinary lives on ordinary streets'.

5 GP Profiles

5.1 The GP profiles provide detailed information and analysis at practice level, for all practices in Barking and Dagenham, on their achievement and patient outcomes. They can be used as a starting point for identifying areas of primary care activity that have the most influence on health outcomes. They show that there is much variation between practices and, in some cases, a gap between local performance and London averages. Information in the profiles includes key socio-demographic characteristics of the practice registered population, health protection, health improvement, primary care outcomes, secondary care activity, and mortality. More information on GP Profiles will be given in a report which will be presented to the Health and Wellbeing Board in September 2013. The GP profiles are searchable by postcode at https://www.myhealth.london.nhs.uk/find-and-compare, and a link to the My Health London homepage is available on the Barking and Dagenham CCG website.

6 Update following June Chair's Report

6.1 There have been no changes to the status of measles in Barking and Dagenham since the last Chair's Report other than that the GP led MMR Temporary Catch-Up Programme was started in June. It is still too early to accurately gauge the Programme's uptake.

HEALTH AND WELLBEING BOARD

16 JULY 2013

Title:	**Sub-Group Reports**
Report of the Chair of the Health and Wellbeing Board	
Open	**For Information**
Wards Affected: NONE	**Key Decision:** NO
Report Authors: Andrew Marsh, Graduate Management Trainee (with information supplied from sub-group chairs)	**Contact Details:** E-mail: andrew.marsh@lbbd.gov.uk Telephone: 0208 227 2595
Sponsor: Councillor M Worby, Chair of the Health and Wellbeing Board	

Summary:

At each meeting of the Health and Wellbeing Board, two sub-groups are due to report on their progress and performance since their last update to the Board, or in this case to update the Board as to what happened at their first meeting. Reporting of sub-groups is rotated, and details of which subgroups are to report at each meeting are listed in the Board's Forward Plan.

At this meeting the **Children and Maternity Group** and the **Public Health Programmes Board** are reporting back to the Board for the first time, and their reports are included below. As performance reporting is due to be discussed at the July Health and Wellbeing Board meeting, performance information has not been included in these initial sub-group reports but will be reflected in future versions.

Recommendations:

The Health and Wellbeing Board are asked to:

- Note the contents of both sub-group reports set out in Appendix 1 and 2.
- Comment on the items that have been escalated to the Board.
- Note the scheduled meeting dates of sub-groups and when each sub-group is expected to report back to the Board (see overleaf).

1. Calendar of Sub-Group Meetings for 2013/14:

Date (*= date not confirmed)	**Sub-group**
03 July 2013	Executive Planning Group
16 July 2013	Public Health Programmes Board
22 July 2013	Integrated Care
23 July 2013	Executive Planning Group
24 July 2013	Children and Maternity
August 2013*	Integrated Care
12 August 2013	LDPB
September 2013*	Integrated Care
02 September 2013	Executive Planning Group
10 September 2013	Public Health Programmes Board
23 September	LDPB
25 September 2013	Children and Maternity
October 2013*	Integrated Care
29 October 2013	Public Health Programmes Board
November 2013*	Integrated Care
04 November 2013	Executive Planning Group
04 November 2013	LDPB
27 November 2013	Children and Maternity
December 2013*	Integrated Care
17 December 2013	LDPB
02 December 2013	Executive Planning Group
03 December 2013	Public Health Programmes Board

Date (*= date not confirmed)	Sub-group
06 January 2014	Executive Planning Group
03 February 2014	Executive Planning Group
04 February 2014	LDPB
03 March	Executive Planning Group
19 March 2014	LDPB

2. Schedule of Sub-group reports

H&WBB Meeting	Sub-group Reports
17 September 2013	Mental Health
	Integrated Care
05 November 2013	LDPB
	Public Health Programmes
10 December 2013	Children and Maternity
	Mental health
11 February 2014	Integrated care
	LDPB
25 March 2014	Public Health Programmes
	Children and Maternity

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APPENDIX 1

Children and Maternity Group

Chair: Sharon Morrow, Chief Operating Officer, Barking and Dagenham Clinical Commissioning Group

Performance

Please note that no performance targets have been agreed as yet.

Meeting Attendance

29 May 2013: 67% (10 of 15)

Action(s) since last report to the Board

This group has not reported to the Health and Wellbeing Board before, therefore this is instead a list of recent actions to demonstrate the work that the Children and Maternity Group is doing and to give context to future reports to the Board.

a) The group reviewed terms of reference and membership. It was proposed that CVS be approached to nominate a representative from the voluntary sector and that the Policy and Performance Manager, LBBD Children's service be invited as a member.

b) Contract issues around allied therapies at Trinity School have been resolved.

c) NELFT provided an verbal update on health visitor recruitment and vacancy rates

d) The group received an update from the CCG Deputy Director of Nursing on improvements made to the quality of BHRUT maternity services following previous inspection reports by CQC; the group discussed the scope of a paper to be presented to the Health and Wellbeing Board (agenda item for July meeting)

e) The group discussed and made suggestions on the scope of a CCG review of services for children with complex needs – concerns were raised about the scope/focus and deliverability within the timescales identified

f) The CCG presented proposals for engaging Children and Young People in the work of the CCG which were endorsed by the group.

g) A draft Performance Framework was discussed with reference to the Health and Wellbeing Strategy delivery plan for pre-birth and early years, primary school, children, adolescence and maternity services.

h) A draft forward plan for the Group has been drawn up, and milestones and deliverables are being mapped out.

Action and Priorities for the coming period

(a) Officers are meeting to map out the reporting arrangements between the Children and Maternity Group other groups focused on children's services e.g. Family Nurse Partnership group

(b) NHS England have been asked to provide a report for the July meeting on plans for recruiting a further 40 health visitors under a *"Call for Action*" and arrangements for MESCH; it is proposed that a report is provided to the Health and Wellbeing Board in November 2013.

(c) Further develop the service review to examine health services for children with special physical and developmental needs pre-birth to 2 years old. This should address specific issues around access to speech and language therapy services and the role the portage (early support) service plays.

(d) A workplan to be drafted to include the actions and deliverables from the Health and Wellbeing Strategy

Items to be escalated to the Health & Wellbeing Board

(a) Direction is needed on the performance framework and which performance indicators are reasonable for each group to monitor.

(b) The Health and Wellbeing Board is asked to consider whether there are opportunities to support the group development.

Contact: Sharon Morrow, Chief Operating Officer, Barking and Dagenham Clinical Commissioning Group
Tel: 020 3644 2372 / E-mail: Sharon.Morrow@barkingdagenhamccg.nhs.uk

APPENDIX 2

Public Health Programmes Board

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

Performance

Please note that no performance targets have been agreed as yet.

Meeting Attendance

28 May 2013: 80% (8 of 10)

Action(s) since last report to the Health and Wellbeing Board

This group has not reported to the Health and Wellbeing Board before, therefore this is instead a list of recent actions to demonstrate the work that the Public Health Programmes Board is doing and to give context to future reports to the Board.

(a) The sub-group agreed that meetings should take place every 6 weeks, for 1½ hours each time, and that a representative from Community Safety should be invited to discuss drug and alcohol issues. It was agreed that this would be Dan Hales, Group Manager Community Safety and Integrated Offender Management (LBBD).

(b) A dedicated accountant for Public Health has been recruited for one year.

(c) A Task and Finish group on obesity in primary care has been set up, chaired by Councillor Worby to discuss an industrial scale programme (in every school) to tackle childhood obesity.

(d) A programme of training for healthcare professionals about encouraging weight management was commissioned from The Public Health Action Support Team (PHAST), a not for profit public health consultancy. The training programme is accredited, and local GPs and other frontline staff will be targeted to attend the course.

Action and Priorities for the coming period

(a) Establish a performance framework, taking account of returns to the Department of Health and CCG performance reporting. This work has already been started.

(b) Charting who is responsible for delivery and performance management across the life course.

(c) Preparing a Commissioning Intentions Paper by the end of July, and recommending priorities for the Public Health budget. There was agreement that large-scale programmes with large impacts would be preferable, but final decisions are to be taken by the Health and Wellbeing Board.

Items to be escalated to the Health & Wellbeing Board

(a) Can a clear indication of the work of each subgroup be drawn up to avoid duplication across groups?

(b) Can it be established exactly what needs to be reported up to the H&WBB?

(c) Is there an adequate information sharing agreement in place across the partnership? Especially in the light of Caldecott and the fact that information sharing is not covered under the Health and Social Care Act.

Contact: Matthew Cole, Director of Public Health, LBBD

Tel: 020 8227 3657; Email: matthew.cole@lbbd.gov.uk

HEALTH AND WELLBEING BOARD

16 JULY 2013

Title:	**Forward Plan (2013/14)**
Report of the Chief Executive	
Open	**For Comment**
Wards Affected: NONE	**Key Decision:** NO
Report Authors: Glen Oldfield, Clerk of the Board, Democratic Services	**Contact Details:** Telephone: 020 8227 5796 E-mail: glen.oldfield@lbbd.gov.uk
Sponsor: Cllr Worby, Chair of the Health and Wellbeing Board	

Summary:

Attached at Appendix 1 is the Forward Plan for the Health and Wellbeing Board. The Forward Plan lists all known business items for meetings scheduled in the 2013/14 municipal year. The Forward Plan is an important document for not only planning the business of the Board, but also ensuring that we publish the key decisions (within at least 28 days notice of the meeting) in order that local people know what discussions and decisions will be taken at future Health and Wellbeing Board meetings.

Since last being presented to the Board, the Forward Plan has been discussed at Executive Planning Group meetings on 10 June and 03 July. Appendix 1 contains updates and revisions arising from those meetings.

Recommendation(s)

The Health and Wellbeing Board is asked to:

- Make suggestions for business items so that decisions can be listed publicly in the May edition of the Council's Forward Plan with at least 28 days notice of the meeting;
- To consider whether the proposed report leads are appropriate;
- To consider whether the Board requires some items (and if so which) to be considered in the first instance by a sub-group of the Board.

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APPENDIX 1

Health and Wellbeing Board Forward Plan

Board Members should note that by law, Councils are required to publish a document detailing "Key Decisions" that are to be taken by executive committees, of which the Health and Wellbeing Board is now one. This means that the Health and Wellbeing Board will be publishing its key decisions as part of the Council's Forward Plan. This can be found here: http://moderngov.barking-dagenham.gov.uk/mgListPlans.aspx?RPId=180&RD=0 and is indicated on the Forward Plan below.

Tuesday, 17 September 2013 – 18:00 (Agenda publication date: 09 September 2013)					
Item	**Title**	**Board Sponsor**	**Author**	**Key decision**	**On Council Forward Plan**
1.	GP Profiles	Matthew Cole	Matthew Cole		
2.	Adult Social Care Local Account 2012/13	Anne Bristow	Glynis Rogers	Yes	Yes
3.	Urgent Care (to include winter planning issues)	Dr Mohi	Sharon Morrow		Yes
4.	Re-ablement Proposals	Anne Bristow	Bruce Morris Sharon Morrow	Yes	Yes
5.	End of Life Care	Anne Bristow	Bruce Morris Jane Gateley	Yes	Yes
6.	Adult Social Care Funding	Anne Bristow	Glynis Rogers		
7.	Safeguarding Adults Board Annual Report	Anne Bristow	Helen Oliver		
8.	H&WBB Theme report: Protection and Safeguarding	TBC	TBC		

Tuesday, 17 September 2013 – 18:00 (Agenda publication date: 09 September 2013)					
Item	**Title**	**Board Sponsor**	**Author**	**Key decision**	**On Council Forward Plan**
9.	Substance Misuse Services Contracts	Anne Bristow	Glynis Rogers	Yes	Yes
10.	Joint Assessment and Discharge proposals	Anne Bristow	Bruce Morris Sharon Morrow	Yes	Yes
11.	Francis Report: Progress Update	Conor Burke	Jackie Himbury	Yes	Yes
12.	Pharmaceutical Needs Assessment	Matthew Cole	Dawn Jenkin	Yes	Yes
13.	Contracts: Smoking Cessation Locally Enhanced Services	Matthew Cole	Matthew Cole	Yes	Yes
14.	Sub-Group Reports: 1) Mental Health 2) Integrated Care	Cllr Worby	Various		
15.	Chair's Report	Cllr Worby	Cllr Worby		
16.	Q1 Performance and Budget Report	Matthew Cole	Matthew Cole		
17.	Forward Plan	Cllr Worby	Glen Oldfield		

(Last updated following Executive Planning Group meeting on 3rd July)

Tuesday, 5 November 2013 – 16:00 (Agenda publication date: 28 October 2013)					
Item	**Title**	**Board Sponsor**	**Author**	**Key decision**	**On Council Forward Plan**
1.	Children and Families Bill: Relevant Provisions	Helen Jenner	TBC		Yes
2.	HWBB Strategy Review: Older People	Anne Bristow	TBC		
3.	Healthwatch – The First Six Months	Frances Carroll	Frances Carroll		
4.	Urgent Care Board: Update	Conor Burke			
5.	Diabetes Scrutiny: Update on Delivering the Recommendations	Matthew Cole			
6.	0-5s Agenda (commissioning health visiting services)	TBC	TBC		
8.	Health Impact of Older Population	Matthew Cole	Matthew Cole		
9.	H&WBB Theme Report: Care and Support	TBC	TBC		
10.	Sub-Group Reports: 1) LDPB 2) Public Health Programmes	Cllr Worby	Various		
11.	Health and Social Care SAF	Anne Bristow	Pete Ellis		
11.	Chair's Report	Cllr Worby	Cllr Worby		
12.	Q2 Performance and Budget Report	Matthew Cole	Matthew Cole		
13.	Francis Report: Thematic issue	TBC	TBC		

(Last updated following Executive Planning Group meeting on 3rd July)

Tuesday, 5 November 2013 – 16:00 (Agenda publication date: 28 October 2013)					
Item	**Title**	**Board Sponsor**	**Author**	**Key decision**	**On Council Forward Plan**
14.	Winterbourne View: Update	TBC	TBC		
15.	Forward Plan	Cllr Worby	Glen Oldfield		

(Last updated following Executive Planning Group meeting on 3rd July)

Tuesday, 10 December 2013 – 18:00 (Agenda publication date: 02 December 2013)					
Item	**Title**	**Board Sponsor**	**Author**	**Key decision**	**On Council Forward Plan**
1.	Impact of Welfare Reforms	Anne Bristow	TBC		
2.	Contracts: Public Health Commissioning Intentions	Matthew Cole	Matthew Cole	Yes	Yes
3.	H&WBB Theme Report: Prevention	TBC	TBC		
4.	Sub-Group Reports: 1) Children and Maternity 2) Mental Health	Cllr Worby	Various		
5.	Chair's Report	Cllr Worby	Cllr Worby		
6.	Francis Report: Thematic issue	TBC	TBC		
7.	Forward Plan	Cllr Worby	Glen Oldfield		

(Last updated following Executive Planning Group meeting on 3rd July)

Tuesday, 11 February 2014 – 18:00 (Agenda publication date: 03 February 2014)					
Item	**Title**	**Board Sponsor**	**Author**	**Key decision**	**On Council Forward Plan**
1.	HWBB Strategy Review: Working Age Adults	Anne Bristow	TBC		
2.	H&WBB Theme report: Protection and Safeguarding	TBC	TBC		
3.	Sub-Group Reports: 1) Integrated Care 2) LDPB	Cllr Worby	Various		
4.	Chair's Report	Cllr Worby	Cllr Worby		
5.	Q3 Performance and Budget Report	Matthew Cole	Matthew Cole		
6.	Winterbourne View Update	TBC	TBC		
7.	Francis Report: Thematic issue	TBC	TBC		
8.	Forward Plan	Cllr Worby	Glen Oldfield		

(Last updated following Executive Planning Group meeting on 3rd July)

Tuesday, 25 March 2014 – 18:00 (Agenda publication date: 17 March 2014)					
Item	**Title**	**Board Sponsor**	**Author**	**Key decision**	**On Council Forward Plan**
1.	Director of Public Health Annual Report	Matthew Cole	Matthew Cole		Yes
2.	Sub-Group Reports: 1) Children and Maternity 2) Public Health Programmes	Cllr Worby	Various		
3.	Chair's Report	Cllr Worby	Cllr Worby		
4.	H&WBB Theme Report: Improvement and Integration	TBC	TBC		
5.	Francis Report: Thematic issue	TBC	TBC		
6.	Forward Plan	Cllr Worby	Glen Oldfield		

(Last updated following Executive Planning Group meeting on 3rd July)

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