

Notice of Meeting

HEALTH & WELLBEING BOARD

Tuesday, 10 February 2015 - 6:00 pm
Conference Room, Barking Learning Centre, 2 Town Square, Barking, IG11 7NB

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Chris Naylor
Chief Executive

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Membership

Cllr Maureen Worby (Chair)	(LBBD) Cabinet Member for Adult Social Care and Health
Dr W Mohi (Deputy Chair)	(Barking & Dagenham Clinical Commissioning Group)
Cllr Laila Butt	(LBBD) Cabinet Member for Crime and Enforcement
Cllr Evelyn Carpenter	(LBBD) Cabinet Member for Education and Schools
Cllr Bill Turner	(LBBD) Cabinet Member for Children's Social Care
Anne Bristow	(LBBD) Corporate Director of Adult and Community
Helen Jenner	(LBBD) Corporate Director of Children's Services
Matthew Cole	(LBBD) Divisional Director of Public Health
Frances Carroll	(Healthwatch Barking & Dagenham)
Dr J John	(Barking & Dagenham Clinical Commissioning Group)
Conor Burke	(Barking & Dagenham Clinical Commissioning Group)
Jacqui Van Rossum	(North East London NHS Foundation Trust)
Dr Stephen Burgess	(Barking Havering & Redbridge University NHS Hospitals Trust)
Sean Wilson	(Metropolitan Police)
John Atherton (Non-voting member)	(NHS England)

AGENDA

1. **Apologies for Absence**
2. **Declaration of Members' Interests**

In accordance with the Council's Constitution, Members of the Board are asked to declare any interest they may have in any matter which is to be considered at this meeting.
3. **Minutes - To confirm as correct the minutes of the meeting on 9 December 2014 (Pages 3 - 18)**
4. **Strategic Commissioning Framework for Primary Care Transformation in London (Pages 19 - 28)**
5. **Health and Wellbeing Outcomes Framework Performance Report - Quarter 3 (2014/15) (Pages 29 - 56)**
6. **NHS England London Commissioning Intentions for 2015/16 (Pages 57 - 68)**
7. **Health and Young Offenders (Pages 69 - 88)**
8. **New Psychoactive Substances (Pages 89 - 94)**
9. **The Care Act 2014: Preparedness of NHS organisations (Pages 95 - 126)**
10. **The Care Act 2014: National and Local Communications (Pages 127 - 137)**
11. **Section 75 Agreement for the Joint Assessment and Discharge Service (Pages 139 - 195)**
12. **Sub-Group Reports (Pages 197 - 207)**
13. **Systems Resilience Group - Update (Pages 209 - 211)**
14. **Chair's Report (Pages 213 - 218)**
15. **Timing of Meetings (Page 219)**
16. **Forward Plan (Pages 221 - 234)**
17. **Any other public items which the Chair decides are urgent**
18. **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.***

- 19. Any other confidential or exempt items which the Chair decides are urgent**

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Our Vision for Barking and Dagenham

One borough; one community; London's growth opportunity

Encouraging civic pride

- Build pride, respect and cohesion across our borough
- Promote a welcoming, safe, and resilient community
- Build civic responsibility and help residents shape their quality of life
- Promote and protect our green and public open spaces
- Narrow the gap in attainment and realise high aspirations for every child

Enabling social responsibility

- Support residents to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults and children healthy and safe
- Ensure everyone can access good quality healthcare when they need it
- Ensure children and young people are well-educated and realise their potential
- Fully integrate services for vulnerable children, young people and families

Growing the borough

- Build high quality homes and a sustainable community
- Develop a local, skilled workforce and improve employment opportunities
- Support investment in housing, leisure, the creative industries and public spaces to enhance our environment
- Work with London partners to deliver homes and jobs across our growth hubs
- Enhance the borough's image to attract investment and business growth

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MINUTES OF HEALTH AND WELLBEING BOARD

Tuesday, 9 December 2014
(6:04 - 8:37 pm)

Present: Cllr Maureen Worby (Chair), Anne Bristow, Dr Stephen Burgess, Cllr Laila Butt, Cllr Evelyn Carpenter, Matthew Cole, Dr John, Cllr Bill Turner, Sharon Morrow, Sean Wilson, Marie Kearns, Gillian Mills and Ann Graham

Also Present: Cllr Eileen Keller

Apologies: Dr Waseem Mohi, John Atherton, Conor Burke, Frances Carroll, Chief Superintendent Andy Ewing, Helen Jenner and Jacqui Van Rossum

71. Declaration of Members' Interests

Dr John declared a pecuniary interest in agenda item 14, 'Procurement Strategy and Waiver for Public Health Services Contracts in Primary Care 2015/16' as he was a provider of General Practitioner services.

72. Minutes - 28 October 2014

The minutes of the meeting held on 28 October 2014 were confirmed as correct.

Councillor Butt arrived during this agenda item

73. Quarter 2 Performance

Matthew Cole, Director of Public Health, presented the report on the Quarter 2 performance and drew the Board's attention to a number of issues including smoking cessation, A&E treatment and ambulance wait times, the cancer pathway and emergency admissions for ambulatory care sensitive conditions.

The Board were advised by BHRUT that the recruitment issues in A&E could take five years to improve because of the high demand across the area.

Councillor Carpenter was concerned that the conception rate per 1,000 to women aged 15 to 17 was still above the national average. Matthew Cole responded that the rate had reduced by 19% since its highest quarter reported, which had seen 38.2 conceptions per 1,000 teenage women, and was reducing steadily, however, a study would be commissioned in the New Year to find out why the Borough was lagging behind the national average and to consider the effect of the two year programme to reduce teenage pregnancies. Marie Kearns commented that the teenage pregnancy rate had been an issue for the Borough for years, if not decades, and we needed to find out why that was still the case as there had been a number of campaigns aimed at reducing the rate.

There was discussion about the feedback from the BAD Youth Forum / Young Inspectors in regards to the alleged refusal of pharmacies to issue condoms or emergency contraception and insisting on age identification. Matthew Cole advised that when problems about a specific pharmacy are reported to Public

Health they would make contact with the Pharmacy concerned to make sure they fully understand and were complying with their contracts, including any staff training that may be required in the Pharmacy. Matthew Cole advised that there would be a new and different way of providing condoms as part of the new Public Health contract provision for sexual health. The provision of a card to enable young people to ask discreetly for contraception provision was also being looked into.

Councillor Butt asked about other contraception provision in the area. Matthew Cole advised that the services were commissioned from GPs and other specialist centres, there were a large number of emergency contraception provider, which were widespread across the Borough. Councillor Butt gave an example of an inaccurate website and advised that she was also aware of two month waiting lists for contraception services appointments and felt these were unacceptable. The Chair suggested that this type of information was passed to Matthew Cole so that effort could be given to resolving such problems.

Comments were made in regard to the Health and Adult Services Select Committee looking at sexual health services as an issue for in-depth scrutiny, due to the long standing teenage pregnancy rates and problems being reported with the provision of sexual health services in the Borough, but this would be dependent on its future scrutiny programme.

The Chair said that there had been a number of occasions where initiatives that worked well in other areas, with similar communities to LBBB, for some reason do not always work in LBBB and we need to consider how we do things differently or look at why they are less effective and she would be discussing with officers in the New Year a possible piece of work around this problem. Dr John, Barking and Dagenham Clinical Commissioning Group, said he welcomed the Chair's view of trying to triangulate why programmes had less success here than in similar areas. Dr John indicated that it may be opportune to look at cross / joint provision, for example could GPs work with schools in regards to obese children.

In response to a question from Councillor Carpenter in regards to the increase in childhood obesity levels Matthew Cole said that they had remained roughly static, based on the recent data releases for London and England. There was then discussion in regards to the phenomenon whereby children who are not overweight become so when they go to primary school, this was a national trend and was unclear why it was occurring. A sustained focus would be needed to reduce the later in life problems that would occur for those children.

Councillor Carpenter was concerned about the potential closure of the Birthing Centre and the loss of midwifery led births at Barking Hospital. Sharon Morrow, Chief Operating Officer, Barking and Dagenham Clinical Commissioning Group, advised that Conor Burke had given assurances that the services will not stop whilst negotiations continue with Barts Health NHS Trust and that should the Barts Health negotiations fail other service providers would be sought and negotiations started. Councillor Keller said that the Birthing Centre had been provided after a long and hard campaign led by the Council and she would wish to record her support for its retention. Councillor Turner commented that should there be any proposed closure of the Birthing Centre this needs a higher profile with much greater public engagement. Councillor Turner added that likewise the GP Practices that could be at risk following the CQC report also would require public

engagement and local discussion. Sharon Morrow said there was no proposal to close the Birthing Centre service and it was not something being suggested from the commissioners, however, it was being reported so that the Board was aware of the risk due to the potential need to change partners.

Dr John said he welcomed the imminent discussion with CQC to explore a number of issues and stated that he was concerned that the CQC had not been to many of the GP practices and CQC had not discussed their findings with the GPs or taken into account mitigating circumstances. Dr John gave the example of his own practice showing a high rate of antibiotic prescription but he had the highest rate of registered sickle cell patients in London. Dr John confirmed that none of the six practices which CQC showed as being of high concern were single handed practices and only one GP had been visited by the CQC.

The Chair asked for comments in regards to the high London Ambulance Service (LAS) conveyance rates from three practices in Barking and Dagenham. Sharon Morrow responded that the CCG had commissioned an enhanced GP service for nursing homes in the Borough, including Alexander Court and Chase View. An interim evaluation had shown a reduction in LAS conveyances across all homes (although not Alexander Court). The CCG will review LAS conveyances from the Ripple Road practice.

Anne Bristow, Corporate Director of Adult and Community Services, advised that how well we share performance trends amongst partners will be picked up in the work on the revised Health and Wellbeing Strategy in the New Year.

The Board:

- (i) Reviewed the overarching dashboard;
- (ii) Noted the further detail provided on specific indicators and responses to the questions raised and that further updates would be provided in due course; and,
- (iii) Welcomed the assurance given by Conor Burke that the Barking Community Hospital Birthing Centre would not close and the issue had only been raised as a risk because negotiations were being held with Barts Health NHS Trust, however should these not be successful other service providers would be approached.
- (iv) Noted that further to Minute 59, 28 October 2014, the London Ambulance Service had been asked by the CCG to provide a formal response in regards to Infant Deaths and this was currently awaited.
- (v) Noted that Sharon Morrow would circulate statistics on the Birthing Centre clientele to the Board members.
- (vi) Noted Matthew Cole would arrange for information on sickle cell to be passed to Councillor Turner.
- (v) Noted a sustained focus would be needed on childhood obesity to reduce the later in life problems and medical interventions that were more likely to occur in adults that had been obese as children.

- (vi) Board Members who found issues of service provision concern for Public Health should inform Matthew Cole of the details in order that an investigation could be undertaken and if necessary action taken.

Councillor Turner arrived during this agenda item

74. Barking and Dagenham CCG Commissioning Intentions 2015/16

Sharon Morrow, Chief Operating Officer Barking and Dagenham Clinical Commissioning Group (CCG) presented the report and explained that whilst the Barking and Dagenham CCG has a two year Operating Plan for 2014 to 2016 it is required to refresh its Operating Plans each year in order to take into account changes in local needs, central planning and financial allocations, which were expected around the 23 December for 2015/16 financial year.

Sharron Morrow drew the Boards attention to the details in the report and in particular to:

- Mental Health – there was likely to be new access targets and a review of recent policy guidance would be undertaken to see what could be done to improve service provision.
- Cancer Services – There would be a drive to improve early diagnosis in 2015/16 as this would have both improved patient outcomes and reduced the treatment costs overall.
- Children’s Services – Increased effort in improving health outcomes for children with special education and disability needs, looked after children, care leavers, youth offenders and early year’s development and targeting childhood obesity. Joint reviews were also planned for children’s therapies and CAMHs.
- Stroke – A review of the stroke rehabilitations pathway was being undertaken to inform and develop a new model of care that meets national standards and improves patient outcomes and experience of services.
- Primary Care Improvement – Plans to develop co-commissioning with NHS England following the release of guidance on 10 November 2014. Away days, workshops would be held.
- Urgent Care – Increased access to GP services in the evenings and weekends was being progressed by the GP Federations and would be part of the procurement of urgent care pathways across three CCGs.
- Planned Care – Reviews of the pathways for diabetes and respiratory diseases would be undertaken as well as development of a community dermatology service.
- Learning Disabilities – It was intended that the commissioning functions for some learning disabilities services would be transferred to LBBDD from April 2015, through a Section 75 Agreement.
- Maternity – Would support improved public health outcomes in related to a reduction of smoking during pregnancy, late access to antenatal care and promote increased breastfeeding.

The Chair commented that the Council would fight the recreation of 'ONEL' (Outer North East London) and stressed that we need our own Health and Wellbeing Board to deal with the issues that affect this Borough, as they are not the same as Havering. The Chair added that whilst it may be easier to commission for three boroughs, it may not be best for the community, especially in Barking and Dagenham.

Councillor Carpenter commented that she was pleased to see Mental Health included.

Councillor Carpenter raised the issue of cultural factors and if they could lead to Sudden Infant Death. Matthew Cole responded that there were links and pointed the Board to the London Health Strategy and commented that and Simon Stevens, Chief Executive, NHS England, needed to look at the role for social prescribing rather than a purely medical role for GPs.

Dr John commented that the area you serve is important and he was not sure if GPs had the latest training to deal with the rapid demographic changes in population and their different cultural practices. Dr John added that localism might be important and there could be a need to look at delivery of information, workforce planning and training now so that they are in place to deliver to the specific community needs.

Ann Graham, Divisional Director, Complex Needs and Social Care, read a number of questions from Sara Baker, Independent Safeguarding Chair of the Local Safeguarding Children Board and Safeguarding Adults Board. Sharon Morrow responded that the CCG were very much focused on the needs of the local authority and provision was based upon the needs assessments that had been undertaken in LBBB, including mental health needs assessment. Further work would be done in regards to the Mental Health Strategy and recognised that the need varies across boroughs.

Marie Kearns commented that the speech and language services appeared to be struggling again: primarily due to the increasing number of children in LBBB. These skills are a vital part of children's development particularly to get them ready for school.

Councillor Turner commented about the lack of detail in the reports.

Councillor Turner was concerned that the CCG Board members were all male. Sharon Morrow confirmed that there were three female members on the CCG Board. Dr John added that it is the Clinical Directors that are all male and they are elected by the GP members to the Board and that for a variety of reasons there may be a lack of female leaders coming forward in the future. Dr John agreed that he would prefer there to be a more female representation but it was dependent on who put themselves forward. The Chair advised she would discuss this issue with Dr Mohi outside of the meeting

The Chair commented on the potential plans for urgent care and stressed that due to the reluctance of some residents to go to Barking there was likely to be more people using Queen's Hospital.

The Board:

- (i) Noted the Clinical Commissioning Group (CCG) was refreshing its Operating Plan for 2015/16 to take into account the updated Joint Strategic Needs Assessment (JSNA), local and national priorities for delivery including the Better Care Fund requirements and financial plans; and,

- (ii) Noted the CCG commissioning intentions for 2015/16, as set out in the report, and the comments in regard to service provision
- (ii) Noted the Section 75 arrangements would be brought back to the Board for sign off in the New Year.

75. Care Act 2014: Update on Implementation

Anne Bristow, Corporate Director of Adult and Community Services presented the report and stressed that there was now only four months to go to stage 1 implementation. Work plans had been put into place but there were still some inter-agency issues to be resolved, together with a lack of financial certainty as the funding would not be known until 17 December 2014.

Anne Bristow also brought specific points to the Boards attention, including:

- Various financial models had been undertaken to see how many people fund their own care; however, this had not resulted in any consistent answer. Despite work to scope the impact on budgets, there was still a significant 'unknown' amount that might be required.
- The Board were reminded that the law brings in a duty to cooperate on adult social care and emphasised duties around integration, and safeguarding. The Regulations were only laid out in November 2014, as a result their implementation was causing some real logistical struggles and the issues being faced were much wider than those just affecting the Council, for example IT and housing provision.
- Whilst there was a five year strategic plan, the Better Care Fund was the beginning of the process and there would be more demands over the coming years.
- Training was needed so that staff understood the implications, the processes and their roles in the new systems. The assessments alone would require a huge cohort of people of different professional disciplines to be trained. Anne added that LBBB had experience in joint training and could help with training for integrated teams.
- There was also a lack of trained advocates, especially in the BME population as there were 98 languages spoken in London.
- A report on a 'prevention strategy' would be brought to the Board next year.
- There were challenges in getting partners to use existing powers and need for this cooperation would become greater.
- The Safeguarding Adults Board becomes statutory from April 2015.
- The effect of 'ordinary residence' and how councils could be responsible for the care for people that no longer have any connection with the area and the cost implications that this would have for councils.
- That a two phase communications campaign was to be run at national level and that the Council was planning a local communications campaign using a mix of materials and methods to engage with existing and potential service users. The local campaign would particularly target carers to increase the number of carers assessed and if necessary put support packages into place.

Anne Bristow asked that all Board partners ensure that they have read the guidance fully to see what it means for them and identify changes that they must do to comply with the Act. If partners have an Implementation Action Plan in place they need to check on how that would be implemented and that it is fully reviewed in view of the November 2014 Regulations. The Health and Adult Services Select Committee planned to scrutinise the implementation programme at its meeting on 20 January 2015.

In response to a question from Councillor Turner about how 'ordinary residence' would change, Anne Bristow gave the example of a service user with a supported tenancy who was funded by LBBB for their care and support. If the service user then moved out of LBBB, their ordinary residence would stay with LBBB, despite the service user being in a new location out of the Borough. LBBB would, therefore, still be responsible for funding the individual's care. It was stated that LBBB could be responsible for funding some people's care for 50 plus years.

Councillor Carpenter asked for clarification as to what was meant by 'Preparing for new market shaping and market management role' in section 3 of the report. Anne Bristow advised that this was about shaping the services in the care and support provider market, and was a signal to providers about what services service users with care and support needs may wish to buy in future years. The Borough's Market Position Statement entitled 'The Business of Care in Barking and Dagenham' was produced in July 2014 and discusses the direction of travel for the Adult Social Care market in Barking and Dagenham, as well as signalling to Providers where there are gaps and opportunities in the market. The Market Position Statement can be found on the Council's Care and Support Hub website: http://careandsupport.lbbd.gov.uk/kb5/barkingdagenham/asch/advice.page?id=Mp_qJPtFLEw

Councillor Carpenter asked about the improved competency levels for commissioning in section 6 of the report. Anne Bristow responded that commissioners are good at big block commissioning but are not always so good when using smaller or specialist providers. This had been picked up as part of the Adult Social Care Peer Review.

Dr John raised the issue of the use of the voluntary sector. Anne Bristow responded that there was a clear political will on the use of the voluntary sector, but there were some challenges that this would cause in regards to competency and cost. There was however potential to look at added value opportunities. The Chair added that it was likely that micro markets will emerge and the voluntary sector would grow to a size that was comfortable for them and it was hoped there would be some balance between the various providers.

The Chair ended the discussion by commenting that she expected all Board Members' organisations to be able to fully implement the requirements of the Care Act and resource and support the necessary partnership working.

The Board:

- (i) Agreed that the CCG and NHS Trusts report back to the H&WBB on their organisations progress and compliance status, at the 10 February 2015 Board meeting.
- (ii) Noted that the report back will be supported by the Council-led Care Act Programme Team and that the reports should outline the actions that must be taken by the CCG and Trusts to be Care Act compliant from 1 April 2015.

76. Adult Social Care Peer Review

Mark Tyson, Group Manager, Integration and Commissioning, presented the report and drew the Boards attention to the presentation slides produced within the report and explained how the Peer Review worked and how feedback is taken in the spirit of self improvement. The Peer Review was undertaken through the auspices of the London Social Care Partnership, between 7 and 10 October 2014 and the emphasis was on councils working together to set standards, share and champion good practice and review each other's performance. This reiterated the importance of accountability to the residents for the services delivered to them at a local level. Mark Tyson added that the Care Act had shifted the focus and created a new style of commissioning, which was the route that LBBB was already following.

Mark Tyson drew the Board's attention to what we do well, where further work was needed and the proposed actions, the details of which were set out in the report, including the follow-up needed from the workshop held on 3 December.

Councillor Turner asked how this would link to economic regeneration as the jobs created would be largely local and low paid. Councillor Turner asked if the employers would offer good quality training of the workforce and if there was a local worker involved in the peer review. Mark Tyson advised that the Personal Assistants Forum and Carers networks had been involved. Anne Bristow advised that quality standards were always at the heart of what we do and would be levered into this area of employment potential. The Council's Regeneration officers recognised that this was a big business opportunity and that there were real long-term jobs and the Council would be looking to see if enough support was being received from Skills for Care, the employer-led workforce development body for adult social care in England.

In response to a question from Dr John, Mark Tyson advised that there had not been a particular session for partners and personal assistants. The Chair added that she was aware that the review team had certainly met with the stakeholders at Marks Gate.

The Board:

- (i) Received the presentation and report, which provided an outline of the findings of the Peer Review team, and the response developed in partnership through the workshop on 3 December 2014;
- (ii) Discussed the Market Management Peer Review and supported the proposed direction of travel in managing the adult social care market in Barking and Dagenham, as set out in the report.

77. Adult Autism Strategy

Anne Bristow, Corporate Director of Adult and Community Services, presented the report and advised that over the last six months the Council had been working with partners to refresh its Adult Autism Strategy and to reflect the new 'Think Autism' national update, the Winterbourne View Concordat, the Care Act and Children and Families Act. The Council had commissioned the Sycamore Trust to consult and engage with local individuals, carers and professionals on the Strategy. The

consultation period had ended in December.

Anne Bristow drew the Board's attention to the aims of the three year plan and the nine priorities, set out in section 2.7 of the report, and advised that the Strategy could be refreshed if there were any significant changes to national guidance.

The proposal was for the Learning Disability Partnership Board (LDPB) to monitor the progress of the Strategy, with them reporting to the Health and Wellbeing Board on its implementation after one year.

An £18,000 innovation grant had been offered by the Department of Health to assist the Council and its partners to implement 'Think Autism', this was a one off grant and could be used for capital works, including electrical equipment and IT developments or for making public areas more autism friendly. The plans for the use of the innovation grant were being worked up and would be submitted to the Department of Health by the 12 December.

Whilst the Adult Autism Strategy and the Children's Autism Strategy were separate documents an integrated approach would underpin both.

Councillor Carpenter said it was a shame that the Adult and Children's Autism Strategies could not have been issued together. The Chair and Anne Bristow confirmed that there were areas of overlap within the strategies and that the Adult Autism Strategy had been produced in discussion with Children's Services. The Children's Strategy was still in development so it was not possible to finalise them at the same time, nor was it appropriate to delay the Adult Strategy and the work that would follow on from it.

Ann Graham, Divisional Director of Complex Needs and Social Care, advised that there would be issues of expectation to manage at the point of transition. Anne Bristow added that the resources and legislative requirements were different for children and adults and accordingly financial resources for adults were less as well. Anne Bristow commended the Adult Autism Strategy to the Board and advised that should there be a need for a refresh of either strategy that could be done in due course.

The Board:

- (i) Noted the explanation from the Corporate Director of Adult and Community Services on the reasons why the Adult Autism Strategy needed to be put into place at this time and that work would be undertaken with Children's Service to ensure synergy with the Children's Autism Strategy where possible, and should any major changes or refresh be necessary these would be brought back to the Board in due course.
- (ii) Agreed the Adult Autism Strategy 2015 to 2017, attached as Appendix 1 to the report
- (iii) Delegated responsibility to the Corporate Director of Adult and Community Services to make any final amendments to the Strategy before publication.
- (iv) Delegated responsibility to the Learning Disability Partnership Board (LDPB) to monitor the progress of the Adult Autism Strategy 2015 to 2017

and agreed to receive a progress report on its implementation from the LDPB in one year.

- (v) Delegated responsibility to the LDPB to make amendments to the Autism Strategy following the final publication of the Think Autism guidance in 2015, on the basis that should amendments be substantial the LDPB shall bring amendments to the Health and Wellbeing Board for agreement, subject to discussion and agreement between the Chairs of the LDPB and the Health and Wellbeing Board.
- (vi) Delegated responsibility to the Corporate Director of Adult and Community Services to finalise the bid for the Autism Innovation Capital Grant before its submission on 12 December 2014.

Councillor Carpenter gave her apologies and left the meeting at this point and took no further part in the discussions or decisions.

78. Update for Board Members on Availability of Adolescent Mental Health Crisis Beds

Gill Mills, Integrated Care Director, NELFT, gave a presentation, which outlined the local position in regards to 'Tier 4' provision for Child and Adolescent Mental Health Services and availability of acute and crises inpatient services for young people with mental health problems. This was particularly in the public eye following press reports concerning a 16 year old girl who having been sectioned had to be held in custody by Police in Devon over a weekend due to a national lack of beds for adolescent mental health crisis.

Since April 2013, CAMHS Tier 4 inpatient beds have moved from being locally commissioned to being nationally commissioned by NHS England (NHSE). Gill Mills drew the Board's attention to the map showing provision across the country, from which it could be seen that beds centred around London and the South East and also showed there was demand on local beds from across the country. A review had been undertaken and as a result NHSE would be tending in the new financial year to increase the number of CAMHS specialist beds by 50. There would also be three new case managers for the London area. Overall it would improve the way young people move in and out of specialised care and provide consistent criteria for admission and discharges based on best practice.

A longer-term strategic review of CAMHS would be undertaken as part of a wider review of specialist services.

Whilst there are sufficient beds in the London area, for London Children, there was pressure on these beds caused by shortages elsewhere. This had resulted in children being moved across the country, sometimes over some distance, into those beds.

Brookside, which was one of 10 facilities in London, had 14 beds acute beds and 4 high dependency beds for 12 to 18 year olds who had severe psychological, behavioural or emotional difficulties and also provided a day service. NELFT also provided the 'Interact service' which enables care to be provided in the community and minimised the need for admission. There had been over 130 admissions to Brookside in the past year and 60% of young people admitted had a personality

disorder and work was being undertaken to reduce the need for admission. The presentation provided details of the admissions from various authorities to Brookside during the twelve month period August 2013 to August 2014 and also the out of area CAHMS beds.

Gill Mills advised the Board of a pilot scheme which was being run to extend access to services until 9.00 p.m., the results of which would be fed into future commissioning.

In response to a question Gill advised that wherever possible a local bed was provided for local young people and also that early intervention and support reduced the need for bed admissions.

The Chair commented that she was concerned that because of the national pressure on local beds there was still potential for a 12 to 18 year old being in a cell rather than a hospital bed. In response Sean Wilson, Deputy Borough Commander, informed of the vigorous risk assessment at point of entry and exit from Police custody and that there were often difficulties on security at hand-over to other partners, which sometimes tied-up several police officers. Alcohol and drug abuse were also an issue. Sean Wilson added that he felt that it was highly unlikely for a situation such as had occurred in Devon to occur in the Metropolitan Police area, primarily due to the size of London and the Metropolitan Police.

Councillor Turner asked if there was currently sufficient bed provision locally to meet demand. Gill Mills responded that general indications were that there was but they were reviewing provision national and locally to see if there was any under capacity for London children in London.

Matthew Cole commented that in the past month there had been over 120 referrals to CAMHS and asked how quickly they had been treated. Gill Mills advised that all referrals were prioritised and all are seen within the 18 week guidelines. Matthew Cole said that he was concerned that 18 weeks was a long time for a child to receive help and there could be an escalation to needing a bed or self harm that could be prevented with early support. Marie Kearns also raised Healthwatch's concern that whilst young people were initially assessed within the 18 weeks there could then be an eight month wait for treatment.

The Board

- (i) Noted the report and received the presentation, which outlined the local position around the availability of acute and crisis inpatient services for young people with mental health problems, including the nearest local bed provision at Brookside in Redbridge, which was one of ten Tier 4 adolescent units within London and contained 14 acute beds and 4 high dependency beds for 12 to 18 year olds;
- (ii) Noted the review and pilot that was being run in regards to extended hours and local provision, the results of which would be fed into future commissioning.
- (iii) Noted that there was a higher level of bed provision in the London area than in the rest of England and wished to place on record the Boards concern that young people from the rest of the England were being set to

London area which was not close to family and friends and the equally young people from London and the South East might be sent out of London due to the pressure for beds.

79. Children's Social Care Annual Report

Ann Graham, Divisional Director, Complex Needs and Social Care, presented the report which provided a review of operational service developments and inspections over the 2013/14 financial year, an overview of local demand pressures and outcomes of the Ofsted Inspection in May 2014 of services for children in need of help and protection, children looked after and care leavers. Overall performance was going well and there had been a period of increased stability, the full details of which were contained within the report.

Ann Graham drew particular attention to both the Adoption Service and the successful launch on 1 April 2014 of the Multi Agency Safeguarding Hub (MASH), which was based in Barking, and the partners involved with it.

The Chair commended the report as providing a comprehensive overview, which was particularly usable for non-child care specialists.

The Board:

- (i) Noted the work undertaken over the year:
- (ii) Noted the service improvements contained within the review report and action taken in response to local demand pressures; and
- (iii) Noted the content and outcomes of the Ofsted inspection of services for children in need, looked after children, care leavers and the Local Authority Children's Services' Improvement Plan, as set out in the report.

80. Barking and Dagenham Safeguarding Children Board (BDSCB) Annual Report 2013-14

Ann Graham, Divisional Director, Complex Needs and Social Care, presented the Barking and Dagenham Safeguarding Children Board (BDSCB) Annual Report 2013/14, attached as Appendix 1 to the report, which demonstrated the impact of the work of the BDSCB partners in safeguarding children and young people within the Borough. In line with statutory guidance the Annual report has been shared with the Chair of the Health and Wellbeing Board and the wider partnership and would also be shared with the Children's Trust.

The Board's attention was drawn to five priorities identified by the BDSCB for 2014/15, the details of which were set out in the report. The evaluation of priorities would be provided in the next BDSCB Annual Report.

The Chair commented that she would wish to see more information on child exploitation and what we were doing to identify potential victims or vulnerable children. Councillor Turner informed the Board that a brief had been sent to all Councillors, a specialist from the Home Office would be visiting the Borough and Ofsted had also undertaken some work. Councillor Turner said it was important not to switch resources to the trends of the day but to identify local needs and

concentrate on those. Councillor Turner also raised the issues of witch craft and spirit exorcism, female genital mutilation and missing children. Councillor Turner added that child exploitation and trafficking was a national problem that crossed different local authority and police force boundaries. Sean Wilson commented that the issues were very complex with those trafficked being too scared of reprisals on families back home or of being deported to come forward and there was often denial by the individual that they were victims.

Ann Graham advised that LBBD had been selected as an area of interest and support due to indicators such as deprivation and teenage pregnancy rates.

The Board:

- (i) Noted the Barking and Dagenham Safeguarding Children Board (BDSCB) Annual Report 2013-14
- (ii) Noted that a report on child exploitation would be provided to the Health and Wellbeing Board in due course.

81. Adoption Annual Report

Ann Graham, Divisional Director, Complex Needs and Social Care, presented the report, which showed improved performance over the last three years, and provided information on the Adoption Diagnostic, the details of which were set out in the report.

Marie Kearns asked if potential adopters were mostly from the Borough. In response Anne Graham advised that they were from a mixed area but were predominantly white, but the service was part of a consortium which tried to fit children where the best match is for each child, regardless of geographical location.

The Chair commented on the work of the Adoption Team and the efforts made to move the service forward and increase the level of children being placed.

The Board:

- (i) Noted the work and performance of the Adoption Service during 2013-14, as set out in the report and its appendix.
- (ii) The Board also wished to commend the Adoption Team for their efforts in improving the service and the number of children placed for adoption.

82. Pharmaceutical Needs Assessment (PNA)

Matthew Cole, Director of Public Health presented the report which informed the Board it had a statutory duty to publish a Pharmaceutical Needs Assessment (PNA) at least every three years and that the PNA was in preparation with a view to it being published by the statutory deadline of 1 April 2015. The PNA would provide an assessment of the local need for pharmaceutical services and NHS England would rely on the PNA when making decision on application to open new pharmacy and dispensing appliance contractor premises.

The Board:

- (i) Noted that the draft Pharmaceutical Needs Assessment (PNA) would be issued on 19 December 2014 for the statutory 60 day public consultation, which would close on 16 February 2015.
- (ii) Noted the draft PNA would be shared with interested members of the Health and Wellbeing Board and we also have a statutory duty to share the draft PNA with neighbouring boroughs' Health and Wellbeing Boards.
- (iii) Noted the final draft PNA will be presented to the Health and Wellbeing Board at its March 2015 meeting in preparation for publication to meet the statutory deadline of 1 April 2015.

83. Contract: Public Health Services in Primary Care Contracts 2015/16

Matthew Cole, Director of Public Health, presented the report and explained that a number of contracts would expire on 31 March 2015 and under the Council's Constitution, Contract Rules, a waiver of tendering requirements was needed as there were exceptional circumstance as to why a procurement exercise could not be undertaken at the current time, the details of which were set out in the report.

The Board:

- (i) Approved the strategy, for the procurement of the Public Health Programmes contracts within the primary care setting from the 1 April 2015, for a period of one year for:
 - (a) NHS Health Check Programme (mandated Council Public Health function)
 - (b) Chlamydia Screening
 - (c) Smoking Cessation Level 2 Service
 - (d) Contraceptive Intrauterine Devices (IUDs) and Contraceptive Implants
 - (e) Pharmacy sexual health Service
 - (f) Shared Care in GP Practices (Drug Treatment Service)
 - (g) Supervised Consumption in Pharmacies (Drug Treatment Service)the details of which were set out in sections 2.1 to 2.6 of the report;
- (ii) In accordance with Contract Rule 6.6.8, waived the requirement to conduct a competitive procurement exercise for the contracts above; and,
- (iii) Delegated Authority to the Corporate Director of Adult and Community Services, in consultation with the Director of Public Health, Head of Legal Services and the Chief Finance Officer to award the Public Health service contracts, as set out above, to the nominated General Practice and

Pharmacy providers.

84. Systems Resilience Group - Update

The Board:

- (i) Received the update from the Systems Resilience Group, including the briefings attached to the report of the Group's meetings held on the 30 September 2014 and 31 October and the verbal update following the meeting held on 24 November 2014.
- (ii) Noted that efforts were clearly continuing to improve performance and patient experience but the Board was still concerned that Accident and Emergency targets were still not being met.

85. Sub-Group Reports

The Board noted update reports from the following:

- (i) Integrated Care Sub-Group
- (ii) Mental Health Sub-Group
- (iii) Learning Disability Partnership Board
- (iv) Children and Maternity Sub-Group
- (v) Public Health Programme Board

86. Chair's Report

The Board noted the Chair's report, which provided information on a number of events / issues:

- (i) Lets make 2015 the year we start to turn the tide on obesity – Health will be one of the areas of focus for the 50th Anniversary of the Borough, and offer the opportunity for individuals to pledge to increase activity levels and undertake more healthy lifestyles. Other activities will highlight heritage, success and future plans.
- (ii) Complex Primary Care Practice Project – Health 1000
- (iii) Health and Wellbeing Board Development Day – 16 April 2015
- (iv) Health and Wellbeing Strategy – consultation during January 2015
- (v) Publication on 15 October 2014 of the London Health Commission's Better Health for London report.
- (vi) News from NHS England in regards to 21st Century IT system and patients digital access to their records.

87. Forward Plan

The Board:

- (i) Noted the draft Forward Plan for the Health and Wellbeing Board and there had been some changes and items added since the publication of the agenda; and,
- (ii) Noted any new items / changes must be provided to Democratic Services by no later than noon 12 January 2015 for them to be considered at the 10 February 2015 meeting or later.

HEALTH AND WELLBEING BOARD

10 FEBRUARY 2015

Title:	Strategic Commissioning Framework for Primary Care Transformation in London		
Open Report	For Information		
Wards Affected: All	Key Decision: No		
Report Author: Paul Roche Programme Director of Primary Care Transformation	Contact Details: E-mail: paul.roche@nhs.net		
Sponsor: John Atherton, NHS England			
Summary: Strong primary care is important for a wide range of health and care ambitions across the capital and it is widely recognised that, despite some great examples, there is a significant transformation challenge to be faced. Responsibilities for shaping and delivering change in primary care sit primarily with providers and commissioners, but a wide range of other partners have close interests and/or potentially positive roles to play. The Strategic Commissioning Framework for Primary Care Transformation provides a new vision for general practice, and an overview of the considerations required to achieve it. From December 2014 to April 2015, a period of engagement will be undertaken locally to fully understand the implications of the Framework, and how it fits into the context of wider plans.			
Recommendation(s) The Health and Wellbeing Board is recommended to: (i) Discuss whether the <i>Framework</i> covers the correct areas; (ii) Discuss whether there are other areas that should be considered in the <i>Framework</i> that currently are not; (iii) Discuss how the <i>Framework</i> could be strengthened.			

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

List of Appendices:

Appendix 1: Strategic Commissioning Framework Presentation

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Strategic Commissioning Framework for Primary Care Transformation in London

Briefing v1.0 - November 2014

There is significant focus on the need for change in Primary Care

Both the Five Year Forward View and the London Health Commission report set out several objectives for Primary Care:

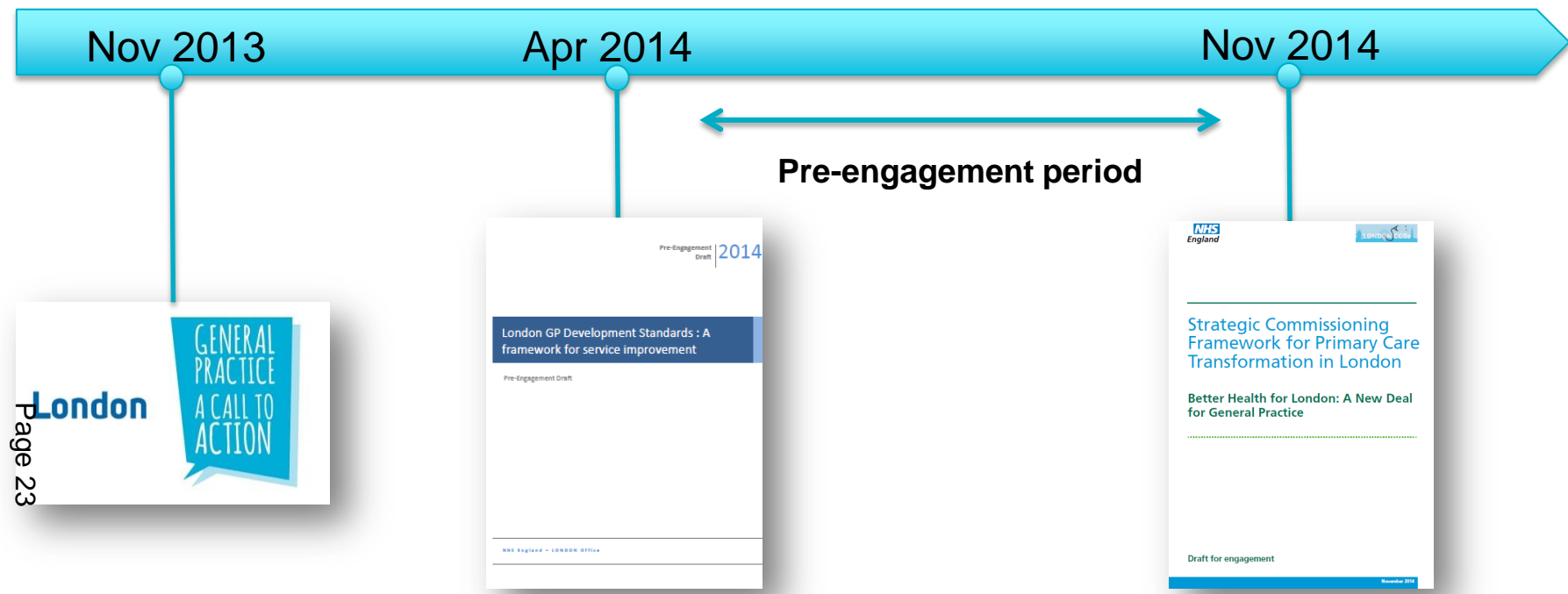


- **Stabilise core funding for general practice and review how resources are fairly made available**
- **Give CCGs more influence over the NHS budget – investment: acute to primary & community**
- **Provide new funding through schemes such as the Challenge fund – innovation, access**
- **Expand as fast as possible the number of GPs, community nurses and other staff.**
- **Design new incentives to tackle health inequalities.**
- **Expand funding to upgrade primary care infrastructure and scope of services**
- **Help the public deal with minor ailments without GP or A&E**
- **Potential new care models** such as Multispecialty Community Providers (MCPs) and Primary & Acute Care Systems (PACS)



- **Increase the proportion of NHS spending on primary and community services**
- **Invest £1billion in developing GP premises**
- **Set ambitious service and quality standards for general practice**
- **Promote and support general practices to work in networks**
- **Allow patients to access services from other practices in the same network**
- **Allow existing or new providers to set up services in areas of persistent poor provision**

London has also been working on how some of the challenges faced by general practice could be mitigated

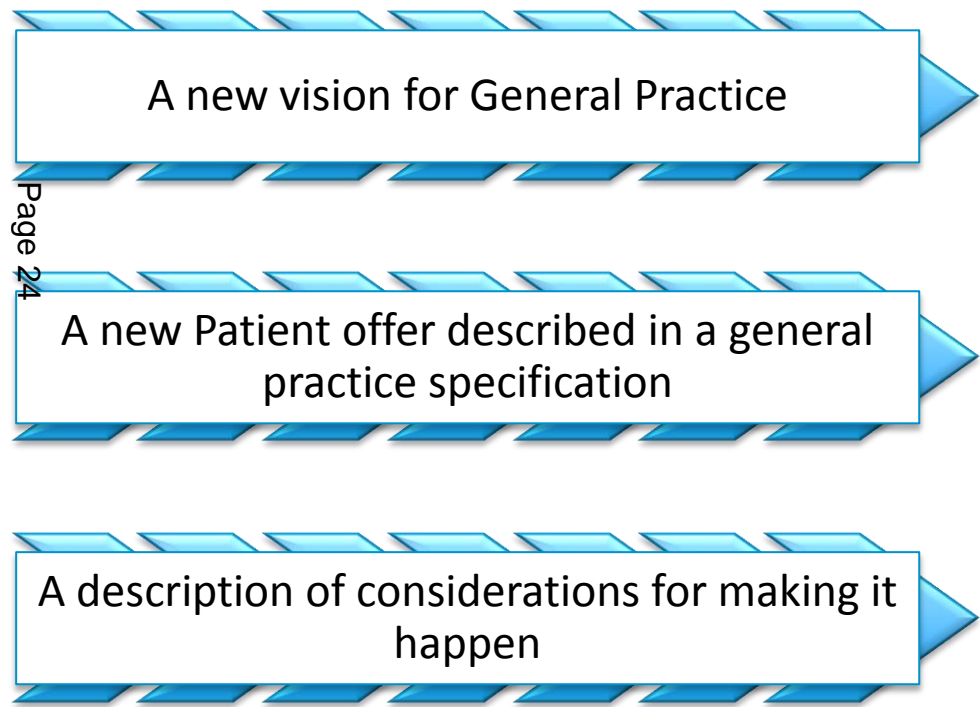


The **Call to Action** outlined some of the challenges of General Practice in London..

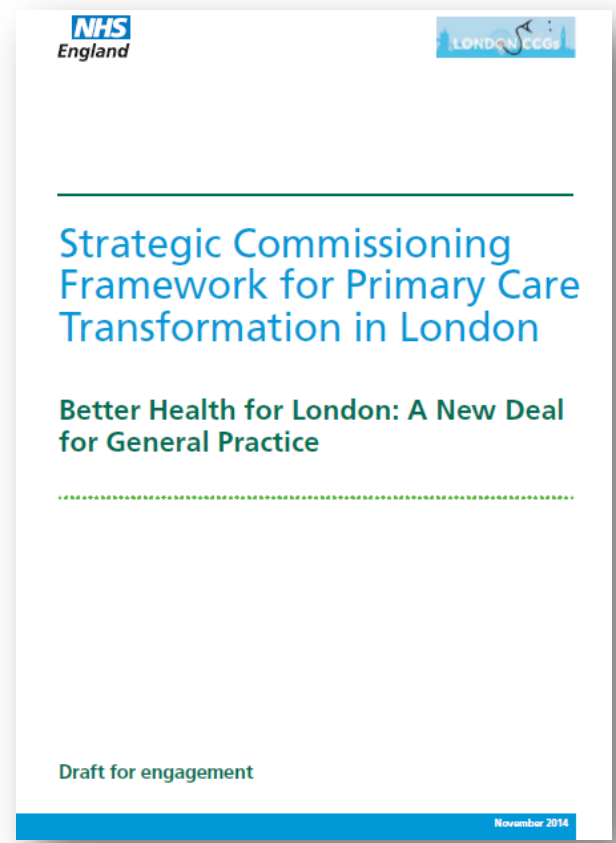
In April a draft publication was released, which outlined **a new patient offer**.
Since then there has been **considerable engagement** to **further strengthen this offer**, and understand the necessary **considerations for delivering it**.

The Strategic Commissioning Framework

The result is a draft *Strategic Commissioning Framework*, aiming to support transforming primary care in the capital



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A new vision for General Practice in London

Patients and clinicians alike have told us about the importance of three areas of care. This forms the basis of the new patient offer (also called the specification)



Accessible Care

Better access primary care professionals, at a time and through a method that's convenient and with a professional of choice.



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Coordinated Care

Greater continuity of care between NHS and other health services, named clinicians, and more time with patients who need it.

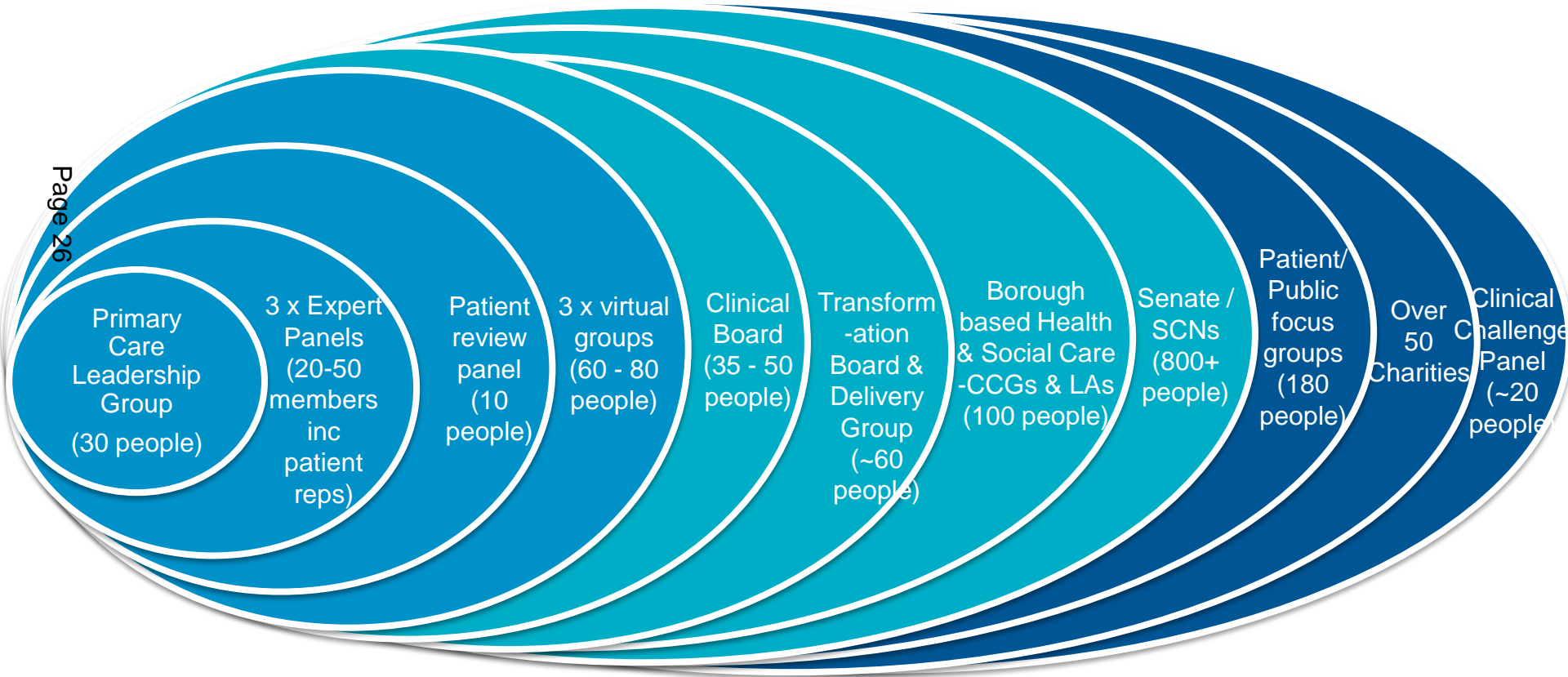


Proactive Care

More health prevention by working in partnerships to reduce morbidity, premature mortality, health inequalities, and the future burden of disease in the capital. Treating the causes, not just the symptoms.

..Which has been widely tested

Following an initial development stage, the specification has been tested with a widening range of patients, clinicians and other stakeholders. Around **1,500** people have now been involved in testing this.



The *Strategic Commissioning Framework* which has been released for engagement reflects the feedback gathered from the above discussions.

The Framework includes several areas of focus to support delivery of the specification

Models of Care

- This area proposes collaborating across groups of practices, and with other partners

Commissioning

- This area outlines the importance of supporting commissioners to work together and support to CCGs taking on co-commissioning

Financial Implications

- This includes the estimated cost shift towards Primary Care required to deliver the new specifications, and the year on year funding shift to achieve this.

Contracting

- This area looks at contractual considerations of delivering the specifications e.g. contracting at a population level

Workforce Implications

- This area looks at the need for the right roles and skills in a practice and as part of a wider team

Technology Implications

- This area looks at the ways technology could be used to deliver the specifications and maximising its use to support empowerment and innovation

Estates Implications

- This area references the findings of the London Health Commission in terms of the variability of Primary Care estate and recommendation for investment

Provider Development

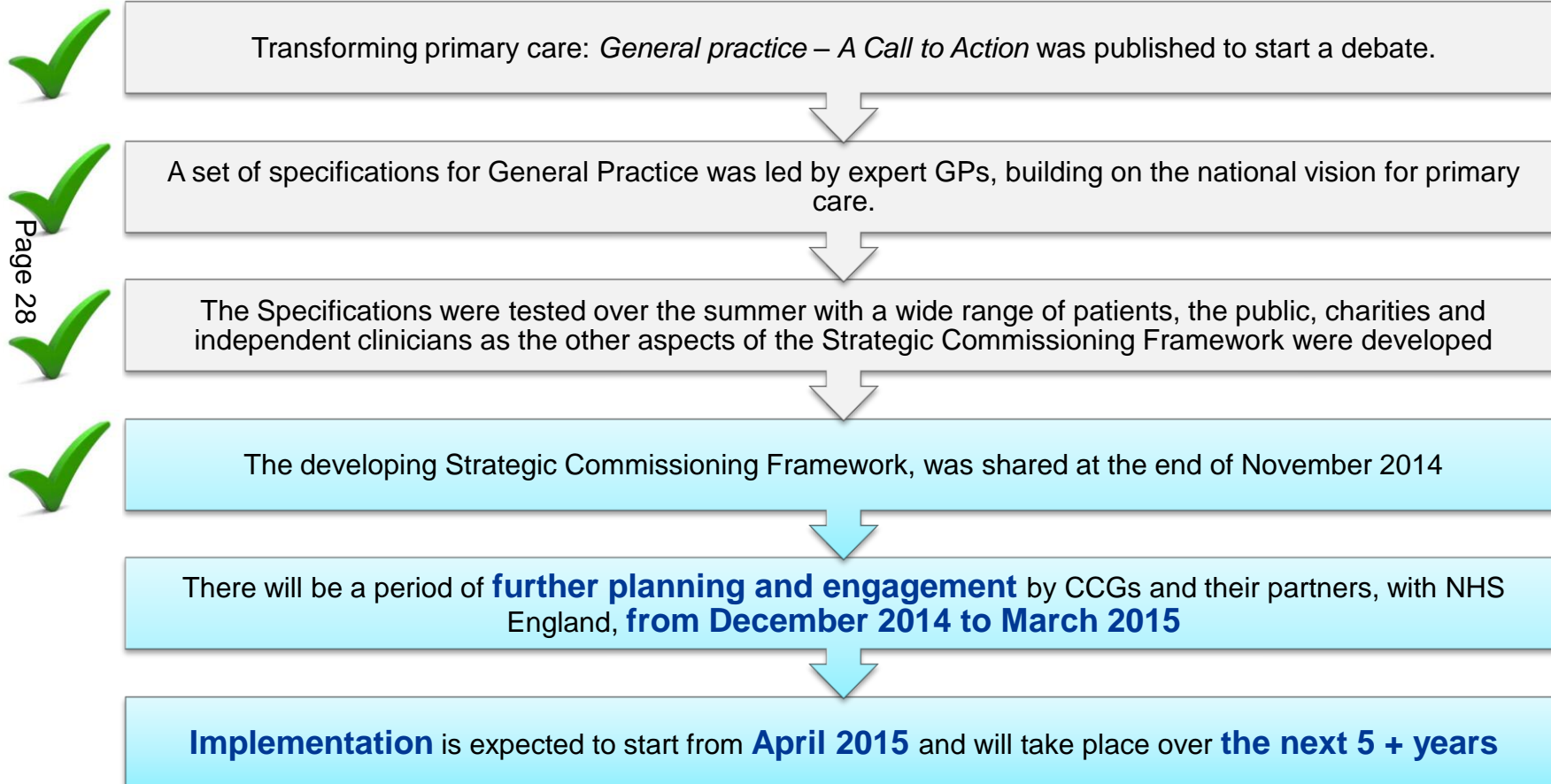
- This area outlines the importance of supporting providers to deliver the specifications and some of the potential areas for development

Monitoring and Evaluation

- This area outlines ways in which tools (largely already existing) can be used to support faster adoption of best practice, as well as for commissioner assurance

Next Steps

The next stage of engagement has begun, and is expected to continue until April 2015. This document will be refreshed and reissued at the end of that period.



HEALTH AND WELLBEING BOARD

10 FEBRUARY 2015

Title: Health and Wellbeing Outcomes Framework Performance Report – Quarter 3 (2014/15)	
Report of the Director of Public Health	
Open Report	For Decision
Wards Affected: ALL	Key Decision: NO
Report Author: Remi Omotoye, Head of Health Intelligence Mark Tyrie, Senior Public Health Analyst	Contact Details: Tel: 0208 227 5907 Email: remi.omotoye@lbbd.gov.uk Tel: 020 8227 3914 Email: mark.tyrie@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	
Summary: As with previous performance reports, the Quarter 3 report shows that significant performance issues remain in A&E, referral to treatment time and on the cancer pathway. Unplanned admissions for ambulatory care sensitive conditions are also highlighted as an area of poor performance. The latest performance figures are reported in the following areas - number of four week smoking quitters, number of NHS Health Check received, proportion of eligible population screened for breast/cervical cancer, statistics on the delayed transfers of care and number of positive Chlamydia screening tests. Published reports from the Care Quality Commission (CQC) inspections for the quarter is summarised for the information of the Board.	
Recommendation(s) Members of the Board are recommended to: <ul style="list-style-type: none"> • Review the overarching dashboard, and raise any questions with lead officers, lead agencies or the chairs of subgroups as Board members see fit. • Note the further detail provided on specific indicators, and to raise any further questions on remedial actions or actions being taken to sustain good performance. • Note the areas where new data is available, specifically the A&E survey, smoking quitters, Chlamydia screening and NHS Health Check. 	

Reason(s)

The indicators within the dashboard were chosen to represent the wide remit of the Board, and to remain manageable. It is important, therefore, that Board members use this opportunity to review key areas of Board business and confirm that effective delivery of services and programmes is taking place. Subgroups are undertaking further monitoring across the wider range of indicators in the Health and Wellbeing Outcomes Framework and, when areas of concern arise outside of the indicators ordinarily reported to the Board, these will be escalated as necessary.

1. Background/introduction

- 1.1.** The Health and Wellbeing Board has a wide remit, and it is therefore important to ensure that the Board has an overview across this breadth of activity.
- 1.2.** A number of significant issues the Board may wish to discuss are the performance against target for:
 - A&E survey
 - Referral to Treatment times
 - Ambulance conveyances
 - NHS Health Check
 - Four week smoking quitters
 - Delayed transfers of care/discharges
- 1.3.** The indicators contained within the report have been rated according to their performance, measured against targets and national and regional averages, with red indicating poor performance, green indicating good performance and amber showing that performance is similar to expected levels.

2. Overview of performance in Quarter 3

- 2.1.** **Appendix A** contains a dashboard summary of performance in Quarter 3 2014/15 against the indicators selected for the Board in July 2014.

3. Data availability and timeliness of indicators chosen

As mentioned in previous reports, there continues to be substantial gaps in monitoring information due to indicators being on annual cycles or having significant delays in the data becoming available. Difficulties remain in data flows to Public Health from parts of the NHS. However, issues are close to being resolved, particularly in relation to access to Hospital Episodes Statistics data.

4. Public Health – highlighted areas Areas of concern

- 4.1.** Appendix B contains detailed sheets for areas of concerning performance highlighted this quarter, as below.
- 4.2.** There are a number of areas where Barking and Dagenham are performing poorly in comparison to national and regional figures that have been reported on in previous performance reports; however, as data for these

indicators are either annual or not due for release this quarter, a further update is not given. These areas include childhood obesity, cancer screening and childhood immunisations. Although updates are not given they still remain priority areas.

4.3. Indicator 8: Number of positive Chlamydia screening tests

Quarter 3 has seen the numbers of positive Chlamydia screenings fall further below target. The monthly target of 49 positives was not met in any of the months, with December alone only achieving 38 positives.

Performance has been below target for this indicator over the course of the financial year but work has been done with the provider (Terrence Higgins Trust) to address the shortfall in performance and also to ensure that Chlamydia testing will be part of the new Integrated Sexual Health procurement. Targets have also been adjusted to a more realistic and attainable figure.

The new Health Services Liaison Officer for Barking and Dagenham has been contacting all GPs and pharmacies in order to promote and publicise the Chlamydia testing and results service. The aim is to increase Chlamydia screening activity and we will be following up all the practices and pharmacies visited monthly to monitor and assess the impact and effectiveness of the training. Additionally, large group joined up training sessions on Chlamydia testing and c-card are run for pharmacies covering pharmacists and counter staff across the rest of the year, this started in Q2 2014/145.

4.4. Indicator 9: Four week smoking quitters

Performance was below target for quarter 3, with 111 successful quitters against the minimum target of 175 quitters. This target is based on 35% of the targeted number of 2,000 service users successfully quitting. After three quarters of the year, the service has seen 117 fewer quitters than the minimum target.

The rate of smoking related deaths has reduced from 404.3 per 100,000 population aged 35 and over in 2009-11 to 386.0 per 100,000 in 2010-12, but remains significantly worse than the England average (291.9 per 100,000).

GP practices have been commissioned to send letters to registered patients who are smokers and not in any smoking cessation programme to encourage them to take up the service; this may increase activity and help to increase the numbers of quitters. A meeting was held with the Stop Smoking Champion from Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT). Several activities are being undertaken to improve referral rates from the acute trust. These include in-depth work with wards and supporting staff to ask patients about their smoking status as well as working to introduce the BabyClear accredited smoking programme for pregnant women. We are also looking at with BHRUT 'Stop before the Op'.

4.5. Indicator 21: Emergency admissions for ambulatory care sensitive conditions

Barking and Dagenham's rate increased over the last three years to 2012/13 but has decreased in 2013/14 to 1,035.4 per 100,000 population; however, this remains significantly higher than both the national and regional averages of 780.9 and 734.6 per 100,000 population, respectively.

Areas of improvement

4.6. Indicator 11: NHS Health Check Received

Quarters 2 and 3 of 2014/15 have seen an upturn in performance, with uptake increased from Quarter 1's level of 2.4% (807) to 3.8% (1,354) and 4.1% (1,505) respectively. The work that is currently being undertaken is aiming to maintain these improvements and, if successful, the yearly target will be met if Quarter 4 has as many health checks as Quarter 3. Quarter 3 figures compare favourably with the equivalent quarters in the previous year and to national and regional averages.

There does, however, remain to be large inequalities in delivery levels across the borough's GP practices. An action plan has been agreed and visits to poorly performing practices continuing with a quality audit planned. Individual Practice performance data is being communicated to all practices on a monthly basis with recommendations on number of weekly health check events required to reach their individual targets. Point of Care Testing (POCT) pilot is being rolled out with 23 surgeries participating initially. Barking and Dagenham have been included in a national pilot to improve the quality of the health check programme at a local level. Discussions are also taking place with regards to cross referral from GP to Pharmacy.

5. CQC Inspections in Quarter 3 2014/15

5.1. Appendix C contains an overview of overview of investigation reports published during the period on providers in the London Borough of Barking and Dagenham, or who provide services to residents in the borough.

During this period, 10 reports were published on local organisations. Of these, 2 did not meet all the required standards set by CQC. The following list outlines the organisations that were inspected:

- Florence Ojuolape Bello
- Reline Care Ltd
- Look Ahead Care and Support Limited
- Chosen Services UK Limited
- Abbeyfield East London Extra Care Society
- Millicent Preston House
- Abbey Care Home Limited
- Dr MF Haq & Partners
- Chinite Resourcing Limited
- Chase View Residential and Nursing Home

The two which did not meet required standards are Chaseview Residential and Nursing home (met 4 out of 5 standards) and The Abbeyfield East London Extra Care Society Limited (met 3 out of 5 standards).

5.2. Abbeyfield East London Extra Care Society – George Brooker House

George Brooker failed 2 of the 5 requirements after an inspection on 21 July 2014 which was triggered by an anonymous complaint to CQC regarding infection control.

This is a 44 bed home with 21 LBBB residents.

The following requirements failed the inspection:

- ‘Caring for people safely and protecting them from harm’, in particular:
 - People should be cared for in a clean environment and protected from the risk of infection
 - People should be protected from abuse and staff should respect their human rights (outcome 7)
- ‘Quality & suitability of management’

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

There was an outbreak of scabies in May 2014 which was not managed effectively for both residents and staff. This is also related to the way management dealt with the control of the spread of scabies amongst staff and residents including the lack of information available. The home was closed during the outbreak; however this should have been done sooner.

The Council have increased Quality Assurance visits since this outbreak to ensure that the CQC actions are being rigorously followed. The staff in the home have had additional training around infection control and maintaining standards of hygiene. We have also reviewed our clients in the home to ensure they are safe. Overall residents have said they have a good quality of life, had a good relationship with the staff and did not feel unsafe at the home.

CQC inspected George Brooker on Monday 26 January 2015 and the Council are awaiting the draft report. Under the new inspection regime which was implemented in October 2014 a group of 6 CQC representatives visited the home, this consisted of 1 Lead Inspector and 5 Specialist Advisors. A group this large has now become normal practice for inspections as it is felt specialist in different fields attending give the opportunity for a more thorough and in depth inspection result.

5.3 Chase View Residential Home

CQC last inspected Chase View in August 2014 (published December 2014)

This home failed 1 of 5 requirements ‘caring for people safely and protecting them from harm’ which related to medicine being given safely, an enforcement action by CQC was placed on the home.

During 2014 there were a number of serious concerns raised including the maintenance and use of equipment. Quality Assurance carried out a number of monitoring visits working with the home management team providing support and advice to meet all CQC requirements. However on 28 July 2014 LBBB took the decision and put an embargo in place and stop placing people in the home as the home management team had failed to implement the improvements required.

An action plan was put in place and Safeguarding Officers closely monitored to ensure that the home were working to the plan and also fulfilling the requirements for CQC.

The embargo was lifted on 9 December as the home had met the requirements of the LBBB action plan; however there is no set date for CQC to inspect the home at present.

Quality Assurance carried out an unannounced monitoring visit in December. This was prompted by concerns raised by the BHRUT End of Life care coordinator regarding the ability of nurses at the home to administer drugs for end of life care. The nursing staff at the home are receiving ongoing training and being supported by the Palliative Care Nurse to put their training into practice, this is also being monitored to ensure good practice by the PCN.

The current manager is leaving at the end of January and the replacement started 2 February. The Council's Quality Assurance team will continue to robustly monitor the home including unannounced visits.

6. Urgent Care Board

National focus is on addressing the unprecedented pressures on A&E services across the country. We, together with our partners, have a comprehensive system wide plan for addressing the pressures in our local A&E department. This is a rapidly changing context here in Barking and Dagenham and the Accountable Officer for NHS Barking and Dagenham CCG and the Corporate Director of Adult and Community Services may wish to verbally update the Board on the current state of play on performance of our local NHS Trust. In January draft guidelines were issued by National Institute for Health and Care Excellence (NICE) aimed at ensuring safe care, outline nurse staffing requirements for consultant led major A&E departments across England. This sets out that hospitals should ensure that they meet minimum nurse to patient ratios in accident and emergency departments.

Appendix D contains detailed information from the Urgent Care Board Dashboard on initiative including the BHRUT Improvement Plan and the operational resilience schemes.

6.1. A&E waiting times

The number of delays faced by ambulances when they arrive at A&E has doubled in the last year according to NHS England figures. There were also rises in delayed discharges and cancelled operations in the past month, compared to a year ago.

Meanwhile, new A&E waiting time figures show performance against the four-hour target has worsened in the New Year. The last three months of 2014 also saw the

worst wait figures for a decade.

BHRUT is performing below the national average for 2014/15 Quarter 3, with 80.5% seen in less than four hours compared to 92.6% in England. Barts Health NHS Trust is performing better than BHRUT, with 89.8% with less than four hours between arrival to admission, transfer or discharge.

6.2. A & E Performance

Below national standard and recovery trajectory

BHRUT December performance (all types) continued below the 95% national standard at 76.8%. This is a decrease of 5.6 percentage points from the November performance of 82.4%. King George Hospital (KGH) December performance deteriorated to 82.8%, from 84.9% in November. Queens Hospital's (QH) performance dropped the most from 80.7% in November to 72.7% in December.

BHRUT overall December performance was below the recovery trajectory as was the case in November. However, at site level, KGH performance was above 90% and above the 95% national standard on more days than in November. 6 days were above the 90% mark as compared to 5 in November and of these, 3 days were above national standard compared to 2 in November.

The Trust-wide year to date position fell to 83.9% from 84.7% in November. KGH fell from 91.7% to 90.9%, while Queens' improving trend reversed with performance decreasing from 79.9% to 79.2%. The most recent data (week ending 4 January 2015) reports BHRUT All Type performance at 72.2%. This is below the recovery plan trajectory of 89.8%. KGH and QH reported 80.5% and 66.6% respectively.

6.3. A&E Attendances (BHR CCGs)

Activity has decreased between October and November and is below plan for the year to date

Total A&E attendances decreased marginally by 5 patients (0.03%) between October and November for BHR CCG patients. Barking and Dagenham CCG at 2.6% recorded the largest decrease in activity, followed by Redbridge CCG at a 0.7% reduction. Havering CCG reported an increase in activity between the two months, at 2.5%. A&E attendances for all BHR CCGs was above plan for the month.

For the year to date (April to November 2014) A&E attendances for BHR CCGs at BHRUT were 52 attendances (0.04%) below plan. Barking and Dagenham CCG attendances were 1.7% below plan. Havering CCG's attendances were 1.0% above plan, and Redbridge CCG's attendances are now 0.3% above plan.

6.4. Overall BHRUT Attendances

Marginal decrease between November and December, and overall increase 2013 to 2014

Overall A&E attendances (all types) at BHRUT decreased by 0.1% between November and December. BHRUT total attendances however increased by 6.9% for the year to December 2014 when compared with the same period in 2013.

Comparing Quarter 2 and Quarter 3 in the financial year 2014/15 (July to September and October to December), demonstrates an increase in total attendances from 62,902 to 66,711 (6.1%). Current 12 months rolling average has increased from the 4,897 figure reported last month to 4,932 per week.

The attendance to admissions ratio deteriorated between November and December at both sites. Queens' range of admission ratios varied between 22.5% and 24.5% in November, to 22.9% -28.5% in December. KGH's range increased from 22.1% - 24.9% in November, to 25.4% - 30.2% in December. The actual volume of non-elective admissions in the same period increased by 1.2% (53 admissions).

6.5 Accident and Emergency survey 2014

Background

A&E is one of the eight core services that CQC inspects and rates in acute hospitals. Patients' experiences of care are a key aspect in determining these ratings. The national findings are presented under the questions Inspectors ask about A&E departments - Are they safe, Caring, Effective and Responsive to people's Needs.

The 2014 A&E survey involved patients who had attended one of 142 acute and specialist NHS trusts with a major accident and emergency department. Patients visited A&E during January, February or March 2014.

Responses were received from 39,320 people and the national response rate for the survey was 34%. In 2012 the response rate was 38%. Patients were eligible to take part in the survey if they were aged 16 years or older and were not staying in hospital at the time the patients were sampled. The findings demonstrate that departments are largely caring; however, more work needs to be done so that services are safer, more effective and more responsive to peoples needs.

In the same survey, people were asked to answer questions about different aspects of their care and treatment. Based on their responses, each NHS Trust was given a score out of 10 for each question (the higher the score the better). Questionnaires were sent to 850 people who had attended an NHS accident and emergency department (A&E) during January, February or March 2014. Responses were received from 239 patients at BHRUT.

Summary:

Feedback from the survey indicate that BHRUT are performing worse than other Trusts nationally in 7 of 8 of the sections in the questionnaire (see table below):

Patient survey section	Patient response	Compared with other trusts
Arrival at A&E	6.8/10	Worse
Waiting times	5.2/10	Worse
Doctors and Nurses (answered by those who saw a doctor or a nurse)	7.5/10	Worse
Care and Treatment	7.0/10	Worse
Tests (answered by those who had tests only)	7.7/10	Worse
Hospital environments and facilities	8.0/10	About the same
Leaving A&E (answered by those who were not admitted to hospital or to a nursing home only)	5.1/10	Worse
Experience overall	7.7/10	Worse

More information regarding the responses to specific questions which were asked can be found here: <http://www.cqc.org.uk/provider/RF4/survey/4#undefined>.

7. Referral to Treatment

7.1. Ambulance Conveyances – November to December decrease

London Ambulance Service has struggled to meet performance targets in 2014 and during January 2015. It has experienced increase in demand for its services and has a shortage of paramedics. The latest data covering November at the London level shows that the service only managed to respond to 64.3% of “red one calls” – the most serious – within 8 minutes against a target of 75%. This was the worst performance in the country.

The total number of ambulance conveyances to BHRUT fell to 5,071 during December compared to 5,240 in November.

Conveyances to Queens Hospital fell by 2.9% from November. Conveyances to King George Hospital decreased by 0.6% in the same period. Ambulance conveyances to Queens fell by 23.6% in the same period, from 233 in November to 178 in December. These reductions are in part driven by reduced green (from 111) conveyances following enhanced clinical triage.

Increase in dispatch time for ambulance response

The DH has set up a pilot scheme in two areas including the London Ambulance Service to put in place an increase the dispatch time for 999 call handlers from one minute to three minutes. This to give extra assessment time to ensure that ambulances more accurately deployed to where they are most needed.

The aim of the proposed change is to evaluate if there is any associated increase in operational efficiency through reducing the number of vehicles sent to each 999 call. Some evidence suggests that giving call handlers extra assessment time to make the right decision for the patient could improve clinical outcomes and improve

their chances of survival.

NHS England is considering a range of new measures to help address an increase in demand on ambulance services in the last two months.

7.2. Delayed Transfers of Care/Discharges – Increase reported between November and December

The national focus is to improve the flow of patients through hospital to alleviate pressures in A&E and to enable a more concerted effort to treat more elective patients. Consequently, delayed discharges of care/discharges receive a lot of attention and are an area of risk locally. There has been an increase from the weekly average of 18 DTOCs in November, to 23 in December.

A comparison of weekend discharges between November and December shows that:

- i) Average Saturday discharges increased from 105 in November to 116 in December.
- ii) While average Sunday discharges increased from 79 in November to 93 in December.
- iii) Monday to Friday average daily discharges are 168 in December 2014.
Rates for both total delayed transfers of care and the social care element of the “responsible” transfers of care are below national and regional averages.

Supporting out of hospital care during winter

The Department of Health allocated an additional £25m of grant funding to local authorities on 16 January, allocated according to the level of need in relation to delayed transfers of care attributable to social care. The Council received a share of this grant funding to address issues around DTOCs. An additional £12m was also allocated to all other local authorities not in the initial cohort to benefit from extra support through the winter.

The local authority has had undertake capacity mapping with residential and care homes and the voluntary sector to consider what extra capacity may be available to help move people out of hospital and into more appropriate settings. Further attention has also been drawn by the Department of Health to the continued use of best practice seen throughout the country.

7.3. BHR CCGs Non-Elective Admissions – decrease between October and November but above plan

Between October and November, non-elective admissions at BHRUT for BHR CCGs decreased by 50 (1.3%). There were decreases of 0.6% for Barking and Dagenham CCG, 1.8% for Havering CCG and 1.4% for Redbridge CCG when comparing the two months.

The November year to date (YTD) position of 29,331 non-elective admissions at BHRUT is below the plan of 29,819 by 488 (1.6%) for BHR CCGs. Over the financial year to date, Barking and Dagenham CCG is 3.4% below plan. Havering CCG has increased to 2.2% above plan from last month's YTD position of 1.9% above plan. Redbridge CCG is 5.5% below plan.

The rolling average number of non-elective admissions between April 2013 and March 2014 was 3,721 per month. The rolling average number of non elective admissions for the 12 months ending November 2014 is 3,405 per month. This represents a decrease of 316 or 0.7%.

In the current financial year the monthly rolling average is 3,666 for the period April to December 2014 this represents a decrease of 7 non-elective admissions (0.02%) per month when compared with the rolling average April to November 2013.

7.4. NHS 111 Service

The percentage of called answered within 60 seconds has continued to deteriorate during November ending 92.8% compared with 95% target. This trend was mirrored across London for the same period ending 91.7%.

8. Mental Health

Highlights of the performance of Mental Health services within Barking & Dagenham is detailed below. The Board should note that future Performance reports will include a simplified Mental Health dashboard.

8.1. Improving Access to Psychological Therapies (IAPT)

1,401 patients were referred for psychological therapies in Quarters 1 & 2 of 2014/15. Improvements were seen in the numbers of IAPT referrals who were waited more than 28 days from first contact to first treatment, with only 9 patients in Quarter 2 compared to 22 in Quarter 1. 421 people in Quarters 1 & 2 completed treatment and are moving to recovery.

8.2. Child and Adolescent Mental Health Services (CAMHS)

The CAMHS team had DNA rates that were higher than the target of 25% in both Quarters 1 & 2, with 25.3% and 27.2% respectively. 100% of staff have completed level one and two safeguarding training, while the all staff that do not currently have level three are scheduled to complete in Quarter 3. 100% of inpatients discharged from hospital received follow up within 7 days in Quarter 1 and Quarter 2.

8.3. Care Programme Approach

In Quarter 1, 1 out of 59 detained patients had an absence without leave episode. In Quarter 2 this was improved to 0 out of 80 patients detained under the Mental Health Act 1983. Quarter 3 was at 0 out of 63, a further improvement.

100% of those in treatment for suicide or self harm saw a reduction between their first months of treatment and their discharge from the service.

9. Mandatory implications

9.1. Joint Strategic Needs Assessment

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

9.2. Health and Wellbeing Strategy

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

9.3. Integration

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

9.4. Legal

There are no direct legal implications at this stage, but a robust and efficient system must be embedded.

9.5. Financial

There are no financial implications directly arising from this report.

10. List of Appendices:

Appendix A: Performance Dashboard

Appendix B: Detailed overviews for indicators highlighted in the report as being in need of improvement and detailed overviews for indicators highlighted in the report as performing particularly well.

Appendix C: Overview of CQC Inspections published in 2014/15 Quarter 3 on providers in the London Borough of Barking and Dagenham.

Appendix D: Urgent Care Board Performance Dashboard – 19/01/2015

Key

Appendix A: Indicators for HWBB - 2014/15 Q3

	Data unavailable due to reporting frequency or the performance indicator being new for the period
..	Data unavailable as not yet due to be released
	Data missing and requires updating
	Provisional end of year figure
DoT	The direction of travel, which has been colour coded to show whether performance has improved or worsened
NC	No colour applicable
PHOF	Public Health Outcomes Framework
ASCOF	Adult Social Care Outcomes Framework
HWBB OF	Health and Wellbeing Board Outcomes Framework
BCF	Better Care Fund

Title	2012/13	2013/14				2013/14	2014/15			DoT	RAG Rating	BENCHMARKING		HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3			England Average	London Average		
1 - Children															
Percentage of Uptake of Diphtheria, Tetanus and Pertussis (DTaP) Immunisation at 5 years old	85.5%	83.8%	85.4%	82.4%	82.4%	..	82.8%	83.3%	..	→	R	88.6%	77.3%	1	PHOF
Year end figures not yet published. Data is published each quarter but when the full year figures are published they adjust for errors in the quarterly data and comprise all the children immunised by the relevant birthday in the whole year. 2014/15 Q3 data is not yet published															
Percentage of Uptake of Measles, Mumps and Rubella (MMR2) Immunisation at 5 years old	85.0%	83.8%	85.5%	80.9%	81.7%	..	82.2%	82.2%	..	→	R	88.5%	79.9%	2	PHOF
Year end figures not yet published. 2014/15 Q3 data not yet published.															
Prevalence of children in reception year that are obese or overweight	25.9%					26.6%				↗	R	22.5%	23.2%	3	PHOF
Prevalence of children in year 6 that are obese or overweight	40.1%					42.4%				↗	R	33.5%	37.6%	4	PHOF
Number of children and young people accessing Tier 3/4 CAMHS services	879	592	627	589	596	1,053	528	546	635	↘	NC			5	HWBB OF
Year end figure is the number of unique people accessing CAMHS over the course of the year.															
Annual health check Looked After Children	71.2%	62.9%	69.2%	86.0%	93.4%	93.4%	84.2%	78.4%	74.8%*	↘	A	84.3%	88.1%	6	HWBB OF
* Up to end of November															
2 - Adolescence															
Under 18 conception rate (per 1000) and percentage change against 1998 baseline.	33.1	47.1	38.2	..	..	..	..	..	..	↘	R	24.8	22.4	7	PHOF
Number of positive Chlamydia screening results	585	126	147	127	111	511	141	141	90*	↗	R			8	HWBB OF
* Up to end of November															
3 - Adults															
Number of four week smoking quitters	1480	431	325	233	185	1,174	141	156	111*	→	R			9	HWBB OF
* Please note that the most recent quarter is an incomplete figure and will be revised in the next HWBB report.															

Key

Appendix A: Indicators for HWBB - 2014/15 Q3

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Title	2012/13	2013/14				2013/14	2014/15			DoT	RAG Rating	BENCHMARKING		HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3			England Average	London Average		
Cervical Screening - Coverage of women aged 25 -64 years	69.4%					72.4%				↗	A	74.2%	70.3%	10	PHOF
Percentage of eligible women screened adequately within the previous 3.5 (25-49 year olds) or 5.5 (50-64 year olds) years on 31st March															
Percentage of eligible population that received a health check in last five years	10.0%	1.9%	3.5%	3.4%	2.6%	11.4%	2.4%	3.8%	4.1%	↗	A	2.2%	2.3%	11	PHOF
Please note that annual figures are a cumulative figure accounting for all four previous quarters.															
4 - Older Adults															
Breast Screening - Coverage of women aged 53-70 years	68.7%					71.2%				→	A	75.9%	68.9%	12	PHOF
Percentage of women whose last test was less than three years ago.															
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	879.1					696.8	240.8	425.3	614.9	↘	NC	668.4	463.9	13	BCF/ASCOF
Year end figure will represent the sum of the four quarter figures. Rate per 100,000 population															
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	91.5%					88.3%				↘	A	81.9%	87.8%	14	BCF/ASCOF
Injuries due to falls for people aged 65 and over	2,336.0					..				↘	A	2,011.0	2,242.0	15	BCF/PHOF
Directly age-sex standardised rate per 100,000 population over 65 years. Unable to calculate more recent figures due to lack of access to HES data.															
5 - Across the Lifecourse															
The percentage of people receiving care and support in the home via a direct payment	42.1%	61.3%	66.6%	71.1%	73.4%	73.4%	74.7%	75.2%	76.2%	↗	G	62.1%	67.4%	16	ASCOF
Delayed transfers of care from hospital	3.0					5.5	4.2	4.7	5.4	↘	A	9.7	6.9	17	ASCOF
Rate per 100,000 population (average per month)															
Delayed transfers due to social care	2.4	0.8	1.1	1.2	1.1	1.1	2.2	1.7	2.9	↗	G	3.1	2.3	18	ASCOF
Rate per 100,000 population (average per month)															

* Data from 2011/12

Key

Appendix A: Indicators for HWBB - 2014/15 Q3

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Title	2012/13	2013/14				2013/14	2014/15			DoT	RAG Rating	BENCHMARKING		HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3			England Average	London Average		
Emergency readmissions within 30 days of discharge from hospital	13.3%*	..	..	..	..	..	..	..	..	→	A	11.8%	11.8%	19	PHOF
Percentage of emergency admissions occurring within 30 days of the last, previous discharge after admission, Indirectly standardised rate - 2011/12 is most recent data and was published in March 2014.															
A&E attendances < 4 hours from arrival to admission, transfer or discharge (type all)	84.1%	88.9%	90.5%	88.4%	86.6%	88.8%	85.6%	86.4%	80.5%	↘	A	92.6%		20	HWBB OF
BHRUT Figure															
Emergency admissions for ambulatory care sensitive conditions	1193.9	1202.1	1163.2	1108.1	1058.7	1035.4*	..	..	..	↘	R	780.9	745.4	21	HWBB OF
DSR per 100,000 population, rolling 12 month average. i.e. 2013/14 Q4 is April 2013 - -March 2014. 2014/15 Q1 is not yet published. *figure is provisional.															

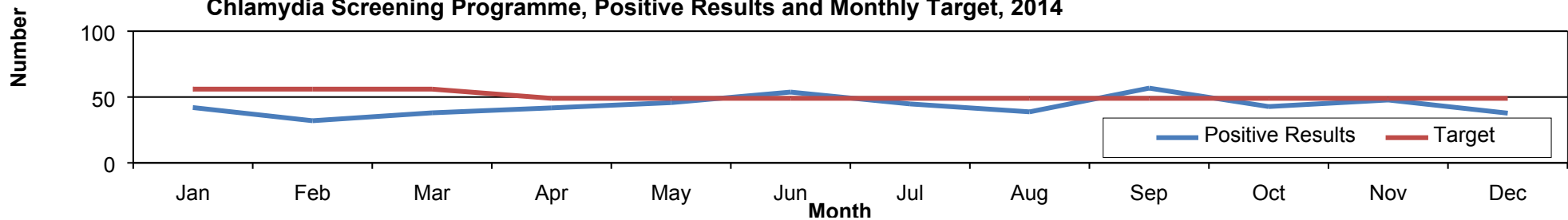
* Data from 2011/12

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Definition	Number of positive tests for Chlamydia.						How this indicator works	This indicator is reported monthly by the Terrence Higgins Trust, who provide numbers screened and testing positive for Chlamydia.					
What good looks like	The number of positive results to be greater than target levels on a monthly basis.						Why this indicator is important	Chlamydia is the most commonly diagnosed sexually transmitted bacterial infection among young people under the age of 25. The infection is often symptomless but if left untreated can lead to serious health problems including infertility in women.					
History with this indicator	2011/12: 587 positive results. 2012/13: 585 positive results (target of 726). 2013/14: 513 positive results (target of 726)												
	Jan-13	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	
Positive Results	42	32	38	42	46	54	45	39	57	43	47	38	
Target	56	56	56	49	49	49	49	49	49	49	49	49	
Quarterly	Quarter 4			Quarter 1			Quarter 2			Quarter 3			
	112/168			142/147			141/147			126/147			

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Chlamydia Screening Programme, Positive Results and Monthly Target, 2014



Performance Overview	Q1 and Q2 of 2014/15 saw improvements in the number of positive screenings, with uptake levels only six screens below the target for both quarters. The number of screens (57) recorded in September 2014 was the highest single monthly figure since June 2012. The monthly target has been met twice in 2014/15 (June and September). Quarter 3 has seen a downturn though, with 19 fewer positives than the quarterly target.	Actions to sustain or improve performance	The new Health Services Liaison Officer for Barking and Dagenham has been contacting all GPs and pharmacies in order to promote and publicise the Chlamydia testing and results service. The aim is to increase Chlamydia screening activity and we will be following up all the practices and pharmacies visited monthly to monitor and assess the impact and effectiveness of the training. Additionally, large group joined up training sessions on Chlamydia testing and c-card are run for pharmacies covering pharmacists and counter staff across the rest of the year, this started in Q2 2014/145.
RAG Rating			
Benchmarking	In 2013/14 Q3, Barking and Dagenham had a Chlamydia positivity rate of 2,137 per 100,000 people aged 15-24 years, Havering had a rate of 1,589, while Redbridge's was 1,206.		

Public Health Performance Indicators
Smoking – Four Week Smoking Quitters

January 2015

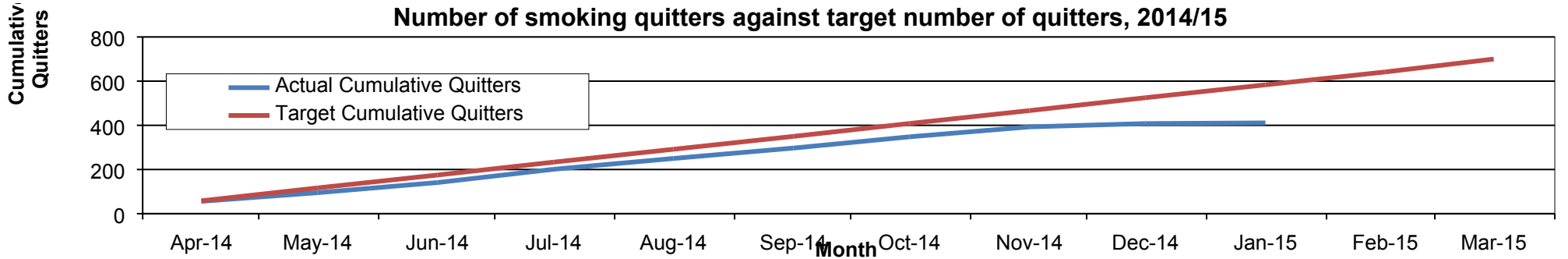
Source: Smoking Cessation Service Date: 01/15

Definition	Numerator – Number of smokers setting an agreed quit date and, when assessed, self-reporting as not having smoked in the previous two weeks. Denominator – Target number of self reported quitters per month		How this indicator works	This indicator is reported quarterly via the NHS Information Centre. A client is counted as a 'self-reported 4-week quitter' when assessed 4 weeks after the designated quit date, if they declare that they have not smoked in the past two weeks.
What good looks like	For the number of quitters to be as high as possible and to be above the target line.		Why this indicator is important	The data allows us to make performance comparisons with other areas and provides a broad overview of how well the borough is performing in terms of four week smoking quitters.
History with this indicator	2011/12: 1,500 quitters. 2012/13: 1,480 quitters. 2013/14: 1,174 quitters			
	Q1	Q2	Q3	Q4
Actual Quitters	141	156	111*	3*
Target Quitters	175	175	175	175

*Incomplete data

Number of smoking quitters against target number of quitters, 2014/15

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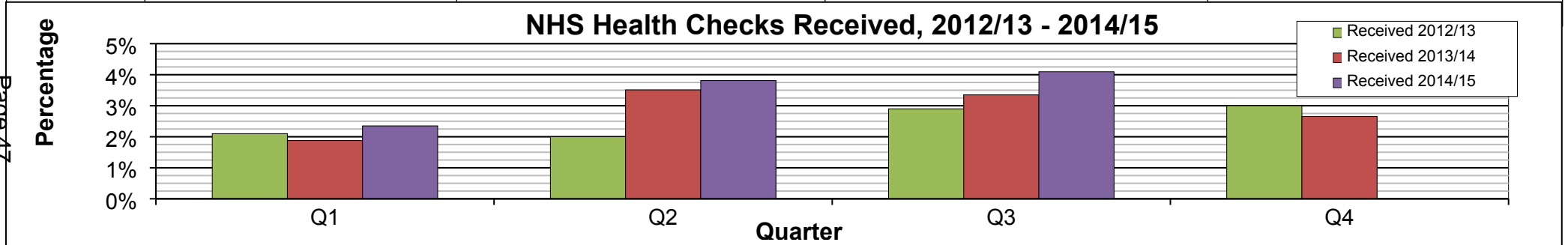


Performance Overview	Performance was below target for quarter one and quarter two, with 141 and 156 successful quitters respectively against the minimum target of 175 quitters. Quarter three data is currently provisional but it is on course to also be below target. This target is 35% of the targeted number of 2,000 service users quitting. Of those attempting to quit this year, 12 have been pregnant women, with 4 of those successful.	Actions to sustain or improve performance	GP practices have been commissioned to send letters to registered patients who are smokers and not in any smoking cessation programme to encourage them to take up the service; this may increase activity and help to increase the numbers of quitters. A meeting was held with the Stop Smoking Champion from BHRT. Several activities are being undertaken to improve referral rates from the acute trust. These include in-depth work with wards and supporting staff to ask patients about their smoking status. They are looking into 'Stop before the Op'.
RAG Rating			
Benchmarking	In 2013/14, there were 1,174 quitters against a target of 1,475. In Havering, there were 1,100 successful quitters; in Redbridge there were 876.		

Definition	Percentage of the eligible population (those between the ages of 40 and 74, who have not already been diagnosed with heart disease, stroke, diabetes, kidney disease and certain types of dementia) receiving an NHS Health Check in the relevant time period.	How this indicator works	Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions is invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and afterwards given support and advice to help them reduce or manage that risk. The national targets are 20% of eligible population should be offered a health check and 75% of those offered should receive a check.
What good looks like	For the received percentage to be as high as possible and to be above target.	Why this indicator is important	The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, and kidney disease. Health Checks has also been chosen as the Health Premiums Indicator.
History with this indicator	2011/12: 12.4% received 2012/13: 10.0% received 2013/14: 11.4% received		

	Q1	Q2	Q3	Q4
Received 13/14	1.9%	3.5%	3.4%	2.7%
Received 14/15	2.4%	3.8%	4.1%	

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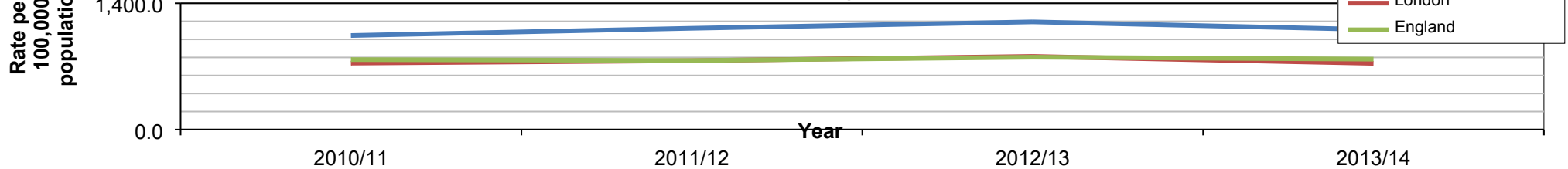


Performance Overview	Quarter 3 has seen a large increase in the percentage of the eligible population receiving health checks, with the quarterly target of 3.75% exceeded by 0.3 percentage points. This further builds on the large improvements seen in quarter 2.	Actions to sustain or improve performance	An action plan has been agreed and visits to poorly performing practices continuing with a quality audit planned. Individual Practice performance data is being communicated to all practices on a monthly basis with recommendations on number of weekly health check events required to reach their individual targets. Point of Care Testing (POCT) pilot is being rolled out with 23 surgeries participating initially. Barking and Dagenham have been included in a national pilot to improve the quality of the health check programme at a local level. Discussions are also taking place with regards to cross referral from GP to Pharmacy.
RAG Rating			
Benchmarking	In Havering, 1.8% of the eligible population received a health check in 2014/15 Q3; while in Redbridge, 3.4% of the eligible population received a health check.		

Definition	Directly age and sex standardised rate of unplanned hospitalisation admissions for chronic ambulatory care sensitive conditions, directly standardised rate (DSR) for all ages per 100,000 registered patients.	How this indicator works	The numerator is Continuous Inpatient Spells (CIPS). The CIP spells are constructed by the HSCIC HES Development team. The denominator is Unconstrained GP registered population counts by single year of age and sex from the NHAIS (Exeter) Systems; extracted annually on 1 April for the forthcoming financial year		
What good looks like	For the number per 100,000 population to be as low as possible, indicating that long term conditions are being effectively managed without the need for hospital admission.	Why this indicator is important	The indicator is intended to measure effective management and reduced serious deterioration in people with ACS conditions. Active management of ACS conditions such as COPD, diabetes, congestive heart failure and hypertension can prevent acute exacerbations and reduce the need for emergency hospital admission.		
History with this indicator	2010/11: 1,042.9 per 100,000 population 2011/12: 1,122.9 per 100,000 population 2012/13: 1,193.9 per 100,000 population				
	2010/11	2011/12	2012/13	2013/14	
B&D	1,042.9	1,122.9	1,193.9	1,035.4	
London	737.0	764.1	811.3	734.6	
England	775.9	765.8	802.8	780.9	

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Unplanned admission due to ambulatory care sensitive conditions



Performance Overview	Barking and Dagenham's rate increased over the last three years to 2012/13 but decreased in 2013/14 to 1,035.4 per 100,000 population. This remains significantly higher than both the national and regional averages.	Actions to sustain or improve performance	Recommended actions to improve on this indicator include: disease management and support for self-management, behavioural change programmes to encourage patient lifestyle change, increased continuity of care with GP, ensuring local, out-of-hours primary care arrangements are effective for those with acute exacerbations and ensuring there is easy access to urgent care without hospital admission unless clinically appropriate.
RAG Rating			
Benchmarking	London 2012/13: 811.3 England 2012/13: 802.8		

Provider Name	Location Name	Weblinks	Location Org Type	Report Date	Inspection Date	Result	Comments / Summary
Florence Ojuolape Bello	Turning Point House	http://www.cqc.org.uk/directory/1-112613265	Social Care Org	Inspection Report published 04 October 2014	01-Sep-14	All standards met	
Reline Care Ltd	Barking Enterprise Centre	http://www.cqc.org.uk/directory/1-777256040	Social Care Org	Inspection Report published 07 October 2014	04-Sep-14	All standards met	
Look Ahead Care and Support Limited	Look Ahead LD Supported Living Service	http://www.cqc.org.uk/directory/1-391946653	Social Care Org	Inspection Report published 09 October 2014	14-Aug-14	All standards met	
Chosen Services UK Limited	Chosen Services UK Limited	http://www.cqc.org.uk/directory/1-228962162	Social Care Org	Inspection Report published 10 October 2014	11-Sep-14	All standards met	
Abbeyfield East London Extra Care Society Limited	The Abbeyfield East London Extra Care Society Limited	http://www.cqc.org.uk/directory/1-112951275	Social Care Org	Inspection Report published 11 October 2014	21-Jul-14	3 out of 5 standards met	<p>Action needed:</p> <ul style="list-style-type: none"> - Safeguarding people who use services from abuse - Cleanliness and infection control - Assessing and monitoring the quality of service provision <p>There were sixty staff working in the home, however two thirds had not completed safeguarding training. This meant staff were unable to identify the different types of abuse and respond appropriately to safeguarding concerns.</p> <p>It was also noted that two thirds had not completed infection control training. Staff were unable to identify the different types of infection and respond appropriately to infection control precautions to minimise cross-infection.</p> <p>The provider carried out an annual satisfaction survey but did not evaluate the responses. The provider did not have procedures in place to assess and monitor the quality of service provided to people living in George Brooker House. This meant there were no means of assessing the quality of the service provided.</p>
London Borough of Barking & Dagenham	Millicent Preston House	http://www.cqc.org.uk/directory/1-454801572	Social Care Org	Inspection Report published 21 October 2014	22-Sep-14	All standards met	
Abbey Care Home Limited	Abbey Care Home	http://www.cqc.org.uk/directory/1-362678647	Social Care Org	Inspection Report published 30	28-Aug-14	All standards met	

Provider Name	Location Name	Weblinks	Location Org Type	Report Date	Inspection Date	Result	Comments / Summary
Dr MF Haq & Partners	Dr MF Haq's Practice	http://www.cqc.org.uk/directory/1-543772087	Primary Medical Services	Inspection Report published 06 November 2014	16-Sep-14	All standards met	
Chinite Resourcing Limited	Chinite Resourcing Limited	http://www.cqc.org.uk/directory/1-326243330	Social Care Org	Inspection Report published 04 November 2014	21-Jul-14	All standards met	
Bupa Care Homes (CFHCare) Limited	Chaseview Residential and Nursing Home	http://www.cqc.org.uk/directory/1-127503453	Social Care Org	Inspection Report published 05 December 2014	04-Aug-14 05-Aug-14 07-Aug-14 14-Aug-14	4 out of 5 standards met	<p>Enforcement action taken: Management of medicines</p> <p>Action needed: Safety, availability and suitability of equipment</p> <p>CQC have taken enforcement action against Chaseview Residential and Nursing Home to protect the health, safety and welfare of people using this service.</p> <p>There were a number of issues with medicine management which included unclear administration guidelines. In one of the units CQC found the clinical room had cupboards which were over full with dressings, creams and stock items. The shelving and storage units were in poor condition and the controlled medicines cabinet was full and cramped. This meant it was difficult for staff to locate items as needed and to ensure stock was rotated according to expiry dates. CQC also found a total of sixteen medicine issues which included not writing explanations for why medicines were not administered and not putting an opening date on liquid medicine.</p> <p>CQC also found from an audit check conducted by the contractor on 27/09/2013 and by the home on 28/07/2014 that some bed rail bumpers posed a health and safety risk because they were not using the correct types.</p>

Accident & Emergency	INDICATOR	SITE	14/09/2014	21/09/2014	28/09/2014	05/10/2014	12/10/2014	19/10/2014	26/10/2014	02/11/2014	09/11/2014	16/11/2014	23/11/2014	30/11/2014	07/12/2014	14/12/2014	21/12/2014	28/12/2014	04/01/2015	TREND	WEEKLY TRAJECTORY	MTD	YTD
			All Types	QH		78.11%	84.82%	77.79%	74.66%	74.65%	71.67%	75.18%	77.08%	80.36%	75.60%	80.52%	87.66%	76.64%	68.18%	72.81%	71.67%	66.55%	↑		70.18%	78.90%
KGH		98.64%		96.79%	92.58%	90.83%	92.68%	89.77%	89.62%	86.06%	82.90%	83.30%	85.82%	88.49%	86.47%	79.57%	81.88%	88.52%	80.48%	↑		83.92%	90.74%
BHRUT		85.74%		89.77%	83.72%	81.50%	81.97%	79.14%	81.08%	80.80%	77.18%	78.73%	82.71%	88.00%	80.60%	72.93%	79.29%	78.32%	72.24%	↑	89.80%		
Type 1	London		94.57%	94.60%	94.42%	94.20%	93.74%	92.64%	93.51%	93.13%	93.11%	92.94%	93.17%	92.87%	91.32%	89.73%	89.01%	91.24%	88.75%				
	QH		77.05%	84.23%	77.06%	73.50%	73.65%	70.60%	74.37%	76.25%	79.54%	74.46%	79.79%	87.57%	75.60%	66.84%	71.71%	71.10%	65.48%	↑		69.13%	78.08%
	KGH		97.99%	95.14%	92.15%	86.55%	89.24%	85.38%	84.96%	79.06%	74.48%	74.47%	78.13%	82.64%	78.12%	68.60%	72.68%	82.69%	69.59%	↑		75.32%	85.98%
	BHRUT		82.77%	87.81%	81.00%	77.98%	78.77%	75.49%	77.89%	77.18%	77.94%	74.46%	79.25%	86.01%	76.35%	67.40%	75.28%	74.38%	66.74%				
	London		91.26%	91.37%	91.07%	90.90%	89.86%	88.12%	89.62%	89.01%	88.89%	88.69%	89.03%	88.74%	86.21%	84.28%	81.98%	85.66%	81.71%				

WEEKLY INDICATORS	SITE	14/09/2014	21/09/2014	28/09/2014	05/10/2014	12/10/2014	19/10/2014	26/10/2014	02/11/2014	09/11/2014	16/11/2014	23/11/2014	30/11/2014	07/12/2014	14/12/2014	21/12/2014	28/12/2014	04/01/2015	TREND	YTD MEDIAN	TARGET	NOTES	
A&E Weekly Activity																				12 Month Rolling Avg			
A&E All Types Attendances including PELC Walk in Centre	QH	2805	2905	2999	2826	2931	3085	3026	2915	3050	3151	3168	3168	3193	3080	3098	2753	2765	↑	2948	2921		Data Source: Trust B2 Report. RAG based on YTD Median
	KGH	1949	2053	2007	2060	1995	2130	2091	2059	2000	2162	2221	2155	2150	2203	2246	1795	1911	↑	2055	1994		
	BHRUT	4754	4958	5006	4886	4926	5215	5117	4974	5050	5313	5389	5323	5343	5283	5344	4548	4676	↑	5006	4931		
UCC Attendances	QH	765	797	819	736	789	858	767	826	684	721	773	706	740	652	668	561	590	↓	788			Data Source: Trust PAG dashboard. RAG based on YTD Median
	KGH - PELC	698	696	624	655	638	666	648	693	660	748	781	755	843	827	822	738	727	↓	696			
	BHRUT	1463	1493	1443	1391	1427	1524	1415	1519	1344	1469	1554	1461	1583	1479	1490	1299	1317	↓	1493			

Ambulance Conveyances																							
Number of ambulance conveyances	QH	818	805	856	817	874	888	929	877	911	951	933	909	957	859	903	879	839	↓	874			Data Source: Trust PAG dashboard. RAG based on YTD Median
	KGH	257	290	294	318	326	310	333	326	313	334	366	290	307	328	368	292	356	↑	318			
	QH - Conveyed Directly to Urgent Care Centre	89	89	112	78	93	90	103	104	63	60	55	55	56	40	49	33	35	↓	102			

NHS 111 Service - PELC covering BHR CCGs & WF CCG																						
Referral Destination - Ambulance Dispatches	10.9%	12.3%	12.2%	12.9%	11.6%	9.6%	13.5%	13.3%	12.4%	11.4%	9.8%	9.1%	9.3%	9.6%	10.2%	9.1%	10.5%	↑	10.5%			Data Source: NHSE Weekly Sitrep Report
Referral Destination - Recommended to attend A&E	8.6%	8.0%	8.6%	9.0%	8.9%	8.6%	8.2%	8.5%	7.5%	9.0%	9.2%	9.1%	8.4%	9.0%	8.7%	7.1%	8.2%	↓	8.5%			
Referral Destination - Recommended to attend Primary Care	61.6%	60.0%	59.0%	57.5%	59.8%	60.6%	59.6%	59.9%	59.7%	59.8%	61.5%	61.5%	63.6%	62.4%	62.4%	64.0%	62.4%	↓	60.6%			
% calls answered within 60 seconds	98.3%	96.7%	98.8%	97.3%	98.6%	97.7%	95.1%	96.9%	97.1%	96.8%	94.7%	92.8%	91.3%	93.1%	92.4%	95.7%	96.4%	↑	96.4%	85%			RAG is based on Winter Period
LONDON - % calls answered within 60 seconds	98.4%	98.8%	98.1%	98.0%	98.1%	95.7%	96.9%	96.0%	97.8%	97.3%	93.6%	91.7%	92.1%	88.5%	89.0%	85.6%	93.2%	↑	95.7%	95%		

Community Treatment Team (CTT)																							
Referrals received vs plan	Community Hub	143	164	140	130	163	175	199	189	195	199	218	198	214	195	233	166		↑	147	97		Data Source: Trust Weekly CTT Dashboard. RAG based on Local Target
	Acute Hub	45	56	25	49	51	43	41	30	43	42	28	20	17	38	38	32		↑	46	32		
Referrals from LAS		17	22	13	20	31	22	24	21	18	29	20	19	12	10	22	22		↑	20			Data Source: Trust Weekly CTT Dashboard. RAG based on YTD Median
Barking and Dagenham	Community Hub	33	40	41	33	36	43	49	47	50	61	59	61	68	46	64	47		↑	41	26		Data Source: Trust Weekly CTT Dashboard. RAG based on Local Target.
	Acute Hub	6	10	5	8	16	11	8	9	7	6	4	1	5	7	6	6		↑	10	15		
Havering	Community Hub	83	91	86	73	98	96	115	112	109	95	110	103	107	122	112	86		↑	81	53		
	Acute Hub	30	37	17	36	21	28	26	13	28	18	15	11	27	24	22			↑	29	19		
Redbridge	Community Hub	24	30	12	23	29	36	34	30	33	42	49	33	38	27	53	30		↑	27	37		
	Acute Hub	7	6	2	2	12	2	2	4	4	3	3	3	0	3	7	2		↑	4	13		

MONTHLY INDICATORS	SITE	Sep-14	Oct-14	Nov-14	Dec-14	TREND	YTD MEDIAN	TARGET	NOTES
Activity (YTD)									
A&E / UCC Attendances (excluding KGH Type 3 attendances)	BHR CCGs @ BHRUT Total	96,772	113,794	130,811		↑		130,863	Data Source: SLAM flex data
	Barking & Dagenham CCG	30,356	35,862	41,224		↑		41,922	RAG Based on Local Target
	Havering CCG	40,131	46,947	53,936		↓		53,378	
	Redbridge CCG	26,285	30,985	35,651		↑		35,563	

Ambulance Conveyances									
Blue Light Activity as a percentage of all ambulance conveyances	Queens	10.0%	12.0%	11.2%		↑	10.1%		Data Source: LAS
	KGH	8.9%	8.6%	10.3%		↓	8.7%		RAG Based on YTD median
	London	10.3%	10.7%	11.4%		↓	9.8%		

Surge Schemes									
YTD TARGET									
Appointments Capacity	Barking and Dagenham	2882	2955			↓		3515	RAG Based on Local YTD Target
Appointments Booked		2363	2423			↓			RAG in development
Appointments Capacity	Havering	528	528			→		528	RAG Based on Local YTD Target
Appointments Booked		323	390			↑			RAG in development

QUARTERLY INDICATORS	SITE	2014-15 QUARTER 2				2014-15 QUARTER 3				TREND	YTD MEDIAN	TARGET	NOTES
Ambulance Conveyances from BHR Residential and Nursing Homes													
LAS call outs from nursing homes within BHR CCGs	Actual	1192											Data Source: LAS
	% change from corresponding quarter in previous year	25.9%								↓			
LAS conveyances from nursing homes within BHR CCGs	Actual	1093											Trend compared to same quarter in previous year.
	% change from corresponding quarter in previous year	30.6%								↓			

Ambulance Conveyances from Havering Residential and Nursing Homes													
Patients conveyed to ED via LAS	Actual	341											Data Source: LAS
	% change from corresponding quarter in previous year	16.0%								↓			

WEEKLY INDICATORS	SITE	14/09/2014	21/09/2014	28/09/2014	05/10/2014	12/10/2014	19/10/2014	26/10/2014	02/11/2014	09/11/2014	16/11/2014	23/11/2014	30/11/2014	07/12/2014	14/12/2014	21/12/2014	28/12/2014	04/01/2015	TREND	YTD MEDIAN	TARGET	NOTES			
																				YTD MEDIAN	TARGET				
Urgent Care Centre																									
Queens UCC Utilisation	QH	42.9%	43.7%	42.9%	40.3%	42.0%	44.7%	39.2%	45.0%	33.0%	33.7%	37.0%	33.6%	34.6%	29.9%	31.7%	30.2%	32.1%	↓	42.0%	45% - 50%	Data Source: Trust PAG dashboard. RAG Based on Local Target			
KGH PELC UCC Utilisation	KGH	35.8%	33.9%	31.1%	31.8%	32.0%	31.3%	31.0%	33.7%	33.0%	34.6%	35.2%	35.0%	39.2%	37.5%	36.6%	41.1%	38.0%	↓	35.4%		Data Source: Trust B2 Report. RAG is based on the YTD Median			
Activity																									
																				YTD MEDIAN	TARGET				
Non-Elective Admissions	BHRUT	879	994	1005	994	984	958	980	962	979	973	987	1021	1017	958	966	1025	893				Data Source: Trust Daily Sitrep. RAG Based on YTD Median			
Attendance to admission ratio	QH	26.3%	28.8%	30.1%	28.5%	23.9%	23.6%	24.0%	24.5%	24.3%	22.5%	23.2%	24.2%	23.5%	22.9%	22.9%	28.5%	24.4%	↓	23.9%		Data Source: Trust PAG dashboard.			
	KGH	26.6%	28.3%	27.5%	30.1%	21.9%	20.9%	21.7%	24.1%	22.7%	22.1%	23.8%	24.9%	27.6%	25.5%	25.4%	30.2%	29.9%	↓	24.1%		RAG Based on YTD Median			
Ambulance Handovers																									
																				YTD MEDIAN	TARGET				
Within 15mins	QH	36.3%	35.6%	37.2%	42.6%	34.7%	33.5%	31.5%	38.6%	37.8%	28.4%	34.1%	38.1%	31.9%	31.4%	36.0%	21.0%	21.0%	↓	35.8%	100%	Data Source: HAS Portal RAG based on LAS Target			
	KGH	38.3%	42.4%	41.4%	37.9%	38.5%	33.2%	40.5%	30.9%	28.9%	31.0%	33.8%	39.1%	32.3%	32.1%	39.6%	31.6%	25.3%	↓	39.3%					
London	46.2%	45.3%	45.2%	46.7%	45.1%	42.1%	44.7%	43.1%	44.1%	44.0%	44.3%	44.6%	42.0%	37.3%	48.2%	38.1%	35.0%	↓	48.1%						
Within 30mins	QH	91.8%	91.7%	91.5%	86.7%	85.0%	85.9%	85.6%	89.4%	89.7%	76.2%	86.6%	93.0%	81.7%	75.1%	89.0%	69.0%	62.8%	↓	89.5%					
	KGH	96.7%	96.7%	97.2%	97.2%	95.8%	97.8%	94.4%	95.5%	90.5%	93.4%	92.3%	96.4%	96.5%	91.3%	95.9%	90.2%	87.9%	↓	96.5%					
London	94.1%	93.2%	92.9%	93.1%	92.2%	91.6%	92.4%	91.2%	91.8%	90.4%	91.7%	92.2%	90.1%	85.6%	95.2%	86.7%	82.6%	↓	94.2%						
Assessment process & specialty response																									
																				YTD MEDIAN	TARGET				
Rapid Assessment & Treatment - Triage < 30 mins	QH	59.4%	60.2%	51.6%	59.1%	53.3%	48.8%	58.0%	56.2%	57.2%	52.0%	56.4%	48.6%	45.5%	42.8%	45.6%	47.0%	49.4%	↓	56.2%	95%	Data Source: Trust PAG dashboard RAG based on Local Target			
	KGH	88.7%	87.5%	84.1%	80.2%	83.4%	77.6%	80.4%	79.5%	70.1%	72.1%	75.8%	75.8%	76.1%	74.4%	67.0%	80.6%	78.6%	↑	83.4%	95%				
Seen by specialty team < 30min of request	QH	10.0%	12.2%	11.0%	11.7%	11.8%	10.1%	10.8%	11.6%	13.0%	10.4%	12.0%	14.3%	10.9%	11.2%	12.0%	10.5%	10.9%	↑	12.2%	80%				
	KGH	26.6%	22.5%	26.7%	23.5%	21.2%	25.9%	23.3%	16.6%	22.0%	19.5%	19.9%	21.2%	25.2%	17.4%	20.9%	25.6%	20.9%	↓	25.1%	80%				
Referred to specialty team < 2hrs of registration	QH	41.2%	42.3%	40.0%	42.9%	40.0%	39.8%	42.0%	39.1%	45.5%	44.1%	46.2%	45.0%	41.0%	39.3%	41.7%	40.0%	42.1%	↑	41.8%	80%				
	KGH	56.2%	54.1%	48.8%	48.1%	47.5%	45.7%	51.0%	49.6%	48.1%	48.3%	48.9%	49.8%	49.0%	44.8%	49.0%	53.9%	40.2%	↑	49.5%	80%				
Non-Elective Length of Stay																									
																				YTD MEDIAN	TARGET				
Non-Elective Length of Stay (days)	QH	6.0	6.1	6.8	6.7	6.5	7.2	6.3	6.4	5.9	6.1	6.5	5.5	5.1	6.9	6.7	6.1	5.8	↓	6.2	4.45	Data Source: Trust PAG dashboard			
	KGH	5.4	5.0	5.4	4.5	5.3	4.6	5.2	4.6	6.9	4.4	4.9	6.7	6.0	5.1	4.5	5.0	5.6	↑	5.1	4.45	RAG based on Local Target			
Longest Wait in ED																									
Longest Wait (minutes)	QH	1335	1460	1263	1534	1529	1615	1669	1284	1270	1376	1375	1048	1308	1730	1469	1671	1636	↑	1346		RAG based on YTD Median			
	KGH	1002	882	1216	1101	1522	1350	1268	1492	1357	1330	1279	1083	1277	1571	1391	1218	1434	↑	1218		RAG based on YTD Median			
MONTHLY INDICATORS																									
MONTHLY INDICATORS	SITE	Sep-14					Oct-14					Nov-14					Dec-14					TREND	CUMULATIVE ACTIVITY APR 13 - NOV 13	YTD TARGET	NOTES
Activity																									
Elective Admissions (YTD) (all 12 NELCSU CCGs)		3,513					4,217					4,917										↑		4,608	Data Source: SLAM flex data RAG based on Local Target Trend based on movement in % difference from contracted plan from the previous month.
Non-Elective Admissions (YTD)	BHR CCGs @ BHRUT Total	21,921					25,651					29,331										↑	29,391	29,819	
	Barking & Dagenham CCG	6,305					7,352					8,393										↓	8,228	8,685	
	Havering CCG	9,557					11,189					12,792										↓	12,088	12,516	
	Redbridge CCG	6,059					7,110					8,146										↓	8,125	8,618	

WEEKLY INDICATORS		SITE	14/09/2014	21/09/2014	28/09/2014	05/10/2014	12/10/2014	19/10/2014	26/10/2014	02/11/2014	09/11/2014	16/11/2014	23/11/2014	30/11/2014	07/12/2014	14/12/2014	21/12/2014	28/12/2014	04/01/2015	TREND	YTD MEDIAN	TARGET	NOTES
DTOCs & Discharges																							
Delayed Transfers of Care			25	35	16	17	8	8	17	18	12	10	25	26	26	17	23	26	22	↑	24.5	20	Data Source: Trust Weekly DTOC Report RAG: Less than 20 Green, 21-39 Amber, 40+ Red
Discharge: Referral & Assessment Process																							
																				YTD MEDIAN	TARGET		
Referrals to Assessment (days)	Foxglove	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	→	0	<1	Data Source: NELFT Weekly Astralos Report RAG: Less than 1 day Green, Greater than 1 day Amber
	Heronwood & Galleon	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	→	0	<1	
	Gray's Court	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	→	0	<1	
	IRS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	→	0	<1	
Assessment to Transfer (days)	Foxglove	1.25	0.75	0.4	0.2	1.6	0.78	1.33	1.11	1	0.67	1.13	0.83	1.38	1	0.44	1.5	2.5	↓	1.11	<2	Data Source: NELFT Weekly Astralos Report RAG: Between 0-2 days Green, between 2-3 days Amber and greater than 3 days Red	
	Heronwood & Galleon	1.43	1.33	1.83	1.75	0.67	0.56	1.14	2	0.50	2.50	0.88	1.6	1.5	1.5	0.5	1.67	0	↑	1.50	<2		
	Gray's Court	0.67	1	2.5	0.63	1	0.63	0.44	1.5	1.00	0.67	0.50	0.92	2	2	1.25	0.9	6	↓	1.38	<2		
	IRS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	→	0	<2		
BHR Intensive Rehab Service																							
																				YTD MEDIAN	TARGET		
New Referrals			22	15	31	18	32	24	24	34	34	52	34	38	40	36	42	10	26	↑	26.5	16	Data Source: Trust Weekly IRS Dashboard RAG Based on Local Target
% Stepdown from Acute Beds			68%	60%	55%	67%	50%	63%	54%	62%	85%	77%	72%	87%	73%	78%	69%	89%	77%	↓	72%		Data Source: Trust Weekly IRS Dashboard RAG Based on YTD Median
New Referrals	Barking & Dagenham CCG	4	4	6	2	5	9	9	7	8	14	11	7	13	13	8	1	5	↑	6	4	Data Source: Trust Weekly IRS Dashboard RAG Based on Local Target	
	Havering CCG	14	7	14	9	23	11	6	14	13	26	12	23	15	16	25	7	15	↑	11	7		
	Redbridge CCG	4	4	11	7	4	4	9	13	13	12	11	8	12	7	9	2	6	↑	7	5		
% Stepdown from Acute Beds	Barking & Dagenham CCG	100%	50%	83%	50%	40%	56%	56%	71%	100%	71%	82%	100%	77%	77%	88%	0%	80%	↑	77%		Data Source: Trust Weekly IRS Dashboard RAG Based on YTD Median	
	Havering CCG	50%	57%	43%	44%	48%	64%	67%	57%	69%	77%	57%	96%	67%	81%	64%	86%	80%	↓	75%			
	Redbridge CCG	100%	75%	55%	100%	75%	75%	44%	62%	92%	83%	82%	50%	75%	71%	67%	100%	67%	↓	73%			
7 day working: Elective and Non-Elective discharges (medical and surgical)																							
																				OCTOBER 2013 BASELINE			
Monday	Number of discharges	390	423	501	533	554	536	531	539	520	539	546	522	736	893	996	872	841	↑	598	15.7%	Each week's data is a total of the last 4 week period Data Source: Trust B2 report. Trend based on October baseline position.	
	% of discharges	11.4%	12.0%	13.6%	14.1%	14.5%	14.1%	14.2%	14.4%	13.8%	14.3%	14.3%	13.5%	15.3%	15.5%	16.9%	17.9%	18.2%					
Tuesday	Number of discharges	563	581	621	623	629	637	629	624	621	619	614	633	785	937	954	794	770	↑	612	16.1%		
	% of discharges	16.5%	16.5%	16.8%	16.4%	16.5%	16.8%	16.8%	16.6%	16.5%	16.5%	16.1%	16.4%	16.4%	16.3%	16.2%	16.3%	16.6%					
Wednesday	Number of discharges	583	614	665	668	684	651	601	593	623	642	650	665	791	928	933	768	828	↑	622	16.4%		
	% of discharges	17.1%	17.4%	18.0%	17.6%	18.0%	17.2%	16.1%	15.8%	16.5%	17.1%	17.1%	17.2%	16.5%	16.1%	15.9%	15.8%	17.9%					
Thursday	Number of discharges	536	561	552	573	570	573	602	614	653	634	657	666	781	957	948	776	652	↓	646	17.0%		
	% of discharges	15.7%	15.9%	15.0%	15.1%	15.0%	15.1%	16.1%	16.4%	17.3%	16.9%	17.3%	17.2%	16.3%	16.6%	16.1%	16.0%	14.1%					
Friday	Number of discharges	655	656	664	680	687	697	702	704	676	652	634	651	842	979	1001	808	710	↓	645	17.0%		
	% of discharges	19.2%	18.6%	18.0%	17.9%	18.0%	18.4%	18.8%	18.8%	17.9%	17.3%	16.7%	16.8%	17.6%	17.0%	17.0%	16.6%	15.3%					
Saturday	Number of discharges	374	385	389	389	381	392	375	392	391	401	406	419	505	590	592	467	444	↓	402	10.6%		
	% of discharges	11.0%	10.9%	10.5%	10.3%	10.0%	10.3%	10.0%	10.5%	10.4%	10.7%	10.7%	10.8%	10.5%	10.3%	10.1%	9.6%	9.6%					
Sunday	Number of discharges	314	308	296	327	305	306	294	283	285	273	298	314	355	467	459	373	386	↑	275	7.2%		
	% of discharges	9.2%	8.7%	8.0%	8.6%	8.0%	8.1%	7.9%	7.5%	7.6%	7.3%	7.8%	8.1%	7.4%	8.1%	7.8%	7.7%	8.3%					
Total	Number of discharges	3415	3528	3688	3793	3810	3792	3734	3749	3769	3760	3805	3870	4795	5751	5883	4858	4631	↓	3800			

Indicator	Site	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Target	Notes	
Prime Minister's Challenge Fund - Access Hubs																
Primary Care	Barking & Dagenham	Total no. of appointments commissioned (Planned)													13,645	Barking and Dagenham due to open November 2014
		Total no. of Patients Seen (Actual)														
		% of appointments utilised														
		No. of DNA's														
		Source of referral (%)														
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SCHEME	PERFORMANCE INDICATOR	Operational Implementation RAG (dates are week ending)			Operational Delivery RAG (dates are week ending)			Operational Delivery Actual (dates are week beginning)					OPERATIONAL DELIVERY										Notes					
		18/12/14	23/12/14	02/01/15	18/12/14	23/12/14	02/01/15	01/12/14	08/12/14	15/12/14	22/12/14	29/12/14	Oct-14		Nov-14		Dec-14		Jan-15		Feb-15		Mar-15		YTD			
													Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Variance	
JAD	Beds saved	Red	Red	Red	Green	Green	Green								14	19	15	19	15		15		15		29	38	9	<p>Green denotes there is no slippage in the timeline and is on target to deliver KPI's as set out in approved plan.</p> <p>Amber denotes there is a weeks slippage in the timeline but is on target to deliver KPI's as set out in approved plan.</p> <p>Red denotes there is more than a weeks slippage in the timeline and/or is off target to deliver KPI's as set out in approved plan.</p>
Enhanced Psychiatric Liaison	Beds saved				Green	Green								2	5	4	7	8		10		10		6	12	6		
CTT/IRS	Beds saved				Green	Green								6	8	8	7	12		12		12		14	15	1		
End of Life	Beds saved	Red	Red	Green		Green								1	0	3	5	6		6		6		4	5	1	<p>Delivery Phase - RAG rating definition</p>	
FOPAL	Beds saved				Red	Red	Red							8	5	13	8	13		15		15		21	13	-8		
LAS / CTT	Ambulance conveyances avoided				Red	Red	Red	17	14	16	11	23	101	48	126	47	126	81	26					379	176	-203	<p>Green denotes that the actuals are at or exceed the targets</p> <p>Amber denotes that the target has not been achieved, with the difference being less than 10%</p> <p>Red denotes that the target has not been achieved, with the difference being 10% or more</p>	
Community Pharmacy	Patients seen - risk of readmission				Red	Red	Red							30	0	50	7	50					80	7	-73			
Primary Care		Amber	Amber	Amber	Red	Red	Red																					

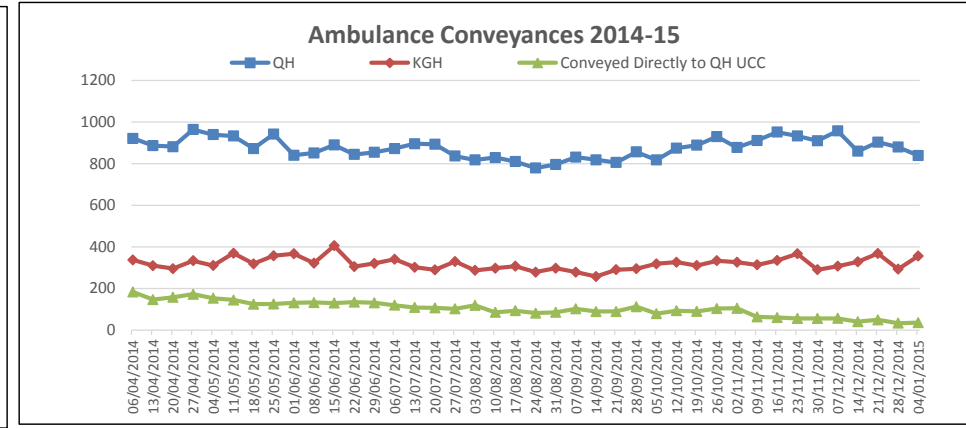
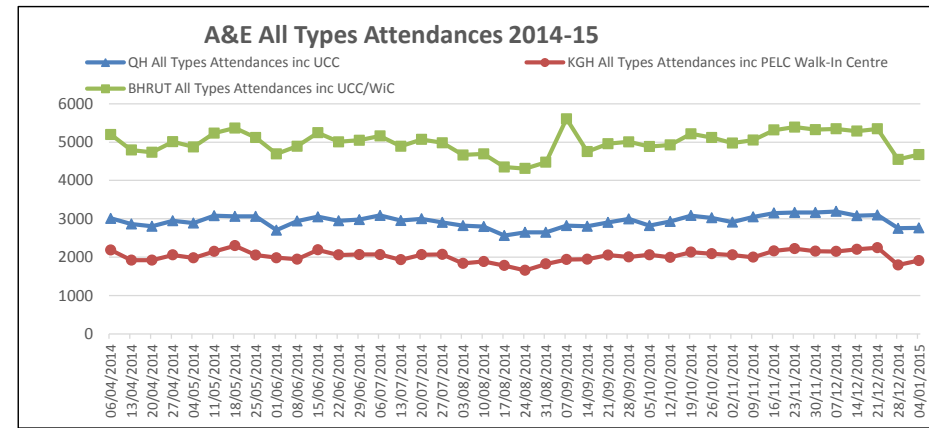
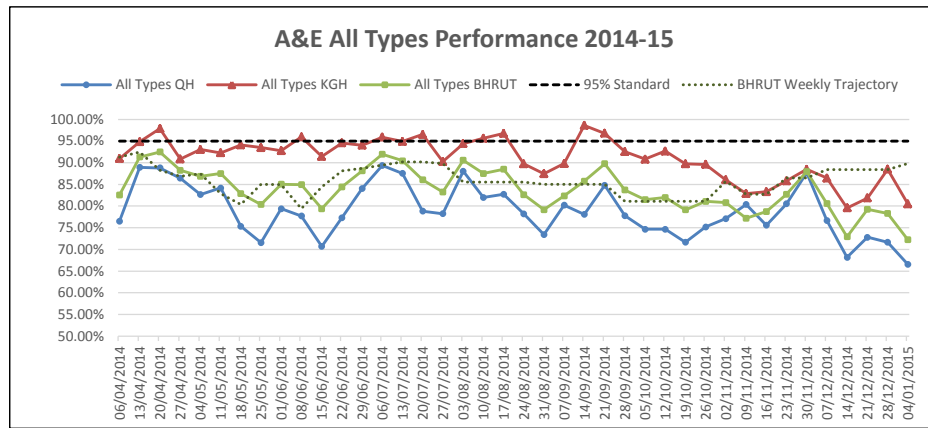
URGENT CARE EXECUTIVE DASHBOARD SUMMARY

Report Production Date: 15/01/2015

RAG Status: ████████

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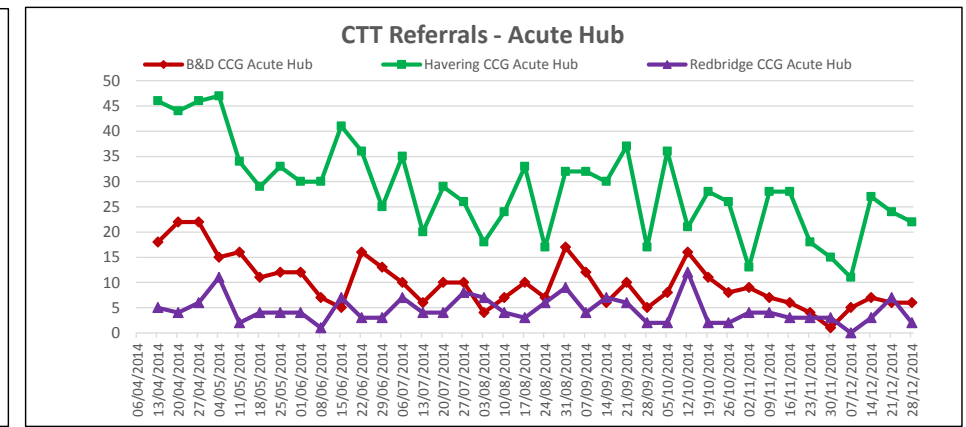
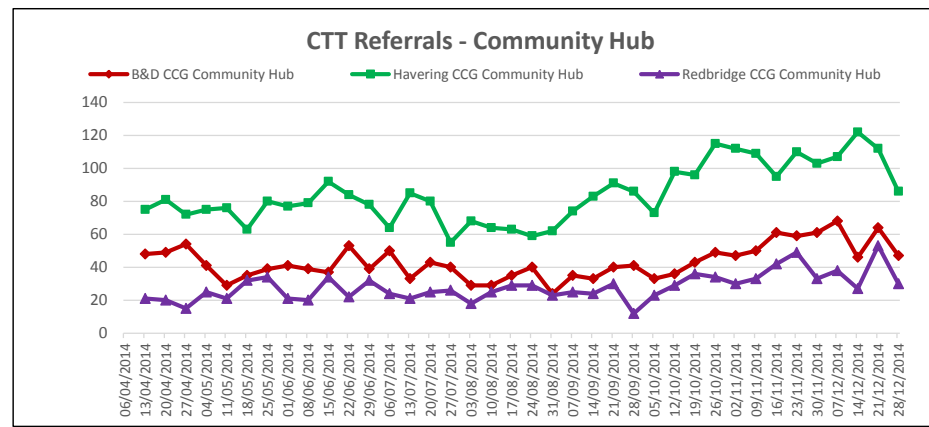
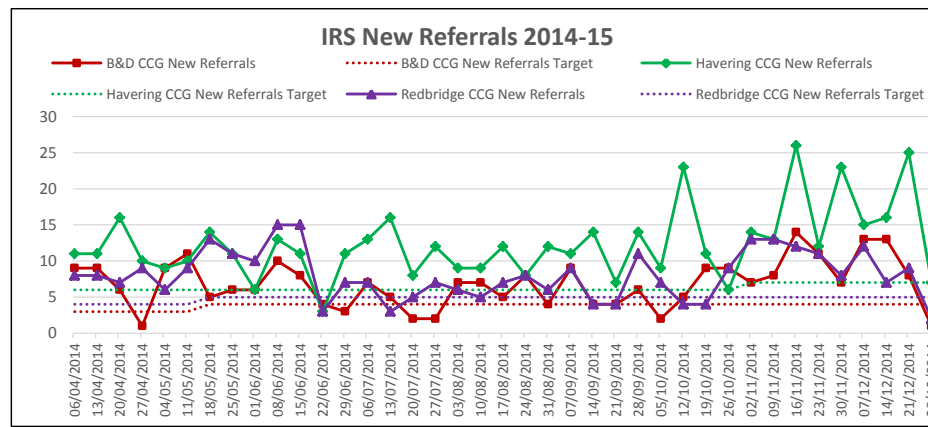
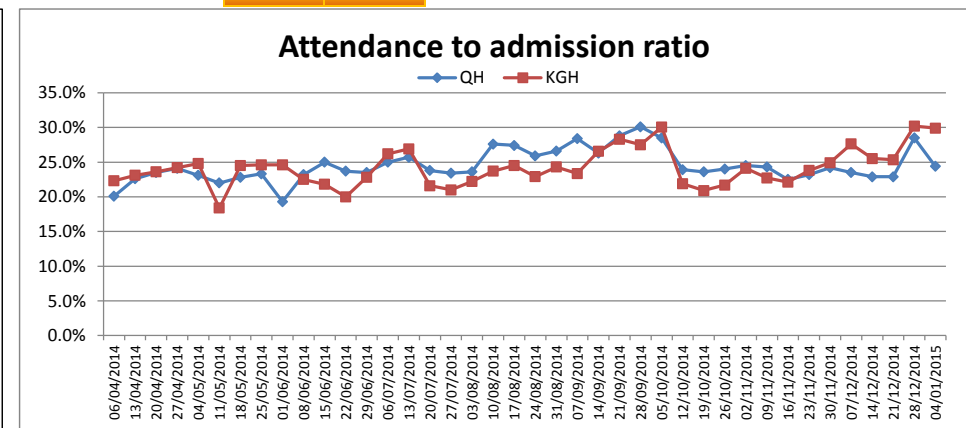
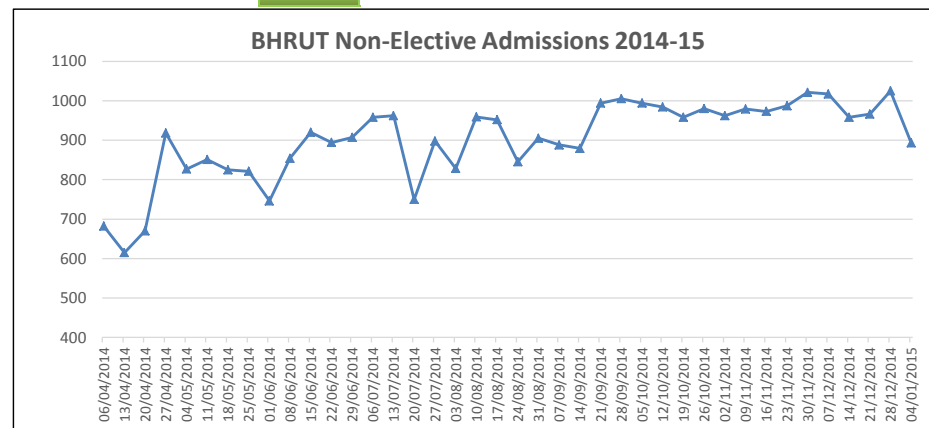
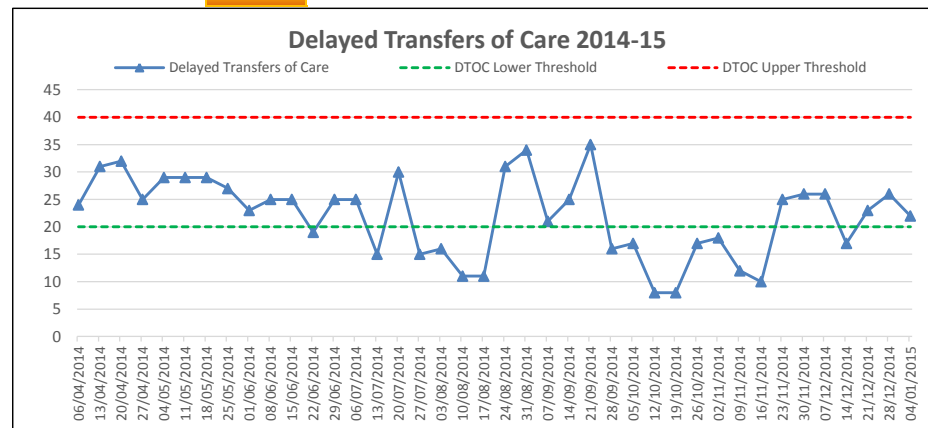
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Barking & Dagenham

Indicator	Current Month	Previous Month	YTD Median	Target	Trend
Current Month: Nov-14					
A&E / UCC Attendances	5362	5506	5270	5154	↑
Non-Elective Admissions	1041	1047	1050	1067	↑
Current Month: Nov-14					
IRS New Referrals	40	25	25	16	↑
CTT - Community Hub	217	161	164	104	↑
CTT - Acute Hub	26	43	42	60	↓

Havering

Indicator	Current Month	Previous Month	YTD Median	Target	Trend
Current Month: Nov-14					
A&E / UCC Attendances	6989	6816	6808	6563	↓
Non-Elective Admissions	1603	1632	1591	1539	↑
Current Month: Nov-14					
IRS New Referrals	65	49	49	28	↑
CTT - Community Hub	426	382	334	212	↑
CTT - Acute Hub	87	111	120	76	↓

Redbridge

Indicator	Current Month	Previous Month	YTD Median	Target	Trend
Current Month: Nov-14					
A&E / UCC Attendances	4666	4700	4537	4373	↑
Non-Elective Admissions	1036	1051	1037	1060	↑
Current Month: Nov-14					
IRS New Referrals	49	24	32	20	↑
CTT - Community Hub	154	122	115	158	↑
CTT - Acute Hub	14	18	19	52	↓

HEALTH AND WELLBEING BOARD

10 February 2015

Title:	NHS England London Commissioning Intentions for 2015/16		
Report of the Director of Public Health			
Open Report		For Decision	
Wards Affected: ALL		Key Decision: No	
Report Author: Joanne Murfitt Head of Public Health, Health in the Justice System and Military Health NHS England London Matthew Cole Director of Public Health		Contact Details: Tel: 011380 70686 Email: joanne.murfitt@nhs.net Tel: 0208 227 3657 Email: matthew.cole@lbbd.gov.uk	
Sponsor: Matthew Cole, Director of Public Health			
Summary:			
<p>The paper in Appendix 1 provides an update on progress on the implementation of the 2015/16 NHS England London commissioning plans. It describes where we are in terms of commissioning plans for the following programmes of care:</p> <ul style="list-style-type: none"> • Antenatal and new born screening • Early years and Child Health Information Systems • Immunisations • Cancer Screening Programmes • Adult Screening Programmes • Health in the Justice System services • Veterans Health 			
Recommendation(s)			
(i) The Health and Wellbeing Board is asked to note and comment on NHS England London commissioning intentions for 2015/16.			
(ii) The Health and Wellbeing Board is asked to agree the advice of the Director of Public Health that NHS England be asked to provide further information to the Board on the arrangements being put in place to improve performance in achieving the optimum uptake of immunisation programmes by the eligible population of Barking and Dagenham.			

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 population. Barking and Dagenham's Director of Public Health (DPH) has a duty to 'provide information and advice to every responsible person and relevant body within, or which exercises functions in relation to, the authority's area, with a view to promoting the preparation of appropriate local immunisation and screening arrangements'. In order to undertake this duty, and to provide appropriate advice as to the adequacy of local health protection arrangements, the DPH needs to be assured and satisfied that there are adequate health protection immunisation and screening plans in place in the Borough.

NHS Public Health Functions Agreement (Section 7A or s.7A) of the NHS Act 2006, as amended by the Health and Social Care Act 2012, outlines the specific responsibilities of NHS England for the commissioning of certain public health services as part of the wider system design to drive improvements in population health.

Where the Director of Public Health identifies issues it will be his or her role to highlight them, and escalate issues as necessary, providing advice, challenge and advocacy to protect the local population.

Appendices:**Appendix 1: NHS England London Commissioning Intentions for 2015/16**

NHS England London Commissioning Intentions for 2015/16

1. Introduction

NHS England (NHSE) is accountable for delivery of the national screening and immunisation programmes in accordance with an agreement between the Secretary of State for Health and the NHSE which sets out the terms in which the Board will exercise a Secretary of State function. Public Health England (PHE) will provide public health advice on the specification of national programmes, and also a quality assurance function with regard to screening.

Directors of Public Health will advise, for example, on whether screening or immunisation programmes in their area are meeting the needs of the population, and whether there is equitable access. They provide challenge and advice to the NHSE on its performance, for example through the joint strategic needs assessment and discussions at the Health and Wellbeing Board on issues such as increasing uptake of immunisations and screening, and how outcomes might be improved by addressing local factors. They also have a role in championing screening and immunisation, using their relationships with local clinicians and clinical commissioning groups, and in contributing to the management of serious incidents.

This paper provides an update on progress on the implementation of the 2015/16 NHS England London commissioning plans. Directors of Public Health and Clinical Commissioning Groups (CCGs) via the Office of CCGs were sent copies of our 2015/16 commissioning intentions in September 2014.

The agreement is based on a shared commitment to protect and improve the public's health – the Department of Health (DH), NHSE and PHE share the vision of working in partnership to achieve the benefits of this agreement for the people of England. NHSE commissioning intentions are available at <http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/12/ph-comms-intent-15-16.pdf>

However the NHSE Board has not yet prioritised all their investment plans and has not yet determined which if any new programmes will be commissioned in 2015/16. This paper therefore focuses in more detail on plans by the NHSE London Public Health team about how the plans will be implemented.

Set out below is an update on where we are in terms of commissioning plans for the following programmes of care:

- Antenatal and new born screening
- Early years and Child Health Information Systems
- Immunisations
- Cancer Screening Programmes
- Adult Screening Programmes
- Health in the Justice System services
- Veterans Health

2. Programmes of Care

2.1 Antenatal and New Born Screening

From December 2014 maternity services are now offering a further 4 routine blood spots tests for metabolic conditions to add to the existing tests performed via a heel prick on all new born babies. The new tests are for homocystinuria, maple syrup urine disease, glutaric aciduria type 1 and isovaleric acidaemia. Although the numbers of babies with these diseases is small, about 30 in England per year, early detection will prevent those babies affected from dying or being severely disabled for the rest of their lives.

During January 2015 there will be changes to the national new born information feeds, with the NHS number being generated by a new service, and improvements to transfer of test result data to child health information services and health visitors. Failsafe checks to ensure that all babies are identified and have full screening results have been established in most areas now.

2.2 Early Years Services

Nationally NHSE has been working with the DH and Local Government Association to agree the funding allocation to underpin the transfer of commissioning responsibilities for Health Visiting and Family Nurse Partnership (FNP) services to Local Authorities from October 2015.

In London we have worked closely with London Council representatives to undertake a very detailed review of Health Visiting service contracts, funding, and workforce and performance issues. As a result of London Council's work, supported by NHSE, the DH has agreed that Local Authorities should be funded above a floor for health visiting services of £160 per head of under 5s population. This importantly recognises the challenges faced by a number of London Councils but it does not necessarily recognise the growth in the under 5s population in a number of boroughs and the implications this has for Health Visiting services. This is being flagged separately by a number of London Councils who are concerned at the financial liabilities that the transfer of services may bring. By the end of January all boroughs should be clear as to the funding that will be transferring to them. We also anticipate that the final mandation of what the service will deliver and how Local Authorities will be monitored will be published shortly.

During January - March 2015 NHSE will be leading contract negotiations with health visiting service providers and will need to agree if contracts are to be novated in October 2016 to a Local Authority or if a Local Authority prefers a new 6 month contract that runs with the current provider from October to March 2016. Local Authorities will also be invited to put forward any inclusions they would like to have negotiated into contracts for the April-September 2015 period.

Assuming that funding and contracts can all be agreed by March 2015 PHE's London team and our NHSE London team will then be keen to work with London councils and their children's commissioners to discuss developments in health visiting services such as the use of the Ages and Stages approach. Ages and Stages Questionnaire (ASQ) is an evidenced based tool to assess the global development of a child at various stages of their development. The DH has specified ASQ 3 to be

used for all two year reviews across England from 1st April 2015. PHE/NHSE are in the process of rolling out a train the trainer package to support implementation. These discussions will also provide an opportunity to talk about what data is available currently and the implementation of national policy changes such as the change from registered to resident for Health Visiting case load management.

We will continue to write separately to Health and Wellbeing Board chairs, DPHs and CCGs to keep them updated on the transfer of commissioning responsibilities for health visiting and FNP services.

2.3 Child Health Information Services

Although Health Visiting and FNP services commissioning transfers to Local Authorities in October 2015, NHSE will remain responsible for the commissioning of Child Health Information Services (CHIS). , This arrangement is currently planned to continue until 2020.

In London there are 23 CHIS services provided by 19 providers most which are very small in size, have had little investment or attention over the years and in general are not sufficiently resilient to meet the challenge that the new commissioning arrangements will require. We have recently undertaken a detailed quality review of each of the CHIS services. As a result of these reviews which were completed between October-December 2014 we have agreed local action plans with service providers. These are focused on actions for example to improve the quality of the current services and to ensure a number of key data linkage projects are delivered e.g. for maternity feeds, and transfer of data from antenatal and newborn screening tests.

Last year we commissioned a CQUIN (commissioning for quality and innovation) payment for CHIS to actively follow up the immunisation outcomes of children looked after by Local Authorities and babies born to hepatitis B mothers. We intend to carry out an audit to check the immunisation status of these children and young people in order to establish whether any further service improvements are needed.

We are also setting up a task and finish group with representatives from London boroughs to agree the future data needs of local authorities as a result of the transfer of Health Visiting and FNP services and to ensure these can be provided by local CHIS services.

In addition we think that there are probably too many small providers and that the numbers of CHIS providers should be reduced to create a smaller number of larger more robust providers. This view is being discussed and the intention is to present a paper to the February meeting 0-19 Children's Board which includes representatives from London boroughs as the Co-Chair as well as Directors of Public Health, Local Authority Children's Commissioners and CCG representation. Once a recommendation is made we will undertake further stakeholder discussions. Any new service model would be in place from April 2016.

2.4 Immunisation

It is acknowledged that London is ranked as the worst performing region in terms of its annual COVER data (routine immunisation for 0-5 year olds). This partly reflects population mobility, levels of deprivation, and increasing birth rates which culminate in a number of challenges to recording and reporting the complete immunisation

record for every child resident in the Borough. We have been in discussion with all London boroughs and CCGs about childhood immunisation performance and the steps we can take as one of the partners tasked with improving performance.

For 2015/16 our commissioning plans include some service redesign to ensure complete courses of immunisations are given to babies identified through antenatal screening as being at risk. This will prevent poor outcomes for babies such as developing liver damage due to Hepatitis B. We also intend to focus on assuring the complete immunisation records for each Looked After Child across all Local Authorities by aligning immunisation uptake data with local authority systems and child health information systems.

London has an incidence of Tuberculosis (TB) of greater than 40 per 100,000 population. This figure is the estimated number of new pulmonary, smear positive, and extra-pulmonary tuberculosis cases per 100,000 population. 40 per 100,000 is the figure when a population becomes more at risk. This means for example for a borough the size of Barking and Dagenham there is expected to be between 50 and 60 new cases of TB per year. As our part of delivering the new London TB strategy we will be commissioning neonatal BCG (TB protection for new-borns) across London. We inherited different commissioning arrangements from Primary Care Trusts and in 2015/16 we will move to having one commissioning model to ensure a consistent offer is made by London maternity services.

We will also learn from a pilot undertaken in Lewisham led by Lewisham CCG with Lewisham and Greenwich NHS Trust and we will fund the offer of a seasonal flu vaccination and pertussis vaccination to all pregnant women again to ensure a consistent offer across London.

We will also continue to roll out the children's flu programme to school years 1 and 2 (age 5 and 6) in all primary schools across London. Following this year's seasonal flu delivery programme we plan to hold a review session in March/April to review the lessons learnt and plan for the 2015/16 flu campaign. Part of this review will look at the role community pharmacists have played as well as what other actions we need to take to improve uptake especially amongst the at risk under 65s group and amongst other priority groups such as pregnant women, mental health, learning disabilities, carers and at-risk non-registered patients. We will invite representatives from local health and wellbeing boards to attend our review session.

For school aged children we are in the process of both working with a number of local authorities to agree an 'add on' schedule to their new contracts for school nursing or where the local authority is not in a position to include an 'add on' we are currently out to procurement for a stand-alone school age children's immunisations service.

It is expected that the new school-aged vaccination service will be able to deliver a number of benefits, particularly in terms of a higher degree of granularity of the data by local authority and school as well as service improvements in terms of uptake of school aged vaccinations such as the Human Papilloma Virus (HPV), Meningitis C and Td/IPV (also known as Teenage Booster) vaccination.

In terms of timescale the deadline for Pre-qualification questionnaires (PQQ) submission is 29/1/15. Invitation to Tender (ITT) submissions are then due to be received by 26th March. Evaluation and contract award will take place in April/May with full mobilisation in place from August 2015. Plans exist in the interim to cover the period from April to August 2015.

2.5 Cancer Screening Programmes

(i) Bowel Screening

To facilitate the introduction of bowel scope screening in London, several of the bowel screening centres are required to reduce the size of the population they serve. We recently agreed to a respecification of the bowel screening centre in North East London. Homerton University Hospital NHS Foundation Trust (and Barts Health Care NHS Trust) previously served north east and north central London. In the new model, the trusts will now provide a service to a smaller number of CCGs' populations. Queens Hospital, part of Barking Havering and Redbridge NHS University Hospitals NHS Trust will be established as a new bowel screening centre serving outer north east London. Similar discussions are taking place between King's College Hospital NHS Foundation Trust and Lewisham and Greenwich Hospitals NHS Trust with the aim of reducing the size of the South East London bowel screening centre. Where people go for their tests should not change, only the administration of the programme in order to comply with national guidance.

(ii) Breast Screening

We have been in discussion with our service providers about our plans to tender the breast screening service. Our focus is currently on stakeholder engagement and user involvement and we are planning to undertake a health equity audit as well as setting up various focus groups to help develop the service specification. Our intention is to undertake any tendering during 2015 with the new service model in place from April 2016. As part of this process we are keen to review how the very few mobile services are operating across London.

(iii) Cervical Cytology Screening

We have been in discussion with representatives from London Councils on opportunistic cervical screening and where responsibility for both commissioning and funding sits given this test can be provide as part of an opportunistic general sexual health consultation for some women. The data shows a very varied position with increases in opportunistic screening in some areas and decreases in others. We know that many councils are looking at their local sexual health provision via their existing contracts and we are keen to work with London Councils given overall cervical screening uptake especially in younger groups of women is falling.

We are also in the process of rolling out a cervical sample takers data base which will require all those who take samples to be registered. This should provide some assurance as to the training and competency of sample takers and help us with work to reduce inadequate samples and contribute to the quality assurance of sample taking in London. The use of the data base will be rolled out in 2015 and we will be keen to talk to local DsPH about how this can form part of the assurance of Community Sexual Health services .

2.6 Adult Screening: Diabetic Eye Services

In September we served notice on all our current Diabetic eye Screening services and launched a re-procurement process. We invited representatives from CCGs and DsPH, along with user representatives to join our steering group which oversees the procurement.

We are about to write out to selected providers to invite a number of them to submit an Invitation to Tender (ITT) bid. Since we issued our re-procurement plans which are based around Strategic Planning Group footprints or groupings of CCGs, we have been working to agree an updated service specification that incorporates new guidance from PHE as a part of best practice. ITT submissions will be received by 18th March with an intention to award a new 3 plus 2 year contract by 18th May with new services in place from October 2015. We will send a separate note setting out the outcome of our procurement. We are also talking to CCGs on the opportunities for some co commissioning of a particular test (Optical Coherence Tomography) which can be performed for some patients at the same time as their annual diabetic eye examination.

2.7 Adult Aortic Aneurism Screening

There are currently five services providing aortic aneurysm screening across London. This is a relatively newly established service and we are not planning to review the current service configuration so there will be no change to our current commissioning arrangements.

3. Health in the Justice System

The Health in the Justice System team is responsible for commissioning and contracting for 9 London prisons, 2 immigration removal centres, 2 initial accommodation centres, 3 sexual assault referral centres commissioned via King's College Hospital NHS Foundation Trust, and 22 Liaison and Diversion Schemes.

During 2014 we have undertaken procurement for health services for the 3 prisons located in the London Borough of Greenwich. These contracts were awarded to Oxleas NHS Foundation Trust and we are in the process of overseeing the handover/transfer of staff from the current provider CareUK to the new provider. This handover will be complete by April 2015. During 2015 we will undertake procurements for the prison health care service in Wormwood Scrubs prison in Hammersmith and Fulham and for Holloway Prison in Islington.

3.1 Health Care transfer from Police to NHS commissioning responsibility

The Health in the Justice System team is working in partnership with the Metropolitan Police Service (MPS) and the Mayor's Office for Policing and Crime (MOPAC) on the proposed transfer of commissioning of healthcare in police custody in London. However recently the Secretary of State decided to make the direction to transfer the legal responsibility for police custody for April 2016 rather than the earlier date of April 2015 that we had been expecting.

The impact of this decision for us in London, however, is very limited. Firstly, the British Transport Police and City of London Police transfer is going ahead on a voluntary basis in 2015, with the procurement process already underway.

We are also working with MPS in preparation for the transfer of their service to us planned for 2016/17. Our preparatory work is already delivering improvements for the MPS in health care provision in areas such as the training for MPS health care

staff, the installation of the NHS N3 network and improvements in clinical facilities in interview/treatment rooms.

3.2 Liaison and Diversion Services

A partnership of two mental health trusts (West London and Central and North West London) was successful in winning the bid to provide Liaison and Diversion services across their respective geographical areas as part of the Wave 2 trial site pilots. The data collected from the pilot sites, nationally, will contribute towards supporting the business case to the Treasury to increase the funding and roll out an enhanced model of police custody and court mental health liaison and diversion services across the country.

3.3 Street Triage

We have also been piloting a street triage service within South London and Maudsley NHS Trust as one of the nine pilots funded by the DH to improve the response to people in crisis who come into contact with the police or other emergency services. The funding for the pilot will come to an end in March 2015 but we have been working with our CCG commissioners who have committed to ensuring that the triage service will continue as part of their overall crisis care. Data coming from the pilot has shown benefits to both users and to the police.

3.4 Transporting Patients assessed Under the Mental Health Act

Working with CCGs via the lead commissioner Brent CCG we have just funded a project to look how best to support and improve the transport provision for patients assessed under the Mental Health Act 2014 who require transportation to inpatient facilities.

Stakeholders recognise that the current service, provided by the London Ambulance Service (LAS) is not meeting the requirements of patients who require transportation, the commissioners of the transport service and the needs of related professionals including the police and Approved Mental Health Professionals among others. The aim of the project is to agree for London a better model of transport to inpatient facilities for such patients.

We expect phase 1 of this scoping work to be completed by March 2015. Brent CCG will then lead any commissioning actions that are agreed.

3.5 GP Registrations

Working with London Probation Trust, we are promoting a scheme to increase the level of GP registration for offenders. The scheme is based on a successful pilot developed by the Director of Public Health in Sutton. Patients will be informed of the scheme by the probation office, substance misuse services or youth offending team, and they will come to their local GP practice with a letter written by one of the above services confirming their involvement with the patient. If they have a place to stay, this will be stated in the letter. The letter will suffice for registration purposes under the category 'documentation from a reputable source' where the practice has a policy of requiring documentation at registration. Where these patients are homeless, GPs will be asked to register them using the local Probation Office, Youth Offending Office or Community Drug Service as the patient's proxy home address.

We will be rolling this out across London starting in Sutton and Wandsworth. With changes to the discharge of offenders through the transforming rehabilitation programme, London prisons will house more offenders reaching the end of their custodial sentences and this project will support the intention to rehabilitate such people back in to society. On average 25,000 offenders are discharged from London prisons every year but this number is set to increase as more offenders are released from London prisons as part of a new policy on rehabilitation.

3.6 Immigration removal centres and work with the Home Office

We recently took over responsibility from the Home Office for commissioning health care in London's 2 Immigration Removal Centres. Both units are based in the London Borough of Hillingdon and close to Heathrow Airport. The units in London only accommodate single men. Other centres nationally house women and children or families. Central and North West London NHS Foundation Trust have also recently been appointed to provide this service.

As part of a national programme of work we will be able to commission our providers to provide a consistent approach to managing torture and trauma cases as well as driving consistency in the healthcare response to general detainee health needs and the consequences for their health related to continued detention, removal or discharge.

Part of our work will be to more closely link to community services to ensure continuity of care for discharged detainees in need of ongoing treatment. To that end we are starting to work with Hillingdon CCG and the London Borough of Hillingdon on managing some specific detainee needs and supporting good safeguarding and good quality of care.

3.7 Paediatric Sexual Assault Referral Centres (SARCs) Services

NHS England is responsible for co-commissioning of SARC services with MOPAC. We have 3 centres across London with services provided by King's College NHS Foundation Trust. Our focus for 2015/16 will be two fold. Partly it will be to improve the physical environment for children who attend by increasing the number of forensic examination suites to reduce waiting times and secondly it will be to review and seek to improve how those who have attended such centres are then followed up and managed locally along pathways for victims of sexual assault and rape. As part of a wider agenda we are also working with colleagues in MOPAC to review the work of the adult SARCs and the Havens and Rape crisis centres to ensure a more coherent approach to providing services to these very vulnerable groups.

4. Veterans Health

Under the arrangements made by NHSE our colleagues in the south of England are responsible for commissioning services for veterans in England as well as liaising with the Defences Medical service. In London our role is to support an active London Armed Forces network. This is part of our delivery of the Armed Forces covenant which supports all armed forces personnel and their families' access to primary care and other services upon discharge. We have at any one time about 18,000 living veterans in London. This covenant supplements and supports the community covenant which all London boroughs have signed up to.

Part of our work in 2015 will be with the 2 London boroughs, Greenwich and Hounslow, who expect to see an increase in veterans as a result of the decant of military bases in Germany.

5. Conclusion

This paper tries to provide a brief overview of our commissioning activities planned for 2015/16. As a result it does not describe our routine business as usual work on for example improving the uptake and coverage of our cancer screening programmes or immunisations in children etc. We will be providing separate reports on our work in this area as far as we are able linked to the publication of new data.

In summary we wish to use the advantage that being one Public Health and Health in the Justice System Team for London can bring and to commission a consistently high quality set of services for London residents. We welcome the commitment and help of a wide range of partners including health and wellbeing boards in meeting this aspiration.

6. Mandatory Implications

6.1 Joint Strategic Needs Assessment (JSNA)

The NHSE commissioning intentions respond to the JSNA, with more detailed work to follow to ensure recommendations in the refreshed JSNA are mapped into commissioning plans.

6.2 Health and Wellbeing Strategy

The Health and Wellbeing Strategy priority areas are reflected in the NHSE commissioning plans. Public health priorities are set out in the in the Strategy, the BHR five year strategic plan, with deliverables for 2015/16 aligned to the NHSE plans.

6.3 Integration

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

6.4 Financial Implications

There are no direct financial implications for Barking and Dagenham as a result of the 2013 Health Protection Profile. 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, however there are competing demands on this cash limited funding.

(Implications completed by Roger Hampson, Group Manager, Finance)

6.5 Legal Implications

The law applicable to the Public Health elements of this programme is set out generally in the body of this report.

The procurement of services through selected contractors is governed by the Public Contracts Regulations 2006, which set out requirements for tendering and

procurement to which Contracting Authorities such as the Council and the NHS must comply.

(Implications completed by Daniel Toohey, Principal Corporate Solicitor)

6.6 **Risk Management**

One of the outcomes we want to achieve for our Joint Health and Wellbeing Strategy is to improve health and wellbeing outcomes through integrated services. The extensions allow for effective integration of services and partnership working.

7. **Supporting Documentation**

None

HEALTH AND WELLBEING BOARD

10 February 2015

Title:	The Health of Young Offenders		
Report of the Director of Public Health			
Open Report		For Decision	
Wards Affected: ALL		Key Decision: NO	
Report Authors: Dr Marion Gibbon Interim Consultant in Public Health		Contact Details: Tel: 0208 227 3039 E-mail: marion.gibbon@lbbd.gov.uk	
Sponsor: Matthew Cole, Director of Public Health			
Summary: Young offenders (aged 10 – 19) are a marginalised group often having complex health needs that are greater than those of the non-offending population. It includes young offenders in secure children’s homes, secure training centres, and young offender institutions as well as those being managed by Youth Offending Services. Young offenders present unique challenges in terms of health care provision, particularly in terms of access. Use of secondary health care services is high among this group and use of primary health care services is low.			
Recommendation(s) The Board is asked to note and comment on the following key recommendations:-			
<ul style="list-style-type: none"> (i) Children’s Services to provide a further report on the support needed and available for those that fall in between troubles families and offending. (ii) NHS Barking and Dagenham Clinical Commissioning Group need to have regard for the adequate provision of health services to support Youth Offending Services with a clear set of outcomes and activity expectations across the breadth of the youth justice system. (iii) All young offenders should have an annual health check encompassing physical, mental health, emotional health and health risk behaviours. The findings and the agreed health outcomes plan agreed with the client should form part of the overall YOS care and support planning records. (iv) YOS Health Services need to be commissioned with adequate resource and a clear set of outcomes and activity expectations across the breadth of the youth justice system. (v) Significant work is needed to educate the wider health community about the needs of young offenders and develop a clear coherent pathway and transition plans for youth offenders; this work could be led by a GP clinical champion who has a special interest in adolescent medicine and the criminal justice system. 			

- (vi) Workforce development planning and training programmes for both health and social care staff should include explicit education on youth justice for all front line professionals. There should also be specific training additional training support on health risk assessment and understanding of the NHS for YOS professionals.

1. Introduction

- 1.1 The age of criminal responsibility in England and Wales is 10 years. Children under this age are not considered as criminally responsible for crimes and cannot be charged with a crime. The youth justice system (YJS) was set up under the Crime and Disorder Act (1968), to prevent young people from reoffending. The formal system begins from age 10 years and over when an offence is committed which goes to court. From 2013 the courts now give restorative solutions and cautions rather than reprimands and warnings.
- 1.2 The Crime and Disorder Act requires that local authorities, the police, probation, and from Spring 2013 Clinical Commissioning Groups (CCGs) set up YOSs to work with children and young people who were offending or at risk of offending. The CCGs were required to:
- co-operate with local authorities in establishing Youth Offending Services (YOSs);
 - contribute to their budget; and
 - provide or nominate a member of the YOS team.
- 1.3 The YOS had to include representatives from the police, probation, health, education and children's services and have responsibility for children and young people sentenced or remanded in custody.
- 1.4 With the extension of the Healthy Child Programme to children aged 5-19, guidance for school health teams highlights the importance of providing enhanced support for vulnerable children and young people.
- 1.5 The aims of this report are:
- to outline the main health needs of the young offender population in Barking and Dagenham; and
 - to determine the extent to which current service provision is addressing the needs of the young offender population.

2. The national context

The legal framework and service drivers

- 2.1 Healthy Children, Safer Communities was published in 2009 (DoH, 2009) which set out the strategy of the Department of Health and the Department for Children, Schools and Families to promote the health and wellbeing of children and young people in contact with the Youth Justice System, this was in response to Lord Bradley's review of people with mental health problems and learning disabilities in the criminal justice system. 'You're Welcome' (DoH, 2011) sets out principles to make services young people friendly and the National Service Framework for Children, Young People and Maternity Services (DoH, 2004) set out guidelines for

the quality of care and highlights the importance of equity of offender services that are based on need regardless of race, gender, disability, age, sexual orientation, religion or belief.

2.2 These policies require:

- the harnessing of mainstream services to reduce offending and reoffending, wherever a person is in the youth justice system and when they are at risk of coming into the system;
- addressing health and wellbeing at all stages of the youth justice system. It makes a commitment to improve the provision of primary and specialist healthcare services for young offenders in the community and to support and promote health and well-being in the secure estate;
- effecting change by policy and decision makers at a national, regional and local level championing a strong response to the health inequalities encountered by children and young people at risk of anti-social and offending behaviour.

Police custody suites

- 2.3 Police custody suites are designated areas in police stations for the processing and if necessary detention, of a person who has been arrested. There is currently no standardised process for screening and assessment of health and wellbeing needs within police custody suites. The treatment of children and young people in custody suites is governed by the Police and Criminal Evidence Act 1984 (PACE). PACE is anomalous with other legislation in the UK in that young people aged 17 are treated as if they were adults for the purposes of police procedure, whereas in all other legislation anyone under 18 is a child or young person.

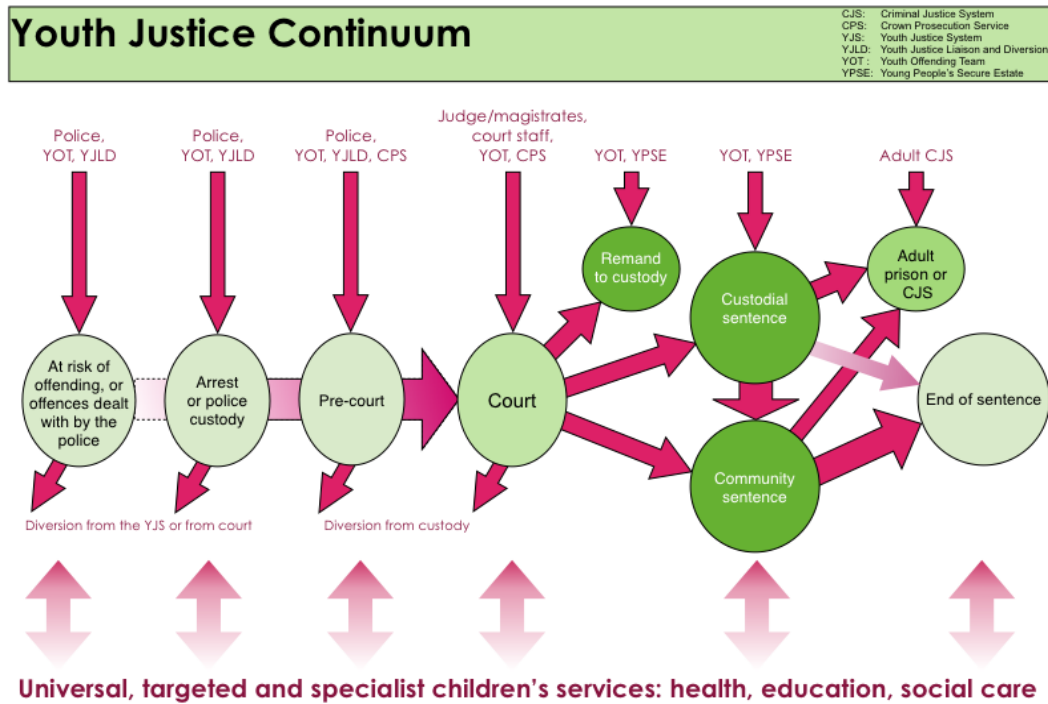
Youth Justice liaison and diversion schemes

- 2.4 The cross-government Health and Criminal Justice Liaison and Diversion programme, led by the Department of Health, includes a major national programme of pilot young justice liaison and diversion (YJLD) schemes for children and young people with mental health, learning or communication difficulties, or other vulnerabilities affection their physical and emotional wellbeing. The purpose of the programme is to identify all health and social care needs at whatever point children and young people enter the YJS, to ensure a systematic access to services and enabling the police and courts to make informed decisions about charging and sentencing.

The secure estate for children and young people

- 2.5 The secure estate for children and young people is the umbrella name for the establishments that hold children and young people when they are in custody (See Figure 1).

Figure 1: Youth Justice Continuum

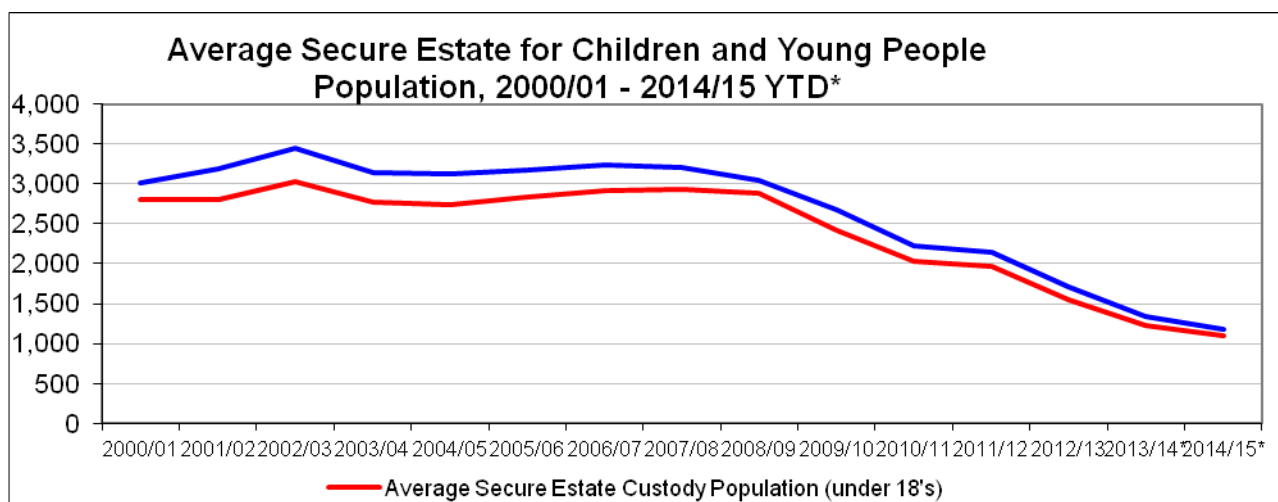


Source: DoH, 2012

Young Offenders – the national picture

2.6 The number of young offenders in custody has fallen over the last six years (See Figure 2).

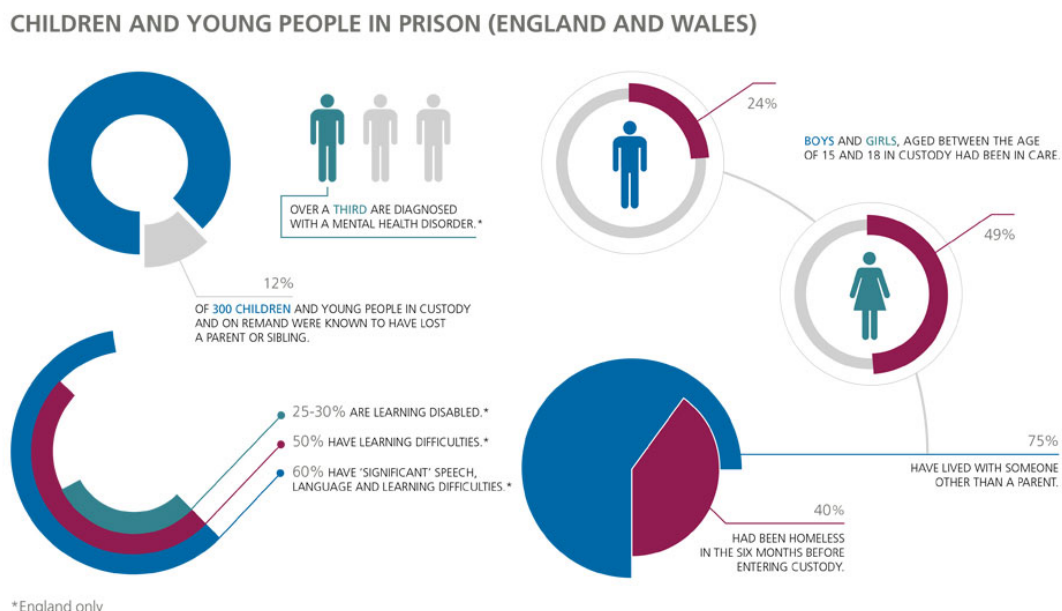
Figure 2: Trend of Young People in prison between 2000/1 – 2014/15



Source: Youth Justice Board 2014 Young Offenders Report September 2014

- 2.7 In 2012-2013 the average population of young people in custody in England and Wales (under 18s) was 1,544. In the 12 months to March 2013, 2,780 young offenders were placed in custody.
- 2.8 Many of the young people who end up in the criminal justice system come from chaotic home lives, often characterised by violence, abuse or neglect, and are not thriving socially, emotionally or physically. They are unable to thrive socially, emotionally or physically, and are among the most vulnerable individuals in our society long before they reach detention.
- 2.9 Three quarters of children and young people in custody have lived with someone other than a parent and 40 per cent had been homeless in the six months before entering custody. 24% of boys and 49% of girls, aged between 15 and 18 and in custody, have been in care. Of 300 children and young people in custody and on remand, 12% were known to have lost a parent or sibling. Approximately 60% of children in custody have 'significant' speech, language and learning difficulties; 25-30% are learning disabled and up to 50% have learning difficulties. Over a third of children in custody were diagnosed with a mental health disorder.

Figure 3: Children and young people in prison

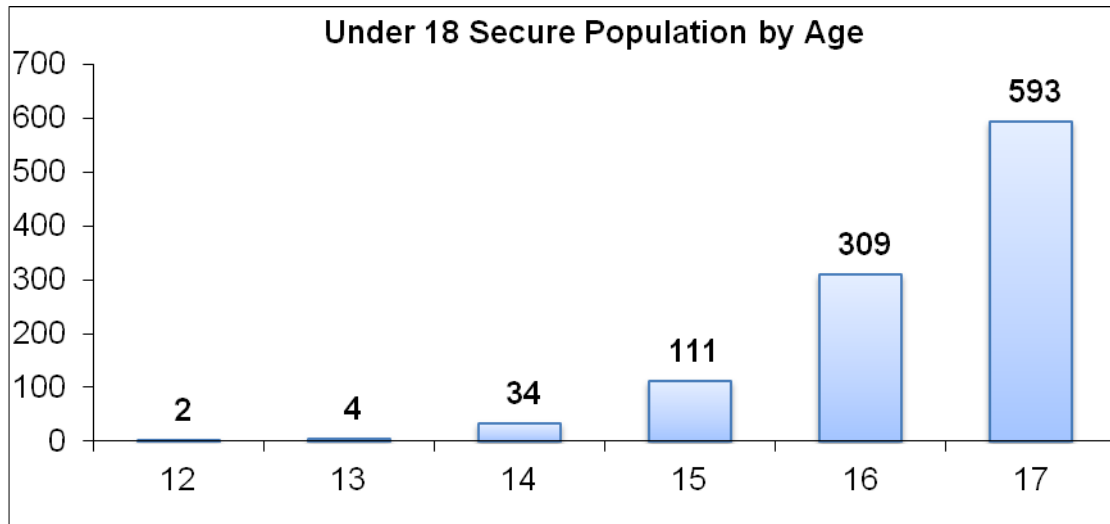


Source: BMA, 2014

Young offenders by age

- 2.10 There is a huge increase in the number of young people in secure units with age (See Figure 4).

Figure 4: Under 18 Secure Population by Age

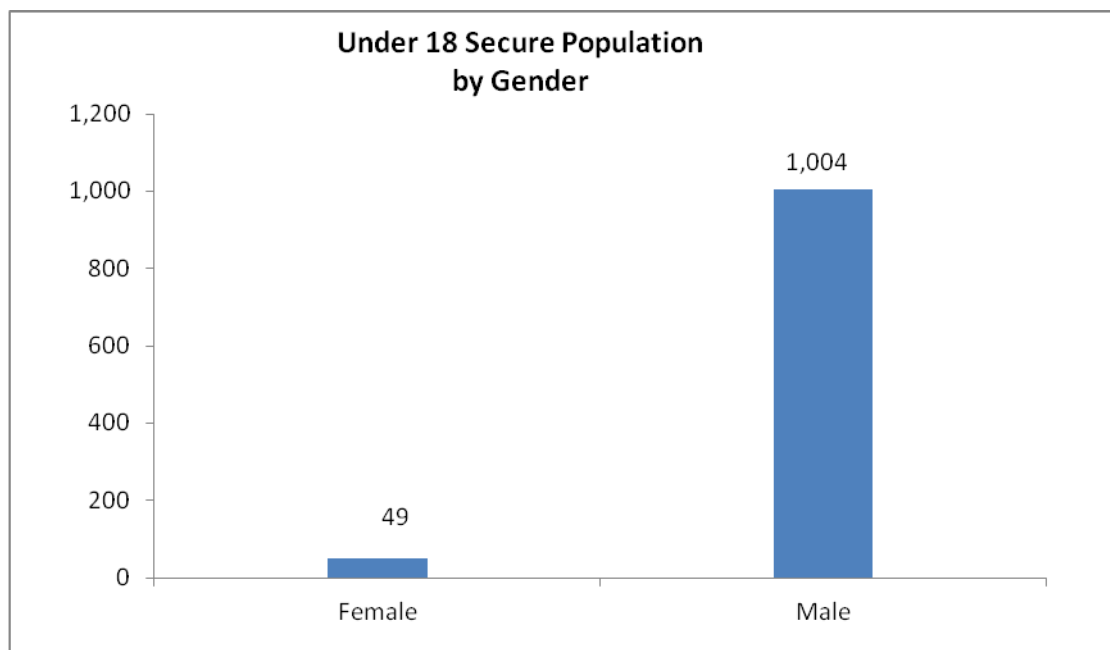


Source: Youth Justice Board 2014 Young Offenders Custody Report September 2014

Young offenders by gender

2.11 Young offenders are predominantly male (See Figure 5)

Figure 5: Under 18 Secure Population by Gender

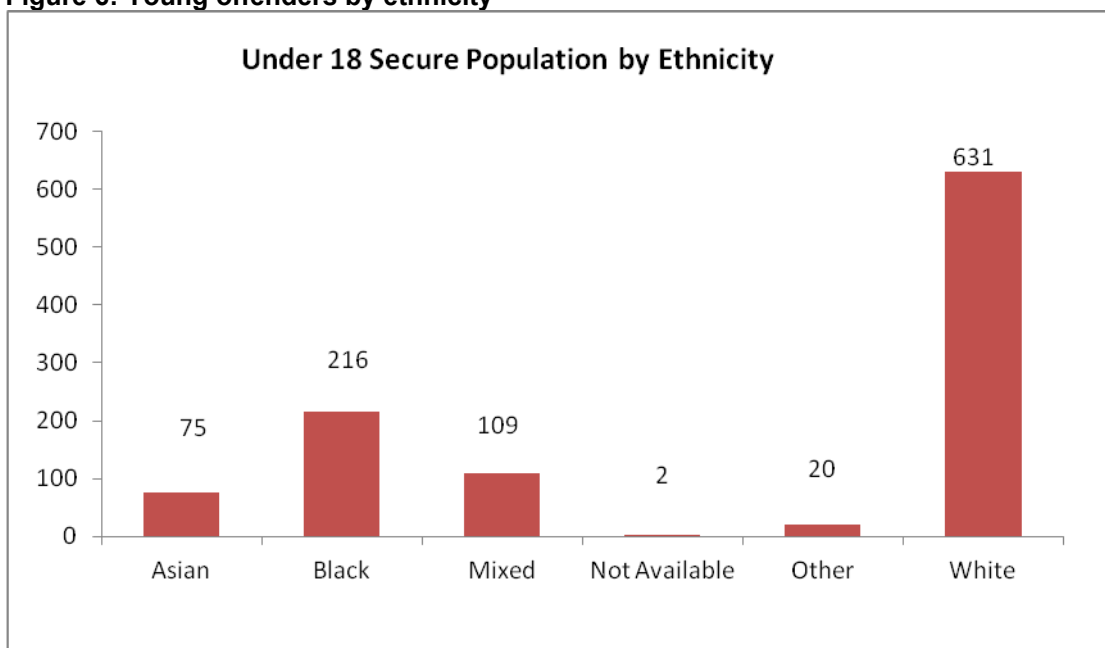


Source: Youth Justice Board 2014 Young Offenders Custody Report September 2014

Young offenders by ethnicity

2.12 Young offenders are predominantly white, however, black and minority ethnic groups are disproportionately represented (See Figure 6).

Figure 6: Young offenders by ethnicity



Source: Youth Justice Board 2014 Young Offenders Custody Report September 2014

3. The local picture – the youth justice system in Barking and Dagenham

3.1 In 2013, for every 100,000 10-17 year olds in the population of Barking and Dagenham, 463.1 received their first reprimand, warning or conviction. The England value is 440.9. The table below shows comparisons to national and regional data.

Table 1: Rates of young people aged 10-17 receiving their first reprimand, warning or conviction.

	First time entrants to the youth justice system (2010)	First time entrants to the youth justice system (2011)	First time entrants to the youth justice system (2012)	First time entrants to the youth justice system (2013)
Barking and Dagenham	957.2	817.6	517.3	463.1
London	983.1	795.9	591.3	458.2
England	901.7	725.6	556	440.9

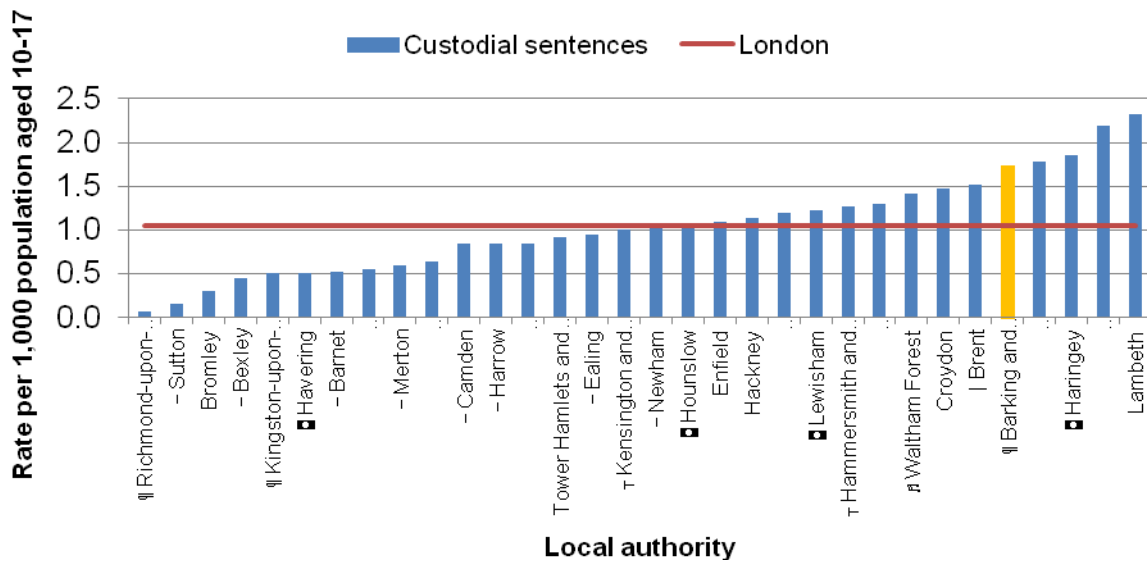
Source: Department for Education. Further information: www.education.gov.uk/rsgateway/DB/STR/d000895/index.shtml

Police custody

3.2 LBBD has the fifth highest rate of custodial sentences for youth offenders in London (See Figure 7)

Figure 7: Custodial sentences for youth offenders

Rate of custodial sentences for youth offenders, Barking and Dagenham and London, rate per 1,000 population aged 10-17 years, 2012/13



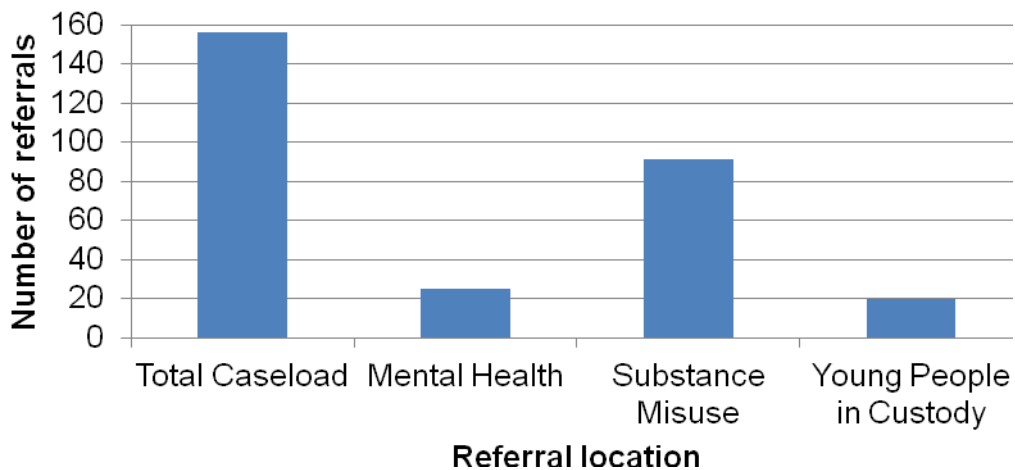
Source: Barking and Dagenham Youth Offending Service

Young offenders being managed by Youth Offending Services

3.3 Substance misuse made up the majority of referrals to the youth offender services, followed by mental health (See Figure 8)

Figure 8: Youth offender referrals

Youth offenders service, referrals in Barking and Dagenham, 2013/14

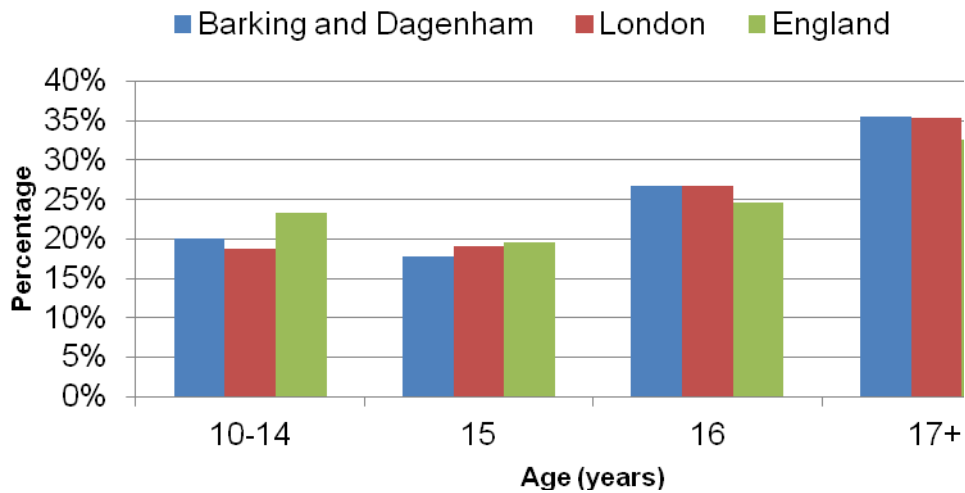


Source: Barking and Dagenham Youth Offending Service

3.4 Almost 36% of referrals are amongst youths over 17 years, about 20% are amongst children aged from 10 to 14 years (See Figure 9).

Figure 9: Age profile of youth offenders

Age profile of youth offenders, Barking and Dagenham, London and England, percentage of all youth offenders, 2012/13

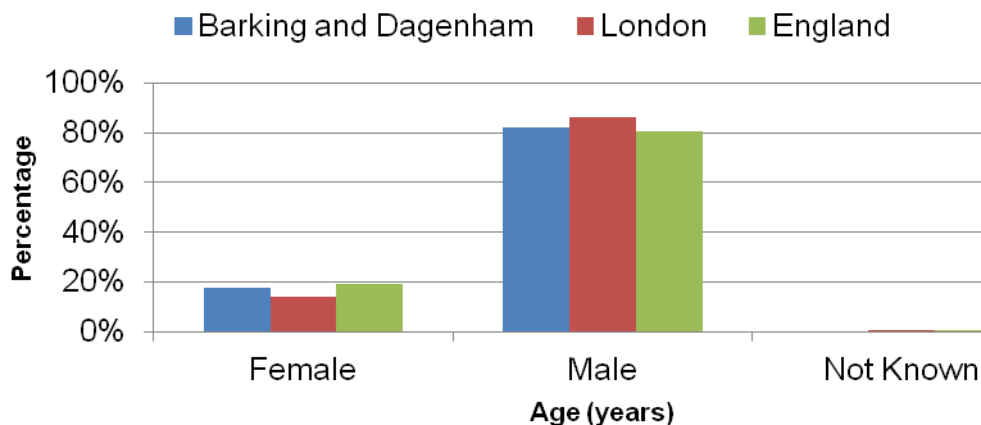


Source: Ministry of Justice

3.5 The majority of offenders in LBBDD are male which is similar to both the London and England picture (See Figure 10).

Figure 10: Gender profile of youth offenders

Gender profile of youth offenders, Barking and Dagenham, London and England, percentage of all youth offenders, 2012/13

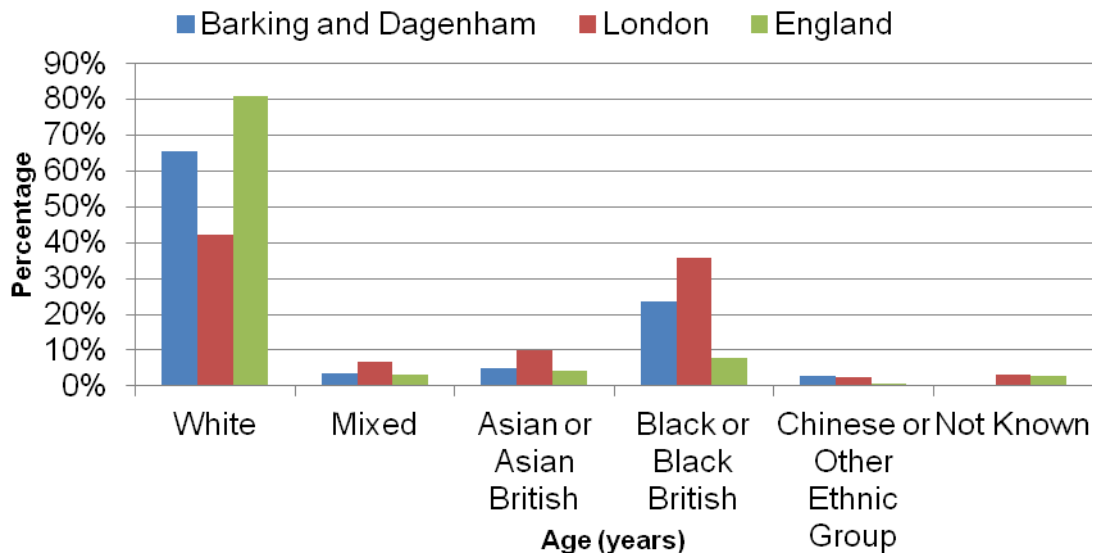


Source: Ministry of Justice

3.6 The majority of youth offenders in LBBDD are amongst the white population (See Figure 11). The proportions of offenders are dissimilar to both London and England.

Figure 11: Ethnicity profile of youth offenders

Ethnicity profile of youth offenders, Barking and Dagenham, London and England, percentage of all youth offenders, 2012/13



Source: Ministry of Justice

Teenage pregnancy

- 3.7 National data suggests there is a higher engagement in crime by male children of adolescent mothers (Maynard, 1997). Estimates also suggest that around 39% of young women under the age of 21 in prison are mothers, and 25% of young men are fathers (NICE 2007).
- 3.8 Table 2 below shows the trend in teenage conception rates in Barking and Dagenham since 2002-2004, while the table shows the under 18 conception rate per 1,000 females aged 15-17 years in Barking and Dagenham compared to national and regional data. In 2002 there were 73.2 conceptions per 1,000 female population aged 15-17 compared to 54.6 in 1998. Over the same period the average rate in England decreased from 42.1 to 41.0 per 1,000 female population aged 15-17.

Table 2: Under 18 conception rate (per 1,000 females aged 15-17 years)

	Under 18 conception rate (per 1,000 females aged 15-17 years) (2012)
Barking and Dagenham	35.4
London	25.9
England	27.7

Source: Department for Education. Further information:

www.education.gov.uk/childrenandyoungpeople/healthandwellbeing/teenagepregnancy/a0064898/under-18-and-under-16-conception-statistics

Risky health behaviours

- 3.9 Evidence suggests substantially higher rates of smoking, alcohol and substance misuse amongst young offenders. Smoking rates amongst young offenders in national and regional surveys are over 80% which is three times higher than the rates within the general population (Home Office, 2005). A Scottish NHS study showed that nearly 80% of 16-24 year-olds in prison identified themselves as a smoker (Taulbut and Gordon, 2008). A further study in 2004 looking at substance misuse amongst young offenders found that 84% were regular smokers at the time of their arrest (Youth Justice Board, 2004). If the 80% prevalence is applied to young offenders in LBBB just over 370 young offenders will be actively smoking.
- 3.10 The evidence suggests alcohol dependence and alcohol misuse are commonplace amongst offenders, and are often contributing factors in criminal activity. In 2006, data collated from the Offender Analysis System (OAS) revealed that 37% of offenders had both a problem with alcohol and/or were binge drinkers, 32% exhibited violent behaviour because of their alcohol misuse and 38% had a criminogenic need relating to alcohol (National Offender Management Service, 2006) i.e. alcohol was a factor in their criminal behaviour. In 2009, figures from the National Health Service showed that 32% of 16-24 year-olds reported drinking over 6/8 units (the maximum recommended level for females/males) in one drinking session in the previous week compared to just 20% of all adults (NHS, 2010). The 2007 evidence suggests that 40% get drunk daily and 49% weekly, applied to the LBBB case load this equates to 185 of young people entering the YJS drinking daily.
- 3.11 Substance misuse of drugs describes a range of behaviours, the 2007 Arrestee Survey found a substantially higher rate of drug use amongst young offenders, with 69% of newly arrested 17-24 year-olds in 2006 compared to 38% of arrestees aged 35yrs (Boreham et al, 2007). Young offenders are more likely to be using cannabis and ecstasy than using heroin or crack cocaine (Ministry of Justice, 2008). If this pattern is replicated in LBBB then an estimated 319 entrants to the YJS will be using drugs and require support and intervention.

Speech, language and communication needs

- 3.12 Over half of children and young people in custody in the YJS have difficulties with speech, language and communication (HM Government, 2009). Estimates of prevalence of speech impairment from the Royal College of Speech and Language Therapists suggests that LBBB has 535 children aged 12-14 years with a speech impairment¹.

Autistic Spectrum Disorders

- 3.13 A study in South East London, (Baird et al, 2006) estimated the prevalence of childhood autism at 38.9 per 10,000 and that of other ASDs at 77.2 per 10,000. This made the total prevalence of all ASDs 116.1 per 10,000 or approximately 1%. If the prevalence rate found in Baird's study were applied to the population aged 5



¹ For more details, please see www.rcslt.org/speech_and_language_therapy/commissioning/sli_plus_intro.

to 16 years of Barking and Dagenham this would give an estimate of approximately 293.0 children.

Learning disability

- 3.14 It is estimated that 25 to 30 per cent of children and young people in the YJS have learning disabilities, and that this rises to around 50 per cent of those in custody (HM Government, 2009).
- 3.15 Estimating the prevalence of learning disability is problematic and should be treated with caution. One general population study (Emerson and Hatton, 2004) estimated that 2% of the total population has a learning disability, and the researchers calculated age related prevalence as follows: 5 to 9 years - 0.96%; 10 to 14 years - 2.26%; and 15 to 19 years - 2.67%.
- 3.16 The estimated total number of children with a learning disability in Barking and Dagenham are shown in the table below.

Estimated total number of children with a learning disability

	Barking and Dagenham
 Ages 10 to 14 (2010)	268
 Ages 15 to 19 (2010)	315

Source: Estimates based on ONS population data

Children with a learning disability who suffer from a mental health problem

- 3.17 On the basis of a 40% prevalence of mental health problems associated with learning disability (Foundation for People with Learning Disabilities, 2002), in Barking and Dagenham the number of children with both a learning disability and a mental health problem might be expected to be as follows: 10 to 14 years - 107; and 15 to 19 years - 126.

Looked after children

- 3.18 Evidence suggests that there is considerable overlap between children who are in contact with children's social care services and those in the YJS (Ryan and Tunnard, 2012). In Barking and Dagenham there were 410 looked after children on 31 March 2011, of whom 65 were in residential care.

4. Literature review

- 4.1 Young people in the YJS generally suffer from worse health than other children of a similar age, particularly in terms of mental health problems, learning difficulties, addictions and speech and language problems.

Ethnicity of young people in the YJS

- 4.2 While the majority of children and young people in contact with the YJS are white, children from some minority groups are over-represented nationally. This is particularly noticeable for young people in custody (Ref). In addition, a larger proportion of children from Black and Minority Ethnic (BME) groups have post-traumatic stress disorder than other children, in both community and custody settings (Harrington, et al, 2005).

Mental health of young people in the YJS

- 4.3 One of the key objectives in the Government's 'No Health without Mental Health' (HMG, 2011) is to, 'Improve early recognition and intervention for mental health problems in children and young people, including those in or at risk of moving into the youth justice system'. Self-harm is an issue of concern particularly those in the secure estate (DoH, 2009). Of prisoners, aged 16-20 years, around 85% show signs of a personality disorder and 10% exhibit signs of psychotic illness (Mental Health Foundation, 2007). There is a particularly high prevalence of depression and self-harm among young women in custody (Douglas and Plugge, 2006). About 30% of adolescents who self harm report previous episodes that have not been mentioned previously or to a medical professional. Self-harm is a risk factor for suicide and Hawley et al found that characteristics of those who self-harm are similar to those who commit suicide. The following factors seem to indicate a risk:

- violent method of self-harm;
- multiple previous episodes of self-harm;
- apathy, hopelessness, and insomnia;
- being an older teenage male;
- substance misuse; and
- previous admission to a psychiatric hospital.

Models of service provision to address the needs of youth offenders

- 4.4 A review undertaken in 2010 of YOT services identified several models of provision (Khan and Wilson, 2010). These included six different models as shown below:

The lone health practitioner model

- 4.5 Practitioners tended to be located full time in the YOT with low level linkage to local health teams.

The foot in-foot out model

- 4.6 The health practitioner typically had a presence in the YOT team as well as good systematic clinical and operational links with a specific local health team.

The virtual locality health team model

- 4.7 Health workers are located in the YOT and also have strong operational and clinical links with a specific health team outside the YOT; in addition they have developed systematic linkage, networks and joint working practices with broader health and mental health workers in the local area.

Outreach consultative model

- 4.8 We found some examples of an outreach consultative mental health model. This type of service not only provided direct services to very high risk and/or to vulnerable young people in the region or locality, it also provided supervision and clinical and telephone support to health workers in YOTs, in custodial settings, in specialist CAMHS as well as others throughout an area or region.

The internal YOT health team

- 4.9 In some areas, a team of health practitioners have been pulled together in a YOT. Often this type of team has an internally located YOT health manager.

The external YOT health one-stop-shop

- 4.10 Some YOTs had no health presence in the YOT but young people's needs were served through being referred to an external resource specifically commissioned for vulnerable young people in the area.
- 4.11 Each of these models demonstrated strengths and weaknesses. Health practitioners voiced the greatest concerns about the lone practitioner approach. Many workers described feeling professionally isolated and facing persistent struggles with accessing mainstream and specialist health and mental health provision for children and young people in contact with the YOT. Lone health practitioners often ended up working directly with young people and did not always fulfil the originally intended role of being a bridge to mainstream services.

Most effective interventions

- 4.12 There is now strong evidence that the most effective way to reduce both crime and poor outcomes for children is to work with families whose children are at the highest risk, at the earliest point possible, particularly where children are showing early signs of behavioural problems (Fergusson, Horwood and Ridder, 2005). Poor parenting and family dysfunction explains up to 30– 40% of problematic behaviour in children (Patterson, DeBaryshe and Ramsey, 1989), indicating a need to focus predominantly on strengthening parenting skills (Scott, 2008) and on building the child's resilience (Alperstein & Raman, 2003). Parenting interventions offer the best chance of change at this early stage, with consequent reductions in crime and multiple adverse outcomes and improved life chances as these young people mature (Sainsbury Centre for Mental Health, 2009).

5. Current Service Model to address the health of youth offenders in LBB

- 5.1 A report was written in 2012 that outlines the health input to the YOS being via a range of funding mechanisms and fluctuation in provision and style of input from 2006.
- 5.2 The YOS team in LBB in 2011 included a full time psychologist, filled by a locum, which replaced the previous two FTE psychologists. Varney (2012) commented that 'there is no structured physical health input provided'. Furthermore, there were two

dedicated YOS Drug and Alcohol workers who are provided through Drug and Alcohol Treatment contracts.

- 5.3 CQC Inspection and local review of health provision for young offenders identified gaps in the provision of support to YOT by community & mental health services.
- 5.4 The service specification for health provision to both youth offending teams and to young people at risk of offending was developed following an ONEL wide review of health provision which was informed by a needs assessment.
- 5.5 The contract variation for health provision to YOS was agreed with the North East London Foundation Trust (NELFT) in 12/13.
- 5.6 Although no additional investment was identified in respect of the remodelled service it was agreed that benefits would be derived through closer working and integration of health professionals with responsibility for vulnerable children across mental health and community health services.
- 5.7 NELFT is commissioned by B&D CCG and Havering CCG to provide the health input into the Youth Offending Service in line with the revised service specification.
- 5.8 The overall aim of the service is to ensure access to integrated health provision for this vulnerable group of young people.
- 5.9 Particular focus on early intervention, prevention and active management of chronic conditions.
- 5.10 The health provision originally comprised 2 WTE clinical mental health specialists (CAMHS) one for each borough (Havering and Barking and Dagenham), a clinical psychologist 0.9 WTE (B&D only) and input from school nursing - regular fortnightly clinic at YOT. Following discussions with YOT, public health and NELFT in 2013/14 – and in the light of identified issues around general health and prevention input it was agreed that the clinical mental health specialist role be changed to a broader health promotion worker.
- 5.11 The contract is monitored as part of CCG NELFT contracting arrangements and a revised suite of KPIs was agreed in discussion with PH, YOT and NELFT below

KPIs	Measurement - comments
Number of ASSET assessments undertaken by YOS worker with completed health section	Number of new ASSET assessments completed in the relevant quarter with completed health section
Number of ASSET assessments reviewed by health worker within 72 hours	Number of new ASSET assessments completed in the relevant quarter with completed health section reviewed within 72 hours by health worker
Number of CYP receiving second tier general health assessment and screening	Number of CYP receiving second tier general health assessment and screening in relevant quarter following completion of ASSET assessment/health review.
Number of CYP who access mental health/physical health care following general health assessment	Number of CYP who access mental health/physical health care following general health assessment in relevant quarter.
Number of CYP stepped up to tier 3 CAMHs	Number of CYP who are stepped up to tier 3 CAMHS in relevant quarter.
Number of CYP smoking at general health assessment	Number of CYP smoking at general health assessment for reporting quarter in question.
Number of CYP in service for over 6 months smoking	Number of CYP on health caseload smoking after 6 months for reporting quarter in question. <i>NB this will not report changes in same cohort but should overtime provide indication of changes in smoking status for CYP with general health interventions</i>

- 5.12 There have been ongoing issues around recruitment and retention to the health promotion post and recent issues with clinical psychology cover. These are being picked up with the provider.
- 5.13 All young people are assessed using that standardised Asset tool which includes a section for assessment of physical and emotional health but there is no training or standardised methodology for case workers conducting the assessment to gather the requisite information. The Asset assessment is sometimes also done in the presence of parents so this may inhibit disclosure, particularly those of risky behaviours.
- 5.14 Historically the LBBD YOS health support has varied and at times has included two full time psychologists, a full time community psychiatric nurse and intermittent support from one of the nurses in the looked after children's health team.
- 5.15 Funding sources are unclear and there is some opacity in what is commissioned as part of the CAMHS provision and as part of the general children's health budget provisions.

- 5.16 The national framework for the child health programme includes provision for young offenders, amongst other vulnerable groups, as part of the general contracting framework, however there is no evidence locally on engagement between these services and the YOS in a proactive way.

Qualitative interviews with youth offending team

- 5.17 As part of the report by Varney (2012) semi-structured interviews were conducted with a sample of the Barking and Dagenham youth offending team to gain a better understanding of the current process for identifying and supporting health needs of young offenders.

- 5.18 The interviews highlighted the following key themes:

- There has been some variation in the model and approach to the YOS health service over the last few years and moved from a mixed model of intermittent health visitor support, two full time psychologists and a community psychiatric nurse to now a fixed term locum full time psychologist with no physical health support. The current capacity is felt to be inadequate to meet the needs of the young people and families attending the service.
- The process of assessment has varied as well, the current model is based on using the Asset tool which is implemented by the case worker with the young person and only if a health issue is identified is a referral made to the YOS Health worker for further assessment and support.
- There has been no local review of whether the Asset tool implemented in this way is an appropriate screening tool for health risk or need and there is an appetite to do local research to review differences between Asset only and Asset Plus a formal health assessment as a model.
- There does not appear to be a structured training programme for staff working in and with the YOS, and this was a gap raised by several individuals in interviews. A lack of structured training has led to a variation in staff understanding of health issues, referrals and follow-up processes.
- Concerns were raised about capacity and location of YOS health support because of the potential challenges in attendance amongst users for off-site providers, there is a strong sense that health services need to come to the YOS location not be an offsite provision.
- Gaps were identified around how integrated the YOS is with other providers and although current staff are working hard to build relationships with children's centres and parenting programmes, there could be more integration with children's services to maximise support for young offenders and for their parents.
- Anger management was often used as language to describe a more complex set of issues reflecting both educational and family situations where young people lack higher skills for expression and although there was some provision from health it lacked the family dimension because of capacity.
- There is a high level of cannabis and alcohol use amongst the client group but limited support service available to address this. There was also a sense that in the wider community and amongst service providers, cannabis was not viewed as a significant health issue.
- There is a strong desire to work more with parents in a multi-disciplinary way and find ways to engage parents and support young people to disclose to parents constructively, this requires specialist skills and support for staff and involvement of psychologists with capacity to undertake family group therapy.

- Concerns were raised about how health could better support the small numbers of offenders where sexual offenses were involved, there was also discussion about the different thresholds for concern and action between agencies which has also been highlighted as an area for action at the Children's Trust. There is national best practice in this area and a structured assessment tool (AIM), which is used effectively elsewhere but requires more capacity to deliver locally and specific training.

5.19 The interviewees were asked to consider the potential for cross-borough provision of a specialist YOS health service, which prompted the following comments:

- Support for more specialist support and input, especially around family therapy, sex offenses and professionals who are used to working with teenagers.
- Concern that attendance is an issue with clients so there is a need for at least 3 days a week onsite presence to support opportunistic interventions as well as programmed activities.
- Need for work which is holistic, encompassing physical and mental health needs and building relationships with mainstream providers, especially GPs.

6. What is the evidence that we are making a difference?

6.1 According to the current management changes have been implemented since 2011 and there is far more integration with other services. The need for more family work has been addressed and this now takes place.

6.2 The review of Asset assessment has been undertaken and LBBB will be changing to Asset Plus, which is far more appropriate for a health and strengths based assessment.

7. What is the perspective of the public on the support available to them?

7.1 The current report has not been able to undertake an in-depth assessment of the perspectives of the public on the support available to them and this would help the commissioning and ongoing development of services.

7.2 More information is needed from the perspectives of the youth offenders in LBBB.

8. Conclusions

8.1 The findings from this report reinforces the need for a coherent health presence as part of the initial assessment of all young people coming into contact with the YOS. There is also a clear need for robust referral pathways with agreed outcomes and follow-up developed in partnership with the young people and the youth offending team.

8.2 There is clear evidence of health needs amongst young offenders and much of this is currently un-identified or unmet in the current provision. The scale and complexity of the caseload suggests that commissioners may want to commission via a two-borough approach that would allow and the need for local provision linked to local YOT services. Such a solution may be beneficial, especially where there is already collaboration between youth justice and children's services.

8.3 The driver for this current piece of work is the over-arching partnership objective to improve outcomes and opportunities for vulnerable children and young people.

9. Recommendations

9.1 Children's Services to provide a further report on the support needed and available for those that fall in between troubles families and offending.

9.2 NHS Barking and Dagenham Clinical Commissioning Group need to have regard for the adequate provision of health services to support Youth Offending Services with a clear set of outcomes and activity expectations across the breadth of the youth justice system.

9.3 All young offenders should have an annual health check encompassing physical, mental health, emotional health and health risk behaviours. The findings and the agreed health outcomes plan agreed with the client should form part of the overall YOS care and support planning records.

9.4 YOS Health Services need to be commissioned with adequate resource and a clear set of outcomes and activity expectations across the breadth of the youth justice system.

9.5 Significant work is needed to educate the wider health community about the needs of young offenders and develop a clear coherent pathway and transition plans for youth offenders; this work could be led by a GP clinical champion who has a special interest in adolescent medicine and the criminal justice system.

9.6 Workforce development planning and training programmes for both health and social care staff should include explicit education on youth justice for all front line professionals. There should also be specific training additional training support on health risk assessment and understanding of the NHS for YOS professionals.

10. Mandatory Implications

10.1 Joint Strategic Needs Assessment

The JSNA has a sub section dedicated to the health of young offenders. This sub section JSNA is up dated annually in conjunction with Community Safety Partnership Strategic assessment.

10.2 Health and Wellbeing Strategy

Children and young people in the youth justice system are at high risk of multiple health inequalities and poor life chances and as such are a key target group for health services charged with narrowing the gap in outcomes between the highest and lowest achieving children. Barriers to progress include higher than average:

- Mental health vulnerabilities,
- Levels of learning disabilities,
- Levels of speech and communication needs,
- Health inequalities,
- Rates of problematic drug and alcohol use.

Research indicates that these young people are less likely to have their needs identified early in primary care or school settings. We also know that their needs remain under identified and supported after entry into the Youth Justice System.

At this point there is no need to change the focus of the Health and Wellbeing Strategy as a result of this report.

10.3 Integration

One of the outcomes we want to achieve for our Joint Health and Wellbeing Strategy is to improve health and wellbeing outcomes through integrated services. The report's recommendations are underpinned for the need for effective integration of services and partnership working.

10.4 Financial Implications

There are no immediate financial implications directly arising from this report.

[Completed by Roger Hampson Group Manager Finance (Adults and Community Services)]

10.5 Legal Implications

There are no legal implications for the following reasons. The programme is being implemented in accordance with DOH Guidance. In accordance with the Guidance key recommendations for the service is to be implemented. Contracts are being strengthened with partner agencies so that the services can be introduced. KPI have been identified and measurement of outcomes devised to address how these will be met. Lastly National Guidance have been interpreted to address issues local to LBBD.

[Completed by Dawn Pele Adult Care Lawyer Legal and Democratic Services]

10.6 Risk Management

The management of risk should efforts to address health and offending in the youth justice system need to build on a firm foundation of non-stigmatising identification and intervention with children as early as possible, using evidence-based parenting approaches, to prevent multiple adverse outcomes and reduce risks of re-offending.

Health, children's (and some adult) services outside the youth justice system should take primary responsibility for these children and young people's outcomes at this earlier stage in their pathway by linking families up with engaging, cost-effective and proven family based interventions.

10.7. Non-mandatory Implications

- Crime and disorder
- Safeguarding
- Property/assets
- Customer impact
- Contractual issues
- Staffing issues

Background Papers used in the preparation of the Report: None

List of Appendices: None

HEALTH AND WELLBEING BOARD

10 FEBRUARY 2015

Title: New Psychoactive Substances	
Report of the Corporate Director of Adult and Community Services	
Open Report	For Information
Wards Affected: All	Key Decision: No
Report Author: Sonia Drozd, Drug Strategy Manager	Contact Details: Tel: 020 8227 5455 E-mail: Sonia.Drozd@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director Adult and Community Services	
Summary: This report presents information about New Psychoactive Substances, which have become more prominent and widely available in recent years. This report has been presented to the Substance Misuse Board The paper outlines the difficulties for the government to legislate against new substances, which are developed extremely quickly and are often sold before research can be undertaken into any potential risks they present. This paper outlines what is known about the current market for New Psychoactive Substances in the Borough and how aware residents are of the substances and their dangers. It also reports recommendations which have been agreed by the Community Safety Partnership Board.	
Recommendation(s) The Health and Wellbeing Board is invited to: <ul style="list-style-type: none"> • Comment on the work to date and suggest any future action • Discuss or make comment on what GPs, pharmacies and other health partners can do in response to this problem. 	
Reason(s) The information in this report builds on the objectives contained in Encouraging Civic Pride and Enabling Social Responsibility priorities, specifically: <ul style="list-style-type: none"> • Promote a welcoming, safe, and resilient community; and • Protect the most vulnerable, keeping adults and children healthy and safe. 	

1. Introduction and Background

- 1.1 New Psychoactive Substances (NPS), also known as legal highs, are intoxicating substances that are not prohibited by UK law or have only recently been made illegal. The prevalence of NPS in the UK is rising in line with advances in technology and increased availability.

- 1.2 At present, there is limited information about the use of NPS locally. The Substance Misuse Strategy team are investigating availability, sources and general use of NPS in the Borough in order to develop a target delivery plan address the issue.
- 1.3 The following report outlines the risks associated with NPS, work conducted to-date to understand the issue locally and presents a set of recommendations which have been agreed by the Community Safety Partnership.
- 1.4 The Health and Wellbeing Board should note that separate work is underway to look at the abuse of prescriptive and over the counter medicines and this will be presented to Health and Wellbeing Board in due course.

2. Proposal and Issues

- 2.1 This is an information report to outline recommendations which have been agreed by the Community Safety Partnership in response to the issue of NPS. As a result there are no proposals contained in this report.
- 2.2 The following recommendations were agreed by the Community Safety Partnership (CSP) Board on 9 March 2014 following consultation with the Borough's Substance Misuse Strategy Board, a sub-group of the CSP:
- Recommendation 1 - Work with licensing to identify vendors of NPS in the Borough and to conduct spot purchasing – this will give a better picture of the types of NPS being sold in the Borough;
 - Recommendation 2 - Work with hospital admissions in the Borough to identify toxic symptoms and drug induced psychosis and ensure appropriate referrals are made to services;
 - Recommendation 3 - Extend research into NPS with young people to gain more accurate and comprehensive results;
 - Recommendation 4 - Commission NPS training for substance misuse and PSHE leads in schools. It would be beneficial to have at least one individual fully trained in NPS in each service and school;
 - Recommendation 5 - Create a leaflet on the dangers of nitrous oxide and disseminate in the Borough, in particular to parents and schools;
 - Recommendation 6 - Deliver an education programme in all secondary schools in the Borough teaching young people about the risks of NPS and harm minimisation.
- 2.3 Work has taken place on these recommendations following their agreement by the CSP Board.

3. Key Issues

- 3.1 NPS have existed for a long time, mostly created as legal compounds to replace substances that become prohibited. In recent years, with developing technologies,

NPS have become more prominent and available. Where there has been a decline in the use of illegal drugs nationally, the use of 'legal highs' has increased rapidly. It is estimated that 150 NPS were created in the last three years, this equates to a new compound being created every week.

- 3.2 The issue of NPS is particularly significant in the UK. According to the United Nations Office on Drugs and Crime, the UK has the largest market for legal highs in the European Union.
- 3.3 NPS can be broken down into four categories; stimulants, depressants, hallucinogens and synthetic cannabinoids. Common examples of NPS include 'spice' a synthetic cannabinoid and Alpha Methyl-tryptamine (AMT) a compound mimicking ecstasy.
- 3.4 Currently, NPS are readily available online and in 'Head Shops', which can be found on most UK high streets. Legislating against these sellers is a challenge, as enforcers must prove that the vendor is selling the product for human consumption. Further to this, many of the online sites used to sell NPS fall outside of UK jurisdiction making it almost impossible to legislate against them.
- 3.5 At present, UK law allows a 12 month temporary banning order to be placed on any new psychoactive compound that may have a detrimental impact on humans, while further investigations are made into its properties and potential illegalisation. Further to this, the government has launched a review into NPS, which was published in September 2014. The report highlighted recommendations regarding continued research, improved data collection, data sharing and ensuring that the workforce is skilled and competent.

Risks Associated with NPS

- 3.6 Like all psychoactive substances, NPS can have a significant detrimental impact on the user's mental and physical health.
- 3.7 As the majority of NPS are initially legal they are readily accessible and often cheaper than illegal substances, making them an attractive alternative for drug users.
- 3.8 The term 'legal highs' is often used to describe NPS. This is problematic, as it reinforces the legality of drugs (many of which are in fact illegal). In addition, individuals may associate less harm with substances that are legal and be more inclined to use them,
- 3.9 Due to changes in legislation, it is now illegal to suggest that substances may be used for human consumption at point of sale. Where previously substances have included safety information and dosage guidance, packaging now simply states 'not for human consumption'. This has led to individuals being uninformed about what they are consuming and, in some circumstances, over-dosing.
- 3.10 Further to this, as NPS mimic other illegal drugs, individuals may be inclined to consume them in the same way, however NPS can often be more potent than the drugs they mimic and have increased side effects. For example, there are over 300 synthetic cannabinoids, which have been seen to induce psychosis.

- 3.11 It is estimated that one new psychoactive compound is created every week, this heightens risks, as newer substances have had less testing and thus both their short and long-term effects on humans are unknown.

NPS Locally

- 3.12 There have been no reports locally of individuals accessing services as a result of NPS. However, this does not mean that they are not being used in the Borough, as individuals using them may be less likely to present to services as those using more addictive substances such as opiates and crack. Furthermore, service users may not be aware that they are taking NPS.
- 3.13 The Substance Misuse Strategy team have piloted a survey with young people in order to understand the use of NPS in the Borough. There were a total of 13 responses to the pilot, which is a very small sample, but indicated that:
- more than 50% had heard of NPS;
 - more than 30% knew someone who had used NPS;
 - 23% had used NPS themselves;
 - NPS can be purchased in shops in Romford, Stratford and central London and online; and
 - Nitrous Oxide (also known as 'laughing gas') and a synthetic cannabinoids ('spices' and 'herbal cannabis') is consumed by young people in the Borough.
- 3.14 There was an inconsistency in respondents' knowledge of NPS, suggesting that the majority of respondents surveyed were poorly informed about the topic.
- 3.15 Work is now underway to extend this survey to a much wider audience in order to gain a more accurate insight into NPS use among young people locally.
- 3.16 To date, there has been one shop identified in Dagenham that sells hydroponic paraphernalia associated with the production of cannabis. It is unknown whether this shop also sells legal highs. Work needs to be done to investigate if there are any NPS vendors in the Borough.
- 3.17 Information from Subwize, young people's drug and alcohol service, suggests that young people may be consuming NPS in their homes and in parks.
- 3.18 A representative from CRI delivered training on NPS to members of the Substance Misuse Team, a representative from Subwize and a Senior Manager for the Borough's Education Inclusion, School Improvement Service. This was very useful and it would be beneficial to roll this out to further team members and school staff.

What can be done?

- 3.19 Scoping can be conducted to understand the availability and use of NPS locally. Having a better insight into the prevalence of NPS in Barking and Dagenham will enable appropriate strategy and resources to be developed to address the issue. This should involve doing further surveys with young people, but also doing some research with the 'transitional' age group in the Borough (those aged 18-24), as this group have been identified as at risk of using NPS in other Boroughs.

- 3.20 To further build the local NPS picture, work can be done to scope potential NPS vendors in and to use legislation where possible to reduce the selling of NPS to residents.
- 3.21 Education can be used to build factual awareness for young people about the risks associated with using NPS, as well as harm reduction advice for those using NPS. CRI, for example, offer training and awareness building workshops in other Boroughs, which have been reported as an effective way of spreading the important information concerning NPS.
- 3.22 Training can be delivered to substance misuse and school staff to ensure they are up-to-date on information around NPS and can disseminate this to young people and service users. Ensuring that schools are informed is essential to ensure that they can identify signs that a young person may be consuming legal highs and make appropriate referrals. It would be beneficial to have an NPS lead in every secondary school in the Borough.
- 3.23 Work can also be done with hospitals to identify admissions who present toxic symptoms and drug induced psychosis and to ensure that they are referring these individuals to the appropriate services.

4 Consultation

The contents of this report and the recommendations agreed by the CSP Board were subject to consultation with the Substance Misuse Strategy Board. This Board is attended by Health and Wellbeing Board partners, including the Clinical Commissioning Group, NHS England, the Metropolitan Police and LBBD Council.

5 Mandatory Implications

5.1 Joint Strategic Needs Assessment

The report complements the identification of need and the priorities for future action described in the JSNA, specifically section 7.12 Substance Misuse.

5.2 Health and Wellbeing Strategy

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

5.3 Integration

The report outlines a need for further analysis in to the local context and therefore it is too early to define implications on the area of integration.

5.4 Financial Implications

There are no additional financial implications directly arising from this report.

(Implications completed by: Roger Hampson Group Manager Finance (Adults and Community Services))

5.5 Legal Implications

The Legal team have advised that there are no legal implications in this paper

(Implications completed by: Dawn Pelle, Adult Care Lawyer)

5.6 Risk Management

The report outlines a need for further analysis in to the local context and therefore it is too early to define implications on the area of risk management.

5.7 Patient / Service User Impact

The report outlines a need for further analysis in to the local context and therefore it is too early to define implications on the area of patient / service user impact.

6 Non-mandatory Implications

6.1 Crime and Disorder

There is a potential for NPS usage to fuel anti-social behaviour in parks and open spaces in the Borough. This is included within the recommendations.

6.2 Safeguarding

Substance misuse of any kind has an impact on safeguarding and the Substance Misuse Strategy Board will include all relevant safeguarding tools in to local strategies.

Public Background Papers Used in the Preparation of the Report:

None

List of Appendices:

None

HEALTH AND WELLBEING BOARD

10 FEBRUARY 2015

Title:	The Care Act 2014: Preparedness of NHS organisations		
Report of the Corporate Director of Adult and Community Services			
Open Report	For information		
Wards Affected: NONE	Key Decision: NO		
Report Author: Glen Oldfield, Care Act Project Officer	Contact Details: Tel: 020 8227 5796 E-mail: glen.oldfield@lbbd.gov.uk		
Sponsors: Conor Burke, Accountable Officer, BHR CCGs Jacqui Van Rossum, Jacqui Van Rossum, Executive Director Integrated Care & Transformation, NELFT Stephen Burgess, Interim Medical Director, BHRUT			
Summary: The Care Act is an important piece of statute for NHS agencies. Duties that relate directly to the NHS include: Integration to strengthen local strategic planning of health and social care provision New standards of co-operation to safeguard vulnerable adults, including participation on local Safeguarding Adults Boards. Changes to S117 of the Mental Health Act which relate to mental health after care New regulations for Delayed Transfers of Care to strengthen hospital discharge arrangements Other duties require the NHS to support local authorities in the delivery of adult social care functions. This includes: Working to streamline and integrate assessments and care and support plans, combining processes where possible to benefit the service user (e.g. NHS Continuing Health Care; joint packages of care; identification and appointment of advocates) Supporting effective transitions of young people into adult services Supporting individuals in prison or custody Further to these the Care Act introduces entirely new legal obligations to: Promote wellbeing and offer preventative support to maintain wellbeing			

Provide information and advice to the local population

Assess the needs of, and give services to carers

These provisions of the Care Act will have significant policy and commissioning implications which will require alignment of approach and effective partnership working between the Council and the NHS to successfully deliver.

For the reasons outlined above it is essential that NHS partners are engaged with the Care Act and fully aware of its implications so that each organisation is compliant with the duties and requirements in the Act and its Statutory Guidance.

At the last H&WBB meeting (09 December 2014) each NHS organisation was requested to give consideration to the impacts and implications of the Care Act and what steps are being taken to ensure compliance with the Act from 01 April 2015. The recommendation asked that the CCG, NELFT, and BHRUT reports back to the H&WBB in February 2015 to give assurance. To bring structure and consistency to those reports a short list of questions was prepared.

Has the Care Act been discussed at the CCG/Trust Board/governing body?

Are you conducting / sending staff on training?

Does the Care Act require any changes to your policies and procedures?

What the issues or challenges for your organisation and how are you addressing these?

What are the issues, if any, that need to be escalated to the H&WBB for discussion?

The responses to the questions have been collated at Appendix 1 for the Board to review.

To support NHS partners in understanding the parts of the Care Act which relate to them, the Care Act Programme Team has produced a summary of the statutory guidance that highlights the duties and requirements that directly impact NHS agencies. This is can be found at **Appendix 2**.

Separate to this process the London Social Care Partnership has organised a voluntary framework for London based Mental Health Trusts to use to self-assess local activity which supports implementation of the Care Act. NELFT has completed the self-assessment framework document. The framework is a useful tool to pinpoint issues or areas of development for NELFT. It is therefore suggested that senior officers from NELFT work with the Care Act Programme Team to ensure that actions arising from the self-assessment are taken forward in the context of the wider implementation programme.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

- (i) Note the submissions at **Appendix 1** from NHS organisations that give the H&WBB assurance of Care Act awareness and preparedness.
- (ii) Note the duties and requirements highlighted at **Appendix 2**.

1. Financial Implications

- 1.1. The implementation of the Care Act is a work stream of the Better Care Fund Plan. There are a number of funding streams to support the implementation of the Care Act in 2015/16, including £513k funding contribution from the CCG. Recommendations on the allocation of these resources will be presented to the March meeting of the Health and Wellbeing Board.

(Comments completed by Roger Hampson, Group Manager Finance, Adults and Community Services)

2. Legal implications

- 2.1. The legal implications are that if the various NHS organisations are not prepared their actions could leave LBBB open to either complaints or ultimately legal challenge.
- 2.2. They have to be clear as to the authorities' duties under the statute and how they can effectively assist in meeting these duties.

(Comments completed by Dawn Pelle, Adult Social Care Lawyer)

Background Papers Used in Preparation of the Report:

- The Care Act 2014: Implementation Update (H&WBB, 09 December 2014)
- Care Act Statutory Guidance (<https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation>)

List of appendices¹

- APPENDIX 1: Collated submissions from NHS organisations
- APPENDIX 2: Summary of Care Act Statutory Guidance for NHS agencies

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APPENDIX 1: Collated submissions from NHS organisations

	1) Has the Care Act been discussed at the CCG/Trust Board/governing body?
NELFT	The implications of the Care Act were the subject of a formal presentation to the Trust Clinical Executive in early January 2015 and a Board level paper will be considered in March of 2015.
B&D CCG	The Care Act 2014 has not specifically been discussed at the CCG governing body. The implementation of the Care Act is a workstream of the Better Care Fund Plan. The Governing Body has signed off the Better Care Fund Plan and approved governance arrangements for the delivery of the BCF schemes. The shadow Joint Executive Management Committee is overseeing the development of the Section 75 agreement for the Better Care Fund.
BHRUT	A paper describing the main provisions of the Care Act and its implications for the Trust is being discussed at the Trust Executive Committee on 27 January 2015. A report from this Committee is sent to each Board meeting

	2) Are you conducting/sending staff on training?
NELFT	<p>Yes – the 2015 NELFT Social Care conference will include a masterclass on the phased introduction of Care Act powers, duties and responsibilities, together with practicalities regarding integrated Health and Social Care services in all six NELFT ICD localities.</p> <p>All NELFT staff and s.75 seconded staff tasked with the completion of relevant assessments are being encouraged to attend the training organised for their Local Authority area.</p>
B&D CCG	Training for GP providers and Practice Managers is being organised through the Protected Time Initiative – the programme for 2015 is being discussed at the informal Clinical directors meeting on 26 th January. Safeguarding adults training is mandatory for CCG staff.
BHRUT	We will support staff to attend any training required. To date, processes have been developed jointly and no training need has been identified.

APPENDIX 1: Collated submissions from NHS organisations

	3) Does the Care Act require any changes to your policies and procedures?
NELFT	Policies and procedures relating to areas such as Adult Safeguarding, Transitions, working with Mentally Disordered Offenders and Transfers of Care are being actively reviewed to ascertain any need for change. Most are believed to contain sufficiently permissive forms of words regarding statutory frameworks so as to avoid the need for revision. Appropriate cross-references to the Act and the Wellbeing principle will be included in all future relevant NELFT policy reviews.
B&D CCG	The CCG will be reviewing the safeguarding assurance framework to ensure compliance with Care Act requirements and is working with the Adult Safeguarding Board to implement the new requirements.
BHRUT	The Trust is reviewing relevant policies which may be affected together with partners.

	4) What the issues or challenges for your organisation and how are you addressing these?
NELFT	<p>A review is being undertaken of all relevant partnership agreements to ensure that these reflect, <i>inter alia</i>:</p> <ul style="list-style-type: none"> • The emerging powers and intentions of Local Authorities with regard to delegation of functions and • The agreement, skills mix and capacity to deal with projected increases in assessment burden for particular services
B&D CCG	<ul style="list-style-type: none"> • The expansion in the offer and delivery of personal health budgets where evidence indicates they could benefit <p>The CCG has established a process to offer and deliver personal health budgets and has been focused on continuing healthcare. The expansion of personal health for adults with long term conditions, learning disabilities and children is an area for further development over the next 12 months.</p> <ul style="list-style-type: none"> • To develop and implement joint plans with the Local Authority to identify and support carers <p>Support for carers has been identified as a scheme that is being taken forward through the Better Care Fund Plan. The CCG has been supporting the Local Authority in developing a joint carers strategy and implementation plan. The Joint Executive Management Committee will oversee the delivery of the plan and the management of risks on behalf of the CCG Governing Body.</p> <ul style="list-style-type: none"> • To accelerate the design and implementation of new models of integrated care

APPENDIX 1: Collated submissions from NHS organisations

	<p>New models are set out in the Five Year Forward View and local areas are invited to test out new delivery models for integrated care. The identification of local schemes that have buy-in from our partners is at an early stage of consideration.</p> <ul style="list-style-type: none"> To manage the potential risks of changes to eligibility criteria/social care assessments on hospital admissions and discharges <p>BCF outcomes have been agreed for emergency admission reduction and delayed transfers of care. Risks to delivery will be managed through the Joint Executive Management Committee. The CCGs has included as an entry in its risk register the risk that implementation of the Care Act 2013 will significantly impact on the delivery of adult social care and this may adversely impact on some of the integrated care pathways that have been established across health and social care.</p> Financial risks <p>The implementation of the Care Act could put a financial pressure in the BCF pooled budget. To mitigate this, a financial risk share agreement is being drawn up between the CCG and Local Authority which will form part of the Better Care Fund Section 75 agreement.</p>
BHRUT	<p>We have identified that there may be issues and challenges relating to acute hospital admission and discharge and safeguarding but these will be managed in agreement with partner agencies and Commissioners.</p>

	<p>5) What are the issues, if any, that need to be escalated to the H&WBB for discussion?</p>
NELFT	<p>None that are solely confined to NELFT. The Trust would, however, welcome some discussion at H&WBB level of the likely / possible disruption to the local market for residential care as price discrimination between LA procured and self-funded provision becomes more obvious to consumers.</p>
B&D CCG	<p>It would be helpful to discuss potential risks to the delivery of the BCF outcomes resulting from the Care Act implementation.</p>
BHRUT	<p>There are no issues the Trust would wish to escalate to the H&WBB.</p>

Answers submitted by:

NELFT: Jacqui Van Rossum, Executive Director Integrated Care & Transformation

BHRUT: Andrea Saville, Head of Governance

B&D CCG: Sharon Morrow, Chief Operating Officer

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Requirements of the Care Act for Partner Organisations

This document has been produced by the London Borough of Barking and Dagenham Care Act Team to set out the requirements that the Care Act 2015 places on partner organisations based on the Care Act Guidance.

It is not a substitute for the Care Act Guidance produced by the Department of Health: it is a heavily summarised document for quick reference purposes

Requirements on partners' safeguarding arrangements are set out on pages 12 to 23.

	Para	PREVENTING, REDUCING OR DELAYING NEEDS	Partner
1	2.15	To prevent needs emerging across health and care, integrated services should draw on a mixture of qualified health, care and support staff, working collaboratively to deliver prevention. This could involve, for instance, reaching beyond traditional health or care interventions to help people develop or regain the skills of independent living and active involvement in their local community.	All partners
2	2.27	Where the local authority does not provide such types of preventative support itself, it should have mechanisms in place for identifying existing and new services, maintaining contact with providers over time, and helping people to access them. Local approaches to prevention should be built on the resources of the local community, including local support networks and facilities provided by other partners and voluntary organisations	All partners
3	2.30	Understanding unmet need will be crucial to developing a longer-term approach to prevention that reflects the true needs of the local population. This assessment should also be shared with local partners, such as through the health and wellbeing board, to contribute to wider intelligence for local strategies. Preventative services, facilities or resources are often most effective when brought about through partnerships between different parts of the local authority and between other agencies and the community such as those people who are likely to use and benefit from these services.	All Partners
4	2.32	Preventing needs will often be most effective when action is undertaken at a local level, with different organisations working together to understand how the actions of each may impact on the other.	All partners
5	2.33	Across the local landscape, the role of other bodies including the local NHS (e.g. GPs, dentists, pharmacists, ophthalmologists etc.), welfare and benefits advisers (e.g. at the Jobcentre Plus), the police, prisons in respect of those persons detained or released with care and support needs,	All partners

		service providers and others will also be important in developing a comprehensive approach to prevention of care and support needs.	
6	2.35	A local authority must cooperate with each of its relevant partners and the partners must cooperate with the local authority, for example, in relation to the provision of preventative services and the identification of carers, a local authority must cooperate with NHS bodies.	All partners

	Para	INFORMATION AND ADVICE	Partner
		Duty to establish and maintain a service	
7	3.14	While the local authority must establish and maintain a service, the duty does not require they provide all elements of this service. Rather, the local authority is expected to understand, co-ordinate and make effective use of other high quality statutory, voluntary and/or private sector information and advice resources available to people within their areas. This may also include provision of a service or parts of a service in conjunction with one or more local authorities, health services, children's services, or reuse of information from other local or national sources. When a local need for additional information and advice services is identified, local authorities should recognise the relevance of independent and impartial advice and should consider carefully whether services should be provided by the local authority directly or by another agency, including independent providers.	Voluntary and private sector information and advice resources Other LAs Health services Children's Services
		What should be provided	
8	3.24	The information and advice service should include, information and advice on: <ul style="list-style-type: none"> • available housing and housing-related support options for those with care and support needs; • effective treatment and support for health conditions, including Continuing Health Care arrangements; • availability and quality of health services; • availability of services that may help people remain independent for longer such as home improvement agencies, handyman or maintenance services; • availability of intermediate care entitlements such as aids and adaptations; • eligibility and applying for disability benefits and other types of benefits; • availability of employment support for disabled adults; • children's social care services and transition; • availability of carers' services and benefits; • sources of independent information, advice and advocacy; • the Court of Protection, power of attorney and becoming a Deputy; • raise awareness of the need to plan for future care costs; • practical help with planning to meet future or current care costs; • accessible ways and support to help people understand the different types of abuse and its prevention. 	Housing Health Home improvement / maintenance services Benefit agencies/ employment support Children's services Carers groups Court of Protection
		Money management	
9	3.45	Different people will need different levels of support from the local authority and other providers of information and advice depending on their financial capability, their care needs and the amount they are expected to contribute. The local authority may be able to provide some of this information itself, for example of welfare benefits, but where it cannot, it should help people access it.	All Partners
10	3.49	Staff within a local authority and other frontline staff should have the knowledge to direct people to the financial information and advice they need explaining the differences and potential benefits from seeking regulated or non-regulated financial advice. Local authorities should ensure frontline staff are able to support people to access the information and advice they need to make good financial decisions.	Front line staff

		Safeguarding	
11	3.53	The information and advice provided must also cover who to tell when there are concerns about abuse or neglect and what will happen when such concerns are raised, including information on how the local Safeguarding Board works.	Safeguarding Adults Board and its partners
		Reviewing and developing a plan or strategy	
12	3.59	<p>The development of information and advice plans and their implementation should be an ongoing and dynamic process, involving all relevant stakeholders, rather than a one off occurrence. The plan and the resulting service should adapt to changing needs and as a result of feedback and learning on what works best. The plan should be reviewed at agreed intervals. As a minimum, the process of developing a local plan should include:</p> <ul style="list-style-type: none"> • engagement with people, carers and family members, to understand what is working and not working for them, their preferences and how their information advice and advocacy needs can best be met; • adopting a 'co-production' approach to their plan, involving user groups and people themselves, other appropriate statutory, commercial and voluntary sector service providers, and make public the plan once finalised; • mapping to understand the range of information, advice and advocacy services, including independent financial advice and different providers available; • coordination with other statutory bodies with an interest in care and support, including local Clinical Commissioning Groups, Health and Wellbeing Boards, local Healthwatch and neighbouring local authorities; • building into the plan opportunities to record, measure and assess the impact of information and advice services rather than simply service outputs. 	<p>All stakeholders</p> <p>Service users and carers Statutory, commercial and voluntary sector provides CCGs HWB HealthWatch Neighbouring LAs</p>
13	3.63	As part of their plans, local authorities should consider the persons and/or places most likely to come into contact with people in need of information and advice at these and other critical points in the person's care and support journey. This may be another statutory party, such as a GP or other NHS professional, other professionals, such as a solicitor or funeral director, care and support and housing providers, or a local group, user-led or charitable organisation, rather than the local authority itself. Local authorities should consider whether independent sources of information and advice may in some circumstances be more trusted – and therefore more effective – than the local authority itself	<p>GPs Health professionals Solicitors Funeral directors Housing Local groups</p>
14	3.68	Some national providers, for example the Money Advice Service and NHS choices, may also offer free access to tools, resources and information content that can be integrated into local authority websites or delivered in paper formats. Local authorities are encouraged to explore how they can make the most of cost-effective partnership opportunities with national providers. Referral or signposting to national sources should only occur where this is deemed to be in the best interests of the person and their circumstances and should not take the place of local services necessary for local authorities to discharge their duty under the Act. Local authorities will need to find the appropriate balance between local and national provision to cost-effectively meet their local need.	National providers

15	3.69	Information and advice provided, whether directly by a local authority or by third parties as part of the information and advice service that the local authority establishes and maintains, should be of a good standard and, where appropriate, delivered by trained or suitably qualified individuals	All providers of information and advice
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	Para	MARKET SHAPING	Partner
16	4.88	The Health and Social Care Act 2012 sets out specific obligations for the health system and its relationship with care and support services. It gives a duty to NHS England, clinical commissioning groups, Monitor and Health and Wellbeing Boards to make it easier for health and social care services to work together to improve outcomes for people. Section 3 of the Care Act places a corresponding duty on local authorities to carry out their care and support functions with the aim of integrating services with those provided by the NHS or other health-related services, such as housing.	NHS CCG Monitor HWBs

	Para	MANAGING PROVIDER FAILURE	Partner
17	5.17	From April 2015, the financial “health” of certain care and support providers will become subject to monitoring by the Care Quality Commission (CQC). The Care and Support (Market Oversight Criteria) Regulations 2014 set out the entry criteria for a provider to fall within the regime. CQC will determine which providers satisfy the criteria using data available to it. It will notify the providers which meet the entry criteria.	CQC
18	5.18	CQC must then assess the financial sustainability of the provider’s business. If it assesses there is a significant risk to the financial sustainability of the provider’s business, there are certain actions CQC may take with that provider (none of which involve local authorities).	CQC
19	5.19	Where CQC is satisfied that a provider in the regime is likely to become unable to continue with their activity because of business failure, it is required to tell the local authorities which it thinks will be required to carry out the temporary duty, so that they can prepare for the local consequences of the business failure. CQC will inform local authorities once it is satisfied the provider is unlikely to be able to carry on because of business failure. CQC’s trigger to contact authorities is that it believes the whole of the regulated activity in respect of which the provider is registered is likely to fail, not parts of it.	CQC
20	5.20	Where CQC considers it necessary to do so to help a local authority to carry out the temporary duty, it may request the provider to provide it with information and CQC must then give the information, and any further relevant information it holds, to the local authorities affected.	CQC
21	5.21	If the CQC is of the view that a provider is likely to become unable to continue with its activity because of business failure, the CQC should work closely together with the affected local authorities to help them fulfil their temporary duty. Local authorities should consider the guidance which it is anticipated CQC will publish early in 2015 on its operation of the market oversight function and how it will work with authorities in such situations.	CQC
22	5.22	In exercising its market oversight functions, CQC must have regard to the need to minimise the burdens it imposes on others.	CQC

	Para	ASSESSMENT AND ELIGIBILITY	Partner
23	6.3	A joint assessment is where relevant agencies work together to avoid the person undergoing multiple assessments (including assessments in a prison, where local authorities may need to put particular emphasis on cross-agency cooperation and sharing of expertise).	All partners
24	6.4	People may approach a local authority for an assessment, or be referred by a third party	All partners
25	6.75	People may have needs that are met by various bodies. Therefore, a holistic approach to assessment which aims to bring together all of the person's needs may need the input of different professionals such as adult care and support, children's services, housing, experts in the voluntary sector, relevant professionals in the criminal justice system, health or mental health professionals.	Children's Services Housing Voluntary Sector Criminal Justice System Health
26	6.77	Where more than one agency is assessing a person, they should all work closely together to prevent that person having to undergo a number of assessments at different times, which can be distressing and confusing.	All partners
27	6.78	Where a person has both health and care and support needs, local authorities and the NHS should work together effectively to deliver a high quality, coordinated assessment	NHS
28	6.81	Whilst local authorities have a duty to carry out an assessment they cannot arrange services that are the responsibility of the NHS (e.g. care provided by registered nurses and services that the NHS has to provide because the individual is eligible for NHS CHC). Responsibility for arranging and monitoring the services required to meet the needs of those who qualify for NHS CHC rests with the NHS.	NHS
29	6.82	Individuals may require care and support provided by their local authority and/or services arranged by CCGs. Local authorities and CCGs therefore have a responsibility to ensure that the assessment of eligibility for care and support and CHC respectively take place in a timely and consistent manner. If, following an assessment for NHS CHC, a person is not found to be eligible for NHS CHC, the NHS may still have a responsibility to contribute to that person's health needs – either by directly commissioning services or by part-funding the package of support. Where a package of support is commissioned or funded by both an LA and a CCG, this is known as a 'joint package' of care. A joint package of care could include NHS-funded nursing care and other NHS services that are beyond the powers of a local authority to meet. The joint package could also involve the CCG and the local authority both contributing to the cost of the care package, or the CCG commissioning part of the package. Joint packages of care may be provided in a nursing or care home, or in a person's own home, and could be by way of joint personal budget.	CCGs
30	6.83	Local authorities and CCGs in each local area must agree a local disputes resolution process to resolve cases where there is a dispute between them about eligibility for NHS CHC, about the apportionment of funding in joint funded care and support packages, or about the operation of refunds guidance. Disputes should not delay the provision of the care package, and the protocol should make clear how funding will be provided pending resolution of the dispute. Where disputes relate to local authorities and CCGs in different geographical areas, the	CCG

		disputes resolution process of the responsible CCG should normally be used in order to ensure resolution in a robust and timely manner. This should include agreement on how funding will be provided during the dispute, and arrangements for reimbursement to the agencies involved once the dispute is resolved.	
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	Para	INDEPENDENT ADVOCACY	Partner
31	7.21	The duty to consider the need for an independent advocate to support a person's involvement in an assessment applies equally to people whose needs are being jointly accessed by the NHS and the local authority or where a package of support is, planned, commissioned or funded by both a local authority and a Clinical Commissioning Group (CCG), known as a 'joint package' of care.	NHS CCG
32	7.23	People who do not retain a right to an Independent Mental Health Advocate (IMHA), whose care and support needs are being assessed, planned or reviewed by the NHS and local authority should be considered for an advocate under the Care Act, if they have substantial difficulty in being involved and if there is no appropriate person to support their involvement.	NHS
33	7.26	There is increasing case law on adult safeguarding from the Court of Protection of which advocates and practitioners should be aware.	Advocates and practitioners
34	7.27	If a safeguarding enquiry needs to start urgently then it can begin before an advocate is appointed but one must be appointed as soon as possible. All agencies need to know how the services of an advocacy can be accessed and what their role is.	All partners

	Para	INTEGRATION, CO-OPERATION AND PARTNERSHIP	Partner
		Duty to Co-operate	
35	15.2	Sections 3, 6 and 7 of the Act require that: <ul style="list-style-type: none"> • local authorities must carry out their care and support responsibilities with the aim of promoting greater integration with NHS and other health-related services; • local authorities and their relevant partners must cooperate generally in performing their functions related to care and support; and, supplementary to this, • in specific individual cases, local authorities and their partners must cooperate in performing their respective functions relating to care and support and carers wherever they can. 	All partners
36	15.15	All public organisations should work together and co-operate where needed, in order to ensure a focus on the care and support (including carers' support) and health and health-related needs of their local population.	All partners
37	15.18	Local Authorities and relevant partners must co-operate when exercising any respective functions which are relevant to care and support. This requirement relates to organisations' existing functions only, and the Act does not confer new functions.	All partners
38	15.21	The local authority must co-operate with each of its relevant partners, and the partners must also co-operate with the local authority, in relation to relevant functions. The Act specifies the "relevant partners" who have a reciprocal responsibility to co-operate. These are: <ul style="list-style-type: none"> • other local authorities within the area (i.e. in multi-tier authority areas, this will be a district council); • any other local authority which would be appropriate to co-operate with 	NHS bodies Department for Work and Pensions Police Prison services Probation services

This is a summarised guide. It is not a substitute for the detailed guidance. It is produced for quick reference only

		<p>in a particular set of circumstances (for example, another authority which is arranging care for a person in the home area);</p> <ul style="list-style-type: none"> • NHS bodies in the authority's area (including the primary care, CCGs, any hospital trusts and NHS England, where it commissions health care locally) • local offices of the Department for Work and Pensions (such as Job Centre Plus); • police services in the local authority areas and prisons and probation services in the local area. 	
39	15.22.	<p>There may be other persons or bodies with whom a local authority should co-operate if it considers this appropriate when exercising care and support functions, in particular independent or private sector organisations. Examples include, but are not limited to, care and support providers, NHS primary health providers, independent hospitals and private registered providers of social housing, the Care Quality Commission and regulators of health and social care professionals.</p>	<p>Independent and Private Sector Social housing providers CQC Regulatory bodies</p>
40	15.25	<p>Co-operation in relation to care and support functions should form part of a local authority and partners' general strategic thinking, which should inform how they exercise these functions day-to-day. However, there will be individual cases where more specific co-operation will be required, and a local authority or partner will need to explicitly ask one another for co-operation, for example, by requesting specific action in an individual case. The Care Act provides an express duty for the local authority and partner to ask each other for co-operation in individual cases.</p>	<p>All partners</p>
41	15.28	<p>Where the local authority or relevant partner decide to use this mechanism, they should notify the other in writing, making clear the relevant Care Act provisions. If the local authority or the relevant partner decides not to co-operate with a request, then they must write to the other, setting out reasons for not doing so. Local authorities and their relevant partners must respond to requests to cooperate under their general public law duties to act reasonably, and failure to respond within a reasonable time frame could be subject to judicial review.</p>	<p>All partners</p>
42	15.30	<p>In order to support joint working, it is important that all partners involved are clear about their own responsibilities, and how they fit together. Section 22 of the Care Act sets out the limits on what a local authority may provide by way of healthcare and so, in effect, sets the boundary between the responsibilities of local authorities for the provision of care and support, and those of the NHS for the provision of health care.</p>	<p>NHS</p>
43	15.34	<p>Where the person has a 'primary health need' as set out in regulations and as determined following an assessment of need under national guidance, it is the responsibility of the health service to meet all assessed health and associated care and support needs, including suitable accommodation, if that is part of the overall need.</p>	<p>NHS</p>
44	15.37	<p>The provisions on the discharge of hospital patients with care and support needs are contained in Schedule 3 to the Care Act 2014 and the Care and Support (Discharge of Hospital Patients) Regulations 2014 ("the Regulations"). These provisions enable the NHS to seek reimbursement from local authorities where they consider it necessary in order to assist the NHS and local authorities in working together effectively and efficiently to plan the safe and timely discharge of NHS hospital patients from NHS acute medical care facilities to local authority care and support. The purpose of these provisions is to maintain the existing scope of the reimbursement regime but to update existing</p>	<p>NHS</p>

		provisions to reflect the current NHS and care and support landscape. Also, in light of the drive to improve integration between health and social care provision the recovery of any reimbursement has now been placed on a discretionary rather than mandatory footing.	
45	15.38	Schedule 3 to the Care Act covers: <ul style="list-style-type: none"> • the scope of the hospital discharge regime and the definition of the patients to whom it applies; • the notifications which an NHS body must give a local authority where the NHS considers that it is not likely to be safe to discharge the patient unless arrangements for meeting the patient's needs for care and support are put in place; • the period for which an NHS body can consider seeking reimbursement from a local authority, where that local authority has not fulfilled its requirements to assess or put in place care and support to meet needs, or (where applicable) to meet carers' needs for support, within the time periods set such that the patient's discharge from hospital is delayed. 	NHS
46	15.39	The Regulations and this guidance both set out further details of the form and content of what the various types of NHS notification notices must and should contain to ensure the local authority has relevant information to comply with its requirements to undertake assessments, and to put in place any arrangements necessary for meeting any of the patient's care and support needs, or where applicable, the carer's needs for support. They set out the circumstances when assessment notices and discharge notices must be withdrawn, and determine the period and amount of any reimbursement liability which a local authority may be required to pay the NHS for any delay in the transfer of care.	NHS
47	15.40	Both NHS and local authorities should, using the best evidence available, develop and apply local protocols that ensure that all patients receive appropriate and safe discharge procedures.	NHS
48	15.41	The NHS may seek reimbursement from local authorities for a delayed transfer of care in the circumstances set out in Schedule 3 to the Care Act and its Regulations.	NHS
49	15.42	NHS and local authorities should develop and adopt collaborative approaches to working together in order to reduce the number of delayed days where a patient is ready to be transferred from NHS acute medical care to other settings regardless of whether the patient falls within the scope of the reimbursement regime. The duties to cooperate in the Care Act 2014 also apply to all transfers of care.	NHS
50	15.44	The discharge of hospital patients provisions only apply to NHS hospital patients in England who are receiving acute care, and who the NHS considers are likely to have care and support needs after discharge from hospital and who have not otherwise been expressly excluded. However, even where a patient falls outside the scope of these provisions, this does not mean that the NHS and local authorities should not be working together to deliver the safe and timely discharge of all hospital patients with care and support needs.	NHS
51	15.47	The Act allows an NHS body which has commissioned acute treatment at an independent hospital within the UK to make arrangements for the independent provider to issue assessment or discharge notifications on its behalf. This means that independent providers can take decisions such as whether the patient is likely to need care and support services, when the patient is to be discharged, what follow-up health needs they may have, etc. However, the NHS body will retain ultimate responsibility	NHS Independent providers

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		for the functions, including any claim for reimbursement that might be appropriate.	
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	Para	TRANSITIONS TO ADULT CARE AND SUPPORT	Partner
		Co-ordination and co-operation	
52	16.4	Professionals from different agencies, families, friends and the wider community should work together in a coordinated manner around each young person or carer to help raise their aspirations and achieve the outcomes that matter to them. The purpose of carrying out transition assessments is to provide young people and their families with information so that they know what to expect in the future and can prepare for adulthood.	All partners
53	16.43	Local authorities must also cooperate with relevant external agencies including local GP practices, housing providers and educational institutions. Again, this duty is reciprocal. This cooperation is crucial to help ensure that assessments and planning are person-centred. Furthermore, local health services or schools are vital to identifying young people and carers who may not already be in contact with local authorities.	All partners
54	16.45	The local authority should ensure that all relevant partners are involved in transition planning where they are involved in the person's care and support. Equally, the local authority should be involved in transition planning led by another organisation, for example a child and adolescent mental health service, where there are also likely to be needs for adult care and support.	All partners
55	16.46	Agencies should agree how to organise processes so that all the relevant professionals are able to contribute. For example, this might involve arranging a multi-disciplinary team meeting with the young person or carer. However, it may not always be possible for all the professionals from different agencies to be present at appointments, but where this is the case, they should still be able to contribute. Transition assessments must be person-centred, which means that contributions by different agencies should reflect the views of the person to whom the assessment relates.	All partners
56	16.56	The local authority and relevant partners should consider building on a transition assessment to create a person-centred transition plan that sets out the information in the assessment, along with a plan for the transition to adult care and support, including key milestones for achieving the young person or carer's desired outcomes. An advantage of a transition plan is that it is easier to update and refine without undertaking a new assessment – transition assessments and plans should be reviewed regularly to take account of changes both in circumstances and desired outcomes. The priorities of young people and young carers will often change a lot during their adolescent years, and plans should be updated frequently enough to reflect this.	All partners
57	16.70	For some people with complex SEN and care needs, local authorities and their partners may decide that children's services are the best way to meet a person's needs – even after they have turned 18. Both the Care Act 2014 and the Children and Families Act 2014 allow for this	All partners
58	16.79	Clinical Commissioning Groups (CCGs) should use the National Framework for NHS Continuing Healthcare and supporting guidance and tools to determine what on-going care services people aged 18 years or over should receive. The framework sets out that CCGs should ensure that adult NHS continuing healthcare is appropriately	CCGs

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		represented at all transition planning meetings to do with individual young people whose needs suggest that there may be potential eligibility. CCGs and LAs should have systems in place to ensure that appropriate referrals are made whenever either organisation is supporting a young person who, on reaching adulthood, may have a need for services from the other agency.	
59	16.81	Where a young person has been receiving children's continuing health care from a relevant CCG, it is likely that they will continue to be eligible for a package of adult NHS CHC when they reach the age of 18. Where their needs have changed such that they are assessed as no longer requiring such a package, they should be advised of their non-eligibility and of their right to request an independent review and mediation. The CCG should continue to participate in the transition process, in order to ensure an appropriate transfer of responsibilities, including consideration of whether they should be commissioning, funding or providing services towards a joint package of care.	CCGs

	Para	PRISONS, APPROVED PREMISES AND BAIL ACCOMMODATION	Partner
		NHS Responsibilities	
60	17.7	The local authority will be jointly responsible for after-care with NHS England while the person is in prison.	NHS England
61	17.42	For those assessed as being in need of equipment or adaptations to their living accommodation to meet their needs, local authorities should discuss with their partners in prisons, approved premises and health care services where responsibility lies. Where this relates to fixtures and fittings (for instance a grab rail or a ramp), it will usually be for the prison to deliver this. But for specialised and moveable items such as beds and hoists, then it may be the local authority that is responsible. Aids for individuals, as defined in the Care and Support (Preventing Needs for Care and Support) Regulations 2014, are the responsibility of the local authority, whilst more significant adaptations would be the responsibility of the custodial establishment. Custody services, healthcare providers and local authorities should agree local responsibilities.	Custody services, healthcare providers
		Information sharing	
62	17.23	Prisons and/or prison health services should inform local authorities when someone they believe has care and support needs arrives at their establishment.	Prisons and prison health services
		Movement of an individual	
63	17.50	There will be circumstances where the process to ensure continuity of care will need to differ. The prison or approved premises to which an individual is allocated is a matter for the Ministry of Justice, and individuals may be moved between different custodial settings. In such cases, the Governor of the prison or a representative, should inform the local authority in which the prison is located (the first authority) that the adult is to be moved or is being released to a new area as soon as practicable. Where the new custodial setting or the community, if being released, is in a different local authority area (second authority), the first authority must inform the second authority of the move once it has been told by the prison.	Prison Governors
64	17.51	The prison, local authorities and where practicable, the individual, should work together to ensure that the adult's care is continued during a move.	Custody services

Ordinary Residence			
65	17.58	Given the difficulties associated with determining some offenders' ordinary residence on release, prisons or approved premises, the probation provider (NPS or CRC) and the local authority providing care and support should initiate joint planning for release in advance. Early involvement of all agencies, particularly providers of probation services, should ensure that the resettlement plan is sustainable in the local authority area where the individual will reside. Prisons and probation services should support assessment and care and support planning for those offenders who will require care and support services on their release from prison.	Custody services Probation Service
Integrated Services			
66	17.59	It is essential that local arrangements for the delivery of care and support are made in partnership with health and education commissioners and providers within a custodial environment, as well as the NPS and CRCs so that those with eligible needs experience integrated services.	Health Custody services Probation Services
67	17.60	The duty to promote integration includes health and health related services provided by prisons and providers of probation services.	Health Custody services Probation services
End of Life Care			
68	17.62	The provision of care and support for those in custodial settings extends to those who reach the end of life whilst in prison. For this provision of palliative care, some will transfer to a local hospital, hospice or care home or move to an alternative prison where a more suitable environment is available. In these cases, responsibility for care and support will pass to the NHS or new local authority, once the individual arrives at the new location. Approved Premises are not in general a suitable location for the provision of end of life care.	NHS
69	17.63	Prison managers and health care providers should consider informing local authorities when a prisoner receives a terminal diagnosis or when the condition of such a patient deteriorates significantly. Information could be shared with local authorities for the purpose of offender management under s.14 of the Offender Management Act 2007. The individual's consent should be obtained where possible.	Prison managers Healthcare providers
70	17.64	Where it is not possible to obtain consent to share the information, managers of custodial settings and health care providers should make an individual assessment of the nature of the information and the requirements of the Data Protection Act 1998.	Prison managers Healthcare providers
71	17.67	NHS England is responsible for commissioning healthcare for prisoners, where necessary this includes NHS continuing healthcare.	NHS England
Safeguarding			
72	17.68	The prison must ensure that it has clear safeguarding policies and procedures that are explained to all visiting staff. Prison and probation staff may approach the local authority for advice and assistance in individual cases although the local authority will not have the legal duty to lead enquiries in any custodial setting.	Prison managers Probation staff Care providers
Complaints			
73	17.78	Managers of custodial settings should inform local authorities where an offender wishes to make a complaint about the provision of care and support as soon as they are made aware.	Managers of custodial settings

	Para	DELEGATION OF LA FUNCTIONS	Partner
74	18.12	Care and support functions are public functions and they must be carried out in a way that is compatible with all of the local authority's legal obligations including the Human Rights Act or the Data Protection Act.	Partners carrying out LA functions

	Para	CROSS BORDER PLACEMENTS	Partner
75	21.68	The Responsible Person (i.e. Minister or Northern Ireland Department) to whom the dispute between authorities has been referred must: <ul style="list-style-type: none"> • Consult other responsible persons (i.e. Ministers or NI Department) in determining the dispute. • Notify those responsible persons of their determination. 	Minister or Northern Ireland Department

	Para	SIGHT REGISTERS	Partner
76	22.11	It is expected that NHS services will keep the completed Certificate of Vision of Impairment, signed by the consultant and the patient, for their records. A copy of the certificate should be sent to the relevant local authority and the patient's GP within five working days of its completion.	NHS

ADULT SAFEGUARDING

	SAB1	CHIEF OFFICERS AND CHIEF EXECUTIVES	
77	14.191	All officers, including the Chief Executive of the local authority, NHS and police chief officers and executives should lead and promote the development of initiatives to improve the prevention, identification and response to abuse and neglect. The Chief Officers must sign off their organisation's contributions to the Strategic Plan and Annual Reports	LA NHS Police
78	14.192	Chief Officers should receive regular briefings of case law from the Court of Protection and the High Courts	LA NHS Police
79	14.190	Responsible for promoting prevention, early intervention and partnership working is a key part of a DASS's role and also critical in the development of effective safeguarding.	DASS
		Priority Partners	
80	14.52	Relevant partners of a LA include any other local authority with whom they agree it would be appropriate to co-operate and the following agencies/ bodies who operate within the local authority's area including: <ul style="list-style-type: none"> • NHS England; • Clinical Commissioning Groups (CCGs); • NHS trusts and NHS Foundation Trusts; • Department for Work and Pensions; • the Police; • Prisons; and • Probation services 	NHS CCG DWP Police Prison service Probation
	SAB 2	STAFF	
		Employers of staff who may be working or have contact with vulnerable adults should ensure that the appropriate pre-employment checks through the Disclosure and Barring Service are carried out	
81	14.203	There are three levels of a Disclosure and Barring Service (DBS) check. The standard check The enhanced check The enhanced with barred list check	All employers

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Reporting of Staff			
82	14.96	Members of staff (including people employed by the adult) should be made aware of any complaint or allegation against them. They should be made aware of their rights under employment legislation and any internal disciplinary procedures.	Employers
83	14.100	Employers who are also providers or commissioners of care and support have a duty to the adult as well as a responsibility to take action in relation to the employee when allegations of abuse are made against them. Disciplinary procedures should be compatible with the responsibility to protect adults at risk of abuse or neglect.	Employers who are commissioners
84	14.101	With regard to abuse, neglect and misconduct within a professional relationship, codes of professional conduct and/or employment contracts should be followed and should determine the action that can be taken. Robust employment practices, with checkable references and recent DBS checks are important. Reports of abuse, neglect and misconduct should be investigated and evidence collected.	Employers
85	14.102	Employers should report workers to the statutory and other bodies responsible for professional regulation such as the General Medical Council and the Nursing and Midwifery Council. If someone is removed from their role providing regulated activity following a safeguarding incident the regulated activity provider (or if the person has been provided by an agency or personnel supplier, the legal duty sits with them) has a legal duty to refer to the Disclosure and Barring Service.	Employers
86	14.62	<p>If someone is removed by being either dismissed or redeployed to a non-regulated activity, from their role providing regulated activity following a safeguarding incident, or a person leaves their role (resignation, retirement) to avoid a disciplinary hearing following a safeguarding incident and the employer/volunteer organisation feels they would have dismissed the person based on the information they hold, the regulated activity provider has a legal duty to refer to the Disclosure and Barring Service.</p> <p>If an agency or personnel supplier has provided the person, then the legal duty sits with that agency. In circumstances where these actions are not undertaken then the local authority can make such a referral.</p>	<p>Employer/ Volunteer Organisation</p> <p>Agency or Personnel suppliers</p> <p>LA</p>
Record Keeping			
87	14.87	Employers must ensure all staff keep accurate records, stating what the facts are and what are the known opinions of professionals and others and differentiating between fact and opinion.	Employers
88	14.150	Whenever a complaint or allegation of abuse is made, all agencies should keep clear and accurate records and each agency should identify procedures for incorporating, on receipt of a complaint or allegation, all relevant records into a file to record all action taken. When abuse or neglect is raised managers need to look for past incidents, concerns, risks and patterns. In the case of providers registered with CQC, records of these should be available to service commissioners and the CQC so they can take the necessary action.	<p>All agencies</p> <p>Registered providers CQC</p>

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89	14.151	Staff should be given clear direction as to what information should be recorded and in what format.	Employers
90	14.152	Records should be kept in such a way that the information can easily be collated for local use and national data collections.	Employers
Information Sharing			
91	14.153	All agencies should identify arrangements, consistent with principles and rules of fairness, confidentiality and data protection for making records available to those adults affected by, and subject to, an enquiry. If the alleged abuser is using care and support themselves, then information about their involvement in an adult safeguarding enquiry, including the outcome, should be included in their case record. If it is assessed that the individual continues to pose a threat to other people then this should be included in any information that is passed on to service providers or other people who need to know.	All organisations
Training and Development			
92	14.86	Employers must ensure that staff, including volunteers, are trained in recognising the symptoms of abuse or neglect, how to respond and where to go for advice and assistance.	Employers
93	14.198	Staff governed by professional regulation (for example, social workers, doctors, allied health professionals and nurses) should understand how their professional standards and requirements underpin their organisational roles to prevent, recognise and respond to abuse and neglect.	Professionals
94	14.199	The SAB should ensure that relevant partners provide training for staff and volunteers on the policy, procedures and professional practices that are in place locally, which reflects their roles and responsibilities in safeguarding adult arrangements. This should include: <ul style="list-style-type: none"> • basic mandatory induction training with respect to awareness that abuse can take place and duty to report; • more detailed awareness training, including training on recognition of abuse and responsibilities with respect to the procedures in their particular agency; • specialist training for those who will be undertaking enquiries, and managers; and, training for elected members and others e.g. Healthwatch members; and • post qualifying or advanced training for those who work with more complex enquiries and responses or who act as their organisation's expert in a particular field, for example in relation to legal or social work, those who provide medical or nursing advice to the organisation or the Board. 	SAB Employers Volunteer agencies
95	14.200	Training should take place at all levels in an organisation and be updated regularly to reflect best practice. To ensure that practice is consistent no staff group should be excluded.	All employers
96	14.202	Regular face-to-face supervision from skilled managers and reflective practice is essential to enable staff to work confidently and competently with difficult and sensitive situations	All employers

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97	14.205	Provider agencies should produce for their staff a set of internal guidelines which relate clearly to the multiagency policy and which set out the responsibilities of all staff to operate within it.	Providers
98	14.206	Internal guidelines should also explain the rights of staff and how employers will respond where abuse is alleged against them within either a criminal or disciplinary context	All employers
Mental Capacity Act			
99	14.45	Professionals and other staff must understand and work in line with the MCA – they will need considerable guidance and support from their employers – including regular face to face supervision from skilled managers	Professionals Employers
Designated Adult Safeguarding Manager (DASM)			
100	14.175	Each SAB should establish and agree a framework and process for any organisation under the umbrella of the SAB to respond to allegations and issues of concern that are raised about a person who may have harmed or who may pose a risk to adults.	SAB
101	14.176	Each member of the SAB should have a Designated Adult Safeguarding Manager (DASM) responsible for the management and oversight of individual complex cases and coordination where allegations are made or concerns raised about a person, whether an employee, volunteer or student, paid or unpaid The DASM should keep in regular contact with their counterparts in partner organisations. They should also have a role in highlighting the extent to which their own organisation prevents abuse and neglect taking place.	LA CCG Police Other SAB members
102	14.177	The DASM should provide advice and guidance within their organisation, liaising with other agencies as necessary. The DASM should monitor the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.	LA CCG Police Other SAB members
103	14.178	The DASM will work with care and support providers and other service providers e.g. housing and NHS trusts to ensure that referral of individual employees to the DBS and, or, Regulatory Bodies (e.g. CQC, HCPC, GMC, NMC) are made promptly and appropriately and that any supporting evidence required is made available.	LA CCG Police Other SAB members Service Providers
104	14.179	The DASM will ensure that systems are in place to provide the employee with support and regular updates in respect of the adult safeguarding investigation	LA, CCG Police Other SAB members
105	14.180	The DASM should ensure that appropriate recording systems are in place that provide clear audit trails about decision-making and recommendations in all processes relating to the management of adult safeguarding allegations against the person alleged to have caused the harm or risk of harm and ensure the control of information in respect of individual cases is in accordance with accepted Data Protection and Confidentiality requirements.	LA CCG Police Other SAB members
106	14.181	The local authority DASM will need to work closely with the children's	LA

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		services Local Authority Designated Officer (LADO) and other DASM and LADO for both adults and children in the region or nationally to ensure sharing of information and development of best practice.	Children's Services
107	14.182	There may be times when a person is working with adults and their behaviour towards a child or children may impact on their suitability to work with or continue to work with adults at risk. This may be referred to the DASM from a LADO, if it is not, then information should be shared with the LADO.	All organisations
108	14.183	There may also be times when a person's conduct towards an adult may impact on their suitability to work with or continue to work with children. All these situations must be referred to the LADO.	All organisations
109	14.184	Unless it puts the adult at risk or child in danger, the individual should be informed that the information regarding the allegation against them will be shared. Responsibility lies with the person receiving the information to obtain the consent of the individual to share information.	All organisations
		Senior managers	
110	14.187	Each agency should identify a senior manager to take a lead role in the organisational and in inter-agency arrangements, including the SAB.	All organisations SAB
	SAB 3	WORKING TOGETHER	
		Roles and responsibilities	
111	14.167	Local roles and responsibilities should be clear and collaboration should take place at all the following levels: <ul style="list-style-type: none"> • operational; • supervisory line management; • Designated Adult Safeguarding Managers (DASM); • senior management staff; • corporate/cross authority; • Chief officers/chief executives; • local authority members and local police and crime commissioners; • commissioners; • providers of services; • voluntary organisations, and; • regulated professionals. 	All organisation
112	14.188	Each organisation must recognise and accept its role and functions in relation to adult safeguarding. These should be set out in the SAB strategic plan as well as its own communication channels. They should also have protocols for mediation and family group conferences and for various forms of dispute resolution.	All organisation
		Being aware of safeguarding needs	
113	14.29	Workers across a wide range of organisations need to be vigilant about adult safeguarding concerns in all walks of life including, amongst others in health and social care, welfare, policing, banking, fire and rescue services and trading standards; leisure services, faith groups, and housing. GPs, in particular, are often well-placed to notice changes in an adult that may indicate they are being abused or neglected.	All organisation
		Knowing what to do	

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114	14.30	<p>Regardless of how the safeguarding concern is identified, everyone should understand what to do, and where to go locally to get help and advice. It is vital that professionals, other staff and members of the public are vigilant on behalf of those unable to protect themselves. This will include:</p> <ul style="list-style-type: none"> • knowing about different types of abuse and neglect and their signs; • supporting adults to keep safe; • knowing who to tell about suspected abuse or neglect; and • supporting adults to think and weigh up the risks and benefits of different options when exercising choice and control. <p>Awareness campaigns for the general public and multi-agency training for all staff will contribute to achieving these objectives</p>	<p>All organisation</p> <p>SAB</p>
Policy and Procedures			
115	14.40	All agencies need to understand local inter-agency policies and procedures	All organisation
116	14.41	<p>All agencies should have adult safeguarding policies and procedures. Procedures may include:</p> <ul style="list-style-type: none"> • a statement of purpose relating to promoting wellbeing, preventing harm and responding effectively if concerns are raised; • a statement of roles and responsibility, authority and accountability sufficiently specific to ensure that all staff and volunteers understand their role and limitations; • a statement of the procedures for dealing with allegations of abuse, including those for dealing with emergencies by ensuring immediate safety, the processes for initially assessing abuse and neglect and deciding when intervention is appropriate, and the arrangements for reporting to the police, urgently when necessary; • a full list of points of referral indicating how to access support and advice at all times, whether in normal working hours or outside them, with a comprehensive list of contact addresses and telephone numbers, including relevant national and local voluntary bodies; • an indication of how to record allegations of abuse and neglect, any enquiry and all subsequent action; • a list of sources of expert advice; • a full description of channels of inter-agency communication and procedures for information sharing and for decision making; • a list of all services which might offer access to support or redress; • how professional disagreements are resolved especially with regard to whether decisions should be made, enquiries undertaken for example. 	All organisation
117	14.54	Agencies should implement robust risk management processes in order to prevent concerns escalating to a crisis point and requiring intervention under safeguarding adult procedures	All organisation
118	14.55	Partners should ensure that they have the mechanisms in place that enable early identification and assessment of risk through timely information sharing and targeted multi-agency intervention	All organisation
119	14.99	The Police and Crown Prosecution Service (CPS) should agree	Police

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		<p>procedures with the local authority, care providers, housing providers, and the NHS/CCG to cover the following situations:</p> <ul style="list-style-type: none"> • action pending the outcome of the police and the employer's investigations; • action following a decision to prosecute an individual; • action following a decision not to prosecute; • action pending trial; and • responses to both acquittal and conviction 	<p>CPS LA Care providers Housing providers NHS/CCG</p>
120	14.196	All service providers, including housing and housing support providers, should have clear operational policies and procedures that reflect the framework set by the SABs in consultation with them.	Service providers
121	14.197	Voluntary organisations need to work with commissioners and the SAB to agree how their role fits alongside the statutory agencies and how they should work together. All voluntary organisations that work with adults need to have safeguarding procedures and lead officers	Voluntary sector
Information Sharing – Caldicott Requirements			
122	14.157	Agencies should draw up a common agreement relating to confidentiality and setting out the principles governing the sharing of information, based on the welfare of the adult or of other potentially affected adults. Any agreement should be consistent with the principles set out in the Caldicott Review.	All organisation
123	14.158	Where an adult has refused to consent to information being disclosed for these purposes, then practitioners must consider whether there is an overriding public interest that would justify information sharing (e.g. because there is a risk that others are at risk of serious harm) and wherever possible, the appropriate Caldicott Guardian should be involved	All practitioners
124	14.173	Managers need to develop good working relationships with their counterparts in other agencies to improve cooperation locally and swiftly address any differences or difficulties that arise between front line staff or managers	All organisation
Carers			
125	14.38	If a carer experiences intentional or unintentional harm from the adult they care for, or if the carer intentionally or unintentionally harms or neglects that adult, consider, as part of the assessment, whether support can be provided that removes or mitigates the risk. Other agencies should be involved – police where a criminal offence is suspected, primary healthcare services to be involved in monitoring.	Police and Healthcare
Action following an enquiry			
126	14.89	Action could take a number of courses: it could include disciplinary, complaints or criminal investigations or work by contracts managers and CQC to improve care standards. Those discussions should enable the adult to understand what their options might be and how their wishes might best be realised.	All organisation
Responsibilities post enquiry			

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127	14.94	<p>Once enquiries are completed, the outcome should be notified to the local authority which should then determine with the adult what, if any, further action is necessary and acceptable.</p> <p>It is for the local authority to determine the appropriateness of the outcome of the enquiry. One outcome of the enquiry may be the formulation of agreed action for the adult which should be recorded on their care plan. This will be the responsibility of the relevant agencies to implement.</p>	All organisation
SAB 4 REPORTING AND RESPONDING TO ABUSE			
Information Sharing			
128	14.165	All commissioners or providers of services in the public, voluntary or private sectors should disseminate information about the multi-agency policy and procedures. Staff should be made aware through internal guidelines of what to do when they suspect or encounter abuse of adults in vulnerable situations. This should be incorporated in staff manuals or handbooks detailing terms and conditions of appointment and other employment procedures so that individual staff members will be aware of their responsibilities in relation to safeguarding adults	Commissioners Providers
129	14.34	<p>To ensure effective safeguarding arrangements:</p> <ul style="list-style-type: none"> • All organisations must have arrangements in place which set out clearly the processes and the principles for sharing information between each other, with other professionals and the SAB; this could be via an Information Sharing Agreement to formalise the arrangements; and, • No professional should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult. If a professional has concerns about the adult's welfare and believes they are suffering or likely to suffer abuse or neglect, then they should share the information with the local authority and, or, the police if they believe or suspect that a crime has been committed. 	<p>All organisations</p> <p>SAB members</p> <p>Employers – to make professionals aware</p>
Staff Responsibilities			
130	14.168	Operational front line staff are responsible for identifying and responding to allegations of abuse and substandard practice. Staff at operational level need to share a common view of what types of behaviour may be abuse or neglect and what to do as an initial response to a suspicion or allegation that it is or has occurred. This includes GPs. It is employers' and commissioners' duty to set these out clearly and reinforce regularly.	Employers and Commissioners
131	14.169	There should be effective and well-publicised ways of escalating concerns by front line staff where immediate line managers do not take action in response to a concern being raised	Employers
132	14.170	Concerns about abuse or neglect must be reported whatever the source of harm is. It is imperative that poor or neglectful care is brought to the immediate attention of managers and responded to swiftly, including ensuring immediate safety and well-being of the adult. Where the source of abuse or neglect is a member of staff it is for the employer to take immediate action and record what they have done and why (similarly for volunteers and or students).	Employers
133	14.171	There should be clear arrangements in place about what each agency	All

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		should contribute at this [operational] level. These will cover approaches to enquiries and subsequent courses of action. The local authority is responsible for ensuring effective co-ordination at this level	organisations LA
		Commissioning	
134	14.195	Commissioners have a responsibility to assure themselves of the quality and safety of the organisations they place contracts with and ensure that those contracts have explicit clauses that holds the providers to account for preventing and dealing promptly and appropriately with any example of abuse and neglect.	Commissioners
		SAB 5 SAFEGUARDING ADULT REVIEWS	
		Principles	
135	14.138	The following principles should be applied by SABs and their partner organisations to all reviews: <ul style="list-style-type: none"> • there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice; • the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined; • reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed; • professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith; and • families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. 	SAB All partners
		Involvement of organisations and professionals	
136	14.142	The SAB should ensure that there is appropriate involvement in the review process of professionals and organisations who were involved with the adult. The SAR should also communicate with the adult and, or, their family. In some cases it may be helpful to communicate with the person who caused the abuse or neglect	SAB
		Links with other reviews	
137	14.145	When victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for both a child Serious Case Review (SCR) and a Domestic Homicide Review (DHR). Where such reviews may be relevant to SAR (e.g. because they concern the same perpetrator), consideration should be given to how SARs, DHRs and SCRs can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case.	SAB
138	14.146	In setting up a SAR the SAB should also consider how the process can dovetail with any other relevant investigations that are running parallel, such as a child SCR or DHR, a criminal investigation or an inquest	SAB

139	14.147	Any SAR will need to take account of a coroner's inquiry, and/or, any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process. It will be the responsibility of the manager of the SAR to ensure contact is made with the Chair of any parallel process in order to minimise avoidable duplication.	SAB
Findings from SARs			
140	14.148	All documentation the SAB receives from registered providers which is relevant to CQC's regulatory functions will be given to the CQC on CQC's request.	SAB CQC
SAB 6 SAFEGUARDING ADULTS BOARD			
Role of SAB			
141	14.116	The following organisations must be represented on the SAB: <ul style="list-style-type: none"> • the local authority which set it up; • the CCGs in the local authority's area; and • the chief officer of police in the local authority's area. 	LA CCG Police
142	14.105	The SAB has a strategic role that is greater than the sum of the operational duties of the core partners. It oversees and leads adult safeguarding across the locality and will be interested in a range of matters that contribute to the prevention of abuse and neglect. These will include the safety of patients in its local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders and awareness and responsiveness of further education services.	LA Police CCG Other SAB and sub group members
Working Together Across Different Boards			
143	14.194	Local Authority Health Scrutiny Functions, such as the Council's Health Overview and Scrutiny Committee, Health and Wellbeing Boards (HWBs) and Community Safety Partnerships can play a valuable role in assuring local safeguarding measures, and ensuring that SABs are accountable to local communities. Similarly, local Health and Wellbeing Boards provide leadership to the local health and wellbeing system; ensure strong partnership working between local government and the local NHS; and ensure that the needs and views of local communities are represented. HWBs can therefore play a key role in assurance and accountability of SABs and local safeguarding measures. Equally SABs may on occasion challenge the decisions of HWBs from that perspective.	OSC, Community Safety Partnerships HWB
144	14.132	It is expected that those organisations (LA, Police, HealthWatch and Health and Wellbeing Board) will fully consider the contents of the Annual Report and how they can improve their contributions to both safeguarding throughout their own organisation and to the joint work of the Board	LA Police HealthWatch HWB
Policy and Procedures			
145	14.42	SAB must keep policies and procedures under review. Procedures should be updated to incorporate learning from published research, peer reviews, case law and lessons learned from SAR.	SAB

SAB 7		ENQUIRIES	
Who can carry out an enquiry			
146	14.69	Work with the adult may frequently require the input of a social worker, other aspects of enquiries may be best undertaken by others with more appropriate skills and knowledge. Eg, health professionals should undertake enquiries and treatment plans relating to medicines management or pressure sores.	Key professionals
147	14.70	Although the local authority has the lead role in making enquiries, where criminal activity is suspected, then the early involvement of the police is likely to have benefits in many cases.	LA Police
148	14.71	Police have a duty under legislation to assist those witnesses who are vulnerable and intimidated.	Police
149	14.77	Everyone involved in an enquiry must focus on improving the adult's well-being and work together to that shared aim.	All organisations
150	14.84	The local authority is the lead agency for making enquiries but it may require others to undertake them. The specific circumstances will often determine who is the right person to begin an enquiry. In many cases a professional who already knows the adult will be the best person. They may be a social worker, a housing support worker, a GP or other health worker such as a community nurse. In this role if the local authority has asked someone else to make enquiries, it is able to challenge the body making the enquiry if it considers that the process and/or outcome is unsatisfactory	Partner involvement in enquiries to protect
151	14.85	Where a crime is suspected and referred to the police, then the police must lead the criminal investigations, with the local authority's support where appropriate. The local authority has an ongoing duty to promote the wellbeing of the adult in these circumstances.	Police
Responsibility to act			
152	14.56	The first responsibility to act must be with the employing organisation as provider of the service. However, social workers or counsellors may need to be involved in order to support the adult to recover.	Employers LA
153	14.58	The employer should investigate any concern (and provide any additional support that the adult may need) unless there is compelling reason why it is inappropriate or unsafe to do this eg this could be a serious conflict of interest on the part of the employer, concerns having been raised about non-effective past enquiries or serious, multiple concerns, or a matter that requires investigation by the police	Employer organisations
154	14.79	It is the responsibility of all staff and members of the public to act on any suspicion or evidence of abuse or neglect and to pass on their concerns to a responsible person or agency	All organisations and public
Who to inform			
155	14.57	When an employer is aware of abuse or neglect in their organisation, then they are under a duty to correct this and protect the adult from harm as soon as possible and inform the local authority, CQC and CCG where the latter is the commissioner.	Employer organisations LA CQC CCG

		<p>Where a local authority has reasonable cause to suspect that an adult may be experiencing or at risk of abuse or neglect, then it is still under a duty to make (or cause to be made) whatever enquiries it thinks necessary to decide what if any action needs to be taken and by whom.</p> <p>The local authority may well be reassured by the employer's response so that no further action is required. However, a local authority would have to satisfy itself that an employer's response has been sufficient to deal with the safeguarding issue and, if not, to undertake any enquiry of its own and any appropriate follow up action (e.g. referral to CQC, professional regulators).</p>	LA
156	14.60	There should be a clear understanding between partners at a local level when other agencies such as the local authority, CQC or CCG need to be notified or involved and what role they have	All partners

HEALTH AND WELLBEING BOARD

10 FEBRUARY 2015

Title:	The Care Act 2014: National and Local Communications		
Report of the Corporate Director of Adult and Community Services			
Open Report	For Information		
Wards Affected: ALL	Key Decision: NO		
Report Author: Glen Oldfield, Care Act Project Officer	Contact Details: Tel: 020 8227 5796 E-mail: glen.oldfield@lbbd.gov.uk		
Sponsor: Anne Bristow, Corporate Director, Adult and Community Services			
Summary: On 02 February 2015 a national public awareness campaign about the changes brought about by the Care Act will be launched. This report gives an overview of the national and local approaches to communications and the key activities happening in the borough. The report will be supplemented by a presentation at the meeting which shows the key messages and materials that residents can expect to receive during the course of the campaign. Appendix 1 shares with the Board the stakeholder briefing provided by the Department of Health.			
Recommendation(s) The Health and Wellbeing Board is recommended to:			
<ul style="list-style-type: none"> (i) Note the approach to communications and the activities planned throughout the public awareness campaign to reach residents on the changes to care and support that arise from the Care Act. (ii) Consider ways in which partner organisations can support communications activities 			

1. Approach to national communications

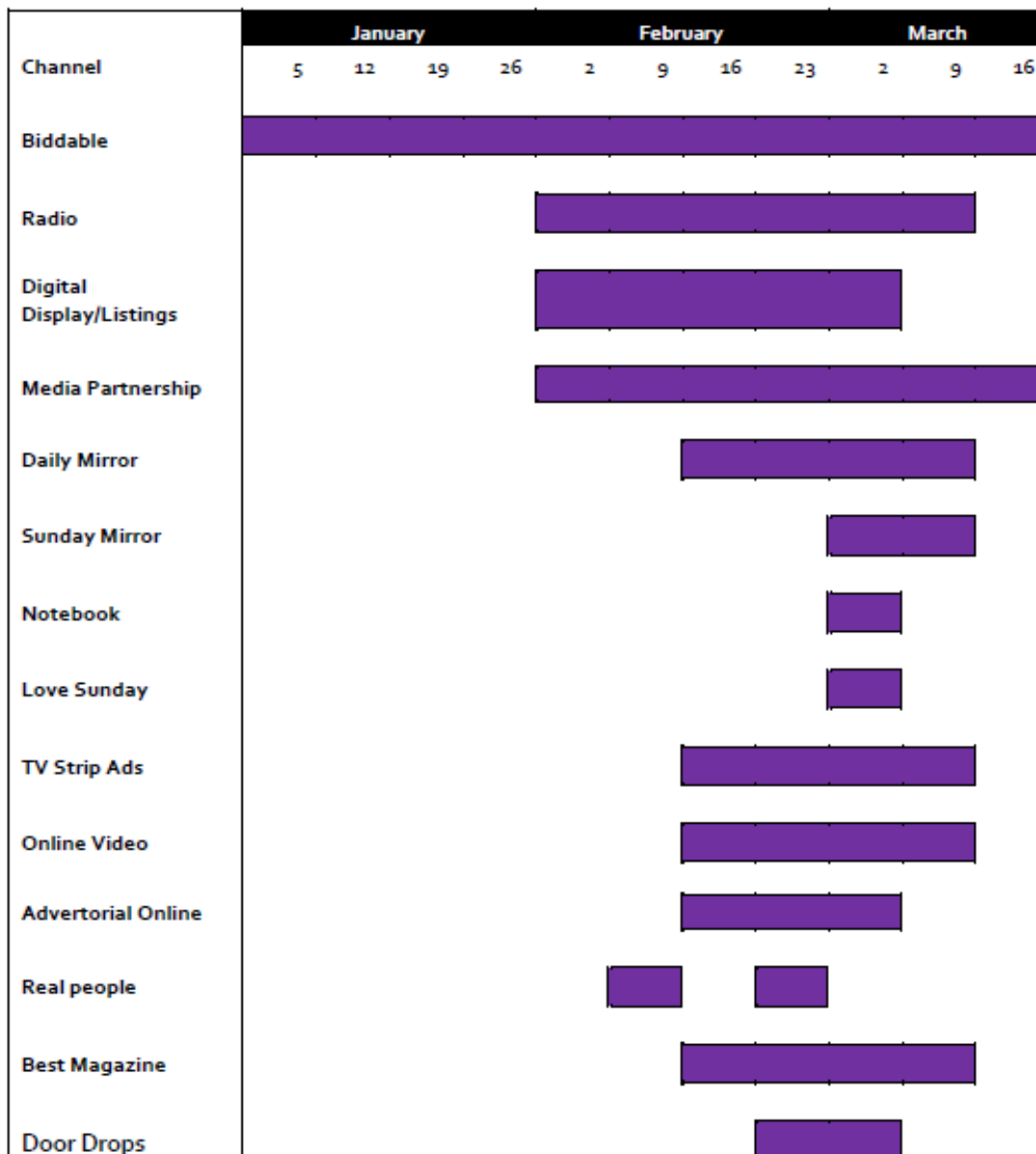
- 1.1. A national communications campaign developed and managed by the Department of Health and Public Health England will be launched on 02 February 2015. The purpose of the campaign is to raise awareness about the Care Act changes which come into effect from 01 April 2015.
- 1.2. The national campaign will use a range of channels and materials which are described in section four of this report. The tone and content of the campaign has been developed in consultation with local authorities and local authorities have been given access to a toolkit of materials to issue local communications while the national campaign runs. In developing local communications, local authorities are recommended to follow the key messages, wording and design themes of the national campaign.
- 1.3. The hub of the national communications campaign is the government's website <https://www.gov.uk/help-care-support> which has key information and a postcode search facility that signposts people who want more information to the local authority. All national communications will use the <https://www.gov.uk/help-care-support> web address to direct traffic to this central point.

2. Key messages

- 2.1. The national communications campaign uses standardised text that describes the reforms to be brought about by the Care Act. The text was developed at the request of local authorities to ensure that, as far as possible, all organisations use the same language and explain the high level changes in the same way.
- 2.2. The text was developed with input from a wide range of local authorities and other stakeholders. The final version was written by a specialist copywriter, following qualitative testing research with citizens directly affected by the Care Act reforms, including carers, domiciliary and residential care service users and members of the healthcare and social care workforces.
- 2.3. The key messages cover:
 - How care and support is changing for the better
 - Needs and eligibility
 - Support for carers
 - Deferred payment agreements

3. Timing of the national campaign

- 3.1. The table overleaf shows the timelines for the revised national communications campaign.



4. National communications channels and materials

4.1. BBC care cost calculator

In April 2016 adult social care funding reforms will be introduced. The major elements of the reforms are the changing of financial thresholds to give more people financial support from the state and introducing a cap on care costs.

The cap on care costs in particular is a landmark change to the way individual care is funded. It means that in a person's lifetime they will pay a maximum of £72,000 towards their care costs. After this point their charges cease and the local authority picks up the tab.

The BBC has developed a cost calculator to help people understand how the new funding system works and how much a person can expect to pay towards their care under the cap. To use the cost calculator tool visit the BBC website:

<http://www.bbc.co.uk/news/health-30990913>

4.2. Radio advertising

National and regional radio advertising is scheduled to start on 2 February and end on 15 March 2015. Two 30 second adverts will run – one focussed on care users and one focussed on informal carers. Both will have a call to action telling people to visit the Gov.UK webpage or to contact their local authority for further information.

The main radio stations to be used relevant to Barking and Dagenham are:

- Classic FM
- Gold
- Heart
- LBC
- Smooth

4.3. Printed media

A media partnership has been established between Department of Health and publishers Trinity Mirror and Hearst. It will use a mix of print and digital titles to convey messages and facts about the care and support reforms. These include:

- Daily Mirror
- Sunday Mirror
- Sunday Mirror – Notebook (Supplement)
- The People – Love Sunday (Supplement)
- Best (Magazine)
- Real People (Magazine)
- Mirror.co.uk (desktop, tablet, mobile)
- Mirror Social Media

4.4. Door drops schedule

2.5 million households will receive leaflets though the post. The aim of the door drops is to reach the harder to find groups of self-funders and informal carers. The leaflets will be sent to households in postcodes identified through Acorn group analysis¹.

In Barking and Dagenham, leaflets will be sent out by post in the last two weeks of February to 3,691 households in Chadwell Heath, postcode RM6.

¹ Consumer classification that segments the UK population

4.5. GP waiting room information service list

As part of the GP waiting room information service, a number of GP practices will receive campaign leaflets. Not all GP practices will receive leaflets – only those that are registered with the GP waiting room information service and have consented to having their information shared with government.

Of the 40 GP practices in the borough, 22 are registered and will therefore receive the information. To ensure information is available from GP practices across the borough, the Council is working with the CCG to provide information materials to all GP practices.

5. Approach to local communications

5.1. As mentioned already, local authorities have been given access to a toolkit of materials which can be adapted for local use. Using these materials the Council will supplement the national communications campaign and undertake the following activities:

- Face-to-face briefings with community groups, provider and service user forums
- Briefings for local providers and staff of partner organisations
- Letters to service users and carers that are known to the authority
- Display of posters and leaflets in civic buildings
- Press release for local media
- Development of a local FAQ list
- Information on LBBB website and Care and Support Hub
- Issuing of information to GP practices (further to that described at paragraph 4.8)

5.2. The Council's contact centre (020 8215 3000) and website are the main points of information listed in all local communications materials. We would encourage partner organisations who receive queries to signpost to these places.

<https://www.lbbd.gov.uk/residents/health-and-social-care/care-act-2014/keeping-you-informed/>

6. Engaging with partners and staff

6.1. Mindful that many partners work with people to deliver care and support, the Department of Health has produced a partner and stakeholder briefing; this is included at **Appendix 2**. This will be adapted for local use and circulated.

6.2. A front line worker briefing is also available and will be circulated to partners by the Care Act Programme Team.

6.3. Lastly, should partner organisations wish to disseminate key messages to residents they can download materials (similar to those available through the local authority toolkit) from the Public Health England Campaign Resource Centre.

<http://campaigns.dh.gov.uk/2014/12/30/care-support-public-information-campaign-materials/>

7. Financial implications

Additional resources of £5k are available to support communication costs in 2014/15 from the £0.5m allocation for Care Act implementation costs agreed by Cabinet to be funded from the departmental reserve.

(Comments prepared by Roger Hampson Group Manager Finance, Adults and Community Services)

8. Legal implications

There are no legal implications.

(Comments prepared by Dawn Pelle, Adult Social Care Lawyer)

Background Papers Used in Preparation of the Report: None

List of appendices

Appendix 1: Partner and stakeholder briefing



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Partner and Senior Stakeholder Briefing

About this briefing

The following document has been put together to brief partners and senior stakeholders (such as Senior Managers, Directors, Board Members) about the forthcoming Care Act reforms.

The briefing provides a summary of care and support, the Care Act and the key changes coming into force in April 2015. It also explains the national and local campaign activity that will inform care users and carers of these changes.

The aim is to enable senior stakeholders to answer questions from customers, clients or colleagues.

Introduction

From April 2015, care and support in England is changing. The new Care Act will introduce a number of reforms that primarily impact existing and new care users, their carers and families.

A national and local campaign has commenced to raise awareness among relevant members of the public about the new reforms. Following testing with consumer audiences, the public information campaign focuses on those reforms coming into effect in April 2015. The focus will shift to the April 2016 reforms later in 2015.

This briefing document provides an overview of the key April 2015 reforms, in the event you are asked about the changes by customers, clients or colleagues.





What is care and support?

- 'Care and support' is the term used to describe the help some adults need to live as well as possible with any illness or disability they may have. It can include help with things like getting out of bed, washing, dressing, getting to work, cooking meals, eating, seeing friends, caring for families and being part of the community.
- It might also include emotional support at a time of difficulty and stress, helping people who are caring for an adult family member or friend or even giving others a lift to a social event.
- Care and support includes the help given by family and friends, as well as any provided by the council or other organisations.

The Care Act: changes to care and support in England

- From April 2015, care and support in England is changing. The new Care Act will help make care and support more consistent across the country.
- The new national changes are designed to put people in control of the help they receive.
- Any decisions about their care and support will consider their wellbeing and what is important to them and their family, so they can stay healthy and remain independent for longer.
- Some changes will be introduced in April 2015 and others in April 2016.
- Anyone currently receiving care, or supporting an adult family member or friend as an unpaid carer, could be affected by the national changes being introduced by the Care Act.

Why the system needs to change

- As people are now living longer and with a better quality of life, the care and support needs they have are different. The way care and support is provided has to change to reflect this.
- The new Care Act has been passed to make care and support, and the way we pay for it, clearer, easier to access and more consistent across the whole of England.





Three key reforms in April 2015

Changes to the needs assessment

- From April 2015, there will be a national level of care and support needs that all councils will consider when they assess what help they can give people. This may result in an individual being eligible for care and support, and will make it easier for them to make plans now and in the future. And if they decide to move to another area in England, councils will also have to work together to make sure that there is no gap in their care when they move.
 - Individuals receiving care and support will be more in control of decisions that affect them. They will know how much it will cost to meet their needs and how much the council will contribute towards the cost. They will have more control over how that money is spent.
 - Everyone's needs are different. They may be physical, mental or emotional. Whatever a person's level of need, their council will be able to put them in touch with organisations to support their wellbeing and help them remain independent for longer.
- **New support for unpaid carers**
 - In England, millions of people provide unpaid care or support to an adult family member or friend, either in their own home or somewhere else. Caring for someone covers lots of different things, like helping with their washing, dressing or eating, taking them to regular appointments or keeping them company when they feel lonely or anxious.
 - From April 2015, changes to the way care and support is provided in England mean carers may be able to get more help so that they can carry on caring and look after their own wellbeing.
 - Carers may be eligible for support, such as a direct payment to spend on the things that make caring easier, or practical support, like arranging for someone to step in when they need a short break. Or they may prefer to be put in touch with local support groups so they have people to talk to.
 - Carers can ask for a carer's assessment. As a result of the assessment, a carer may be eligible for support from the council, who will also offer them advice and guidance to help them with their caring responsibilities.





- **Deferred payment agreements now universal**
 - From April 2015, the deferred payment agreements which some councils in England currently offer, will be available across the whole country. This means that people should not have to sell their homes in their lifetime to pay for their care, as they have sometimes had to do in the past.
 - A deferred payment agreement is an arrangement with the council that will enable some people to use the value of their homes to fund care home costs. If someone is eligible, their council will help to pay their care home bills on their behalf. They can delay repaying the council until they choose to sell their home, or until after their death.
 - Councils may charge interest on the amount owed to them, and there may also be a fee for setting up this arrangement.
 - These will be set to cover the council's costs and not to make a profit.

The key reforms in April 2016

- Major reforms impacting on existing and new care users from April 2016 include the cap on care costs and changes to the means test.
- The public information campaign will focus on these reforms following the election.
- Some information about these reforms can be found at gov.uk/careandsupport

Communicating these changes to the public

- In collaboration with the Local Government Association, ADASS and local authority colleagues, the Department of Health and Public Health England have developed a series of consumer-tested campaign materials and tools to support councils in effectively informing their local communities of the changes to care and support.
- Nationally-driven activity including radio advertising, digital advertising, door drops and a paid-for media partnership will aim to create a positive backdrop for councils to deliver local campaigns and reach harder to find audiences such as self-funded care recipients and unpaid carers.
- Beginning in January 2015, national activity will run up to the end of March 2015 and cease for the pre-election period.





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England

- A second part to the campaign is planned following the election, and will focus on reforms coming into place from April 2016.

Further information about the reforms

- Further details about the reforms can be found at gov.uk/careandsupport should you, customers, clients or colleagues wish to find out more.



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HEALTH AND WELLBEING BOARD

10 FEBRUARY 2014

Title:	Section 75 agreement for the Joint Assessment and Discharge Service		
Report of the Corporate Director of Adult and Community Services			
Open Report		For Decision	
Wards Affected: All		Key Decision:	
Report Author: Bruce Morris Divisional Director, Adult Social Care		Contact Details: Tel: 020 8227 2749 E-mail: bruce.morris@lbbd.gov.uk	
Sponsor: Anne Bristow, Corporate Director, Adult and Community Services			
Summary: <p>The Board has received previous reports regarding the establishment of a Joint Assessment and Discharge Service (JAD) intended to provide an integrated approach to supporting the discharge of patients from BHRUT.</p> <p>The contributing partners are, BHRUT, NELFT, London Boroughs of Barking and Dagenham and London Borough of Havering, and the 3 CCGs covering the local health and social care economy. The JAD does not currently include the London Borough of Redbridge. The London Borough of Barking & Dagenham is the host for the service and has led the implementation programme.</p> <p>The service is now fully operational and a S.75 agreement is required to formalise the partnership arrangements. The agreement requires formal approval from all partners and the Board is recommended to agree to enter into the partnership arrangements described in Appendix 2.</p> <p>This report also describes the services performance to date against agreed measures and, its role in winter planning, and supporting our broader social care and health system at a period of increased demand over the winter period. Performance measures are provided within Appendix 1.</p> <p>In parallel with consideration by the Health and Well Being Board, the relevant Clinical Commissioning Groups Governing Bodies are considering the partnership arrangement so that this can be agreed; and London Borough of Havering is progressing the agreement through its own formal processes.</p>			
Recommendation(s)			
The Health and Wellbeing Board is recommended to:			
(i) Agree the proposed S75 agreement (as provided within Appendix 2) and to note the successful implementation of the Joint Assessment and Discharge Service.			

- (ii) To note the positive performance of the service and its contribution to winter planning and operational resilience across health and social care. (Appendix 1).

Reason(s)

The report supports the Council priority 'enabling social responsibility' and more specifically protecting the most vulnerable, keeping adults and children healthy and safe and ensuring everyone can access good quality healthcare when they need it.

1. Background and Introduction

- 1.1 The Joint Assessment and Discharge Service (JAD) Service went live on the 9th June 2014 and consists of around 50 health and social care staff, with a staffing budget of c.£2m. The Service has completed recruitment of permanent staff, with the exception of 3 of 5 nursing vacancies.
- 1.2 The service is arranged into Ward Groups covering Queen's and King George Hospital. The JAD is the single point of contact for all referrals of people who may require health and/or social care support on discharge with a named worker allocated to each ward. In addition the service covers the intermediate care beds and provides a service for patients placed in hospitals out of the area.
- 1.3 The service has been effectively implemented and is now embedded across both Queens and King Georges Hospitals.
- 1.4 Progress is being made in resolving the IT issues within Queens hospital that were key to implementation in the efficient delivery of the service. However staff are still required to input information to different systems and further development of Health Analytics is required to ease some of the difficulties. An integrated IT system is an aspiration which may be realised at some point in the future.
- 1.5 A training and development plan has now been developed for the service following a Training Needs Assessment involving both ward based and JAD staff. This is aligned to BHRUTs improvement plan. LBBB is providing Care Act briefings for BHRUT for ward based staff to dovetail with training for JAD, as well as briefings on the implications for senior staff.
- 1.6 The CCGs have provided additional nursing capacity to help progress continuing Health Care assessments to reduce such delays.

2. Operational Resilience

- 2.1 The service has formed a key element of the Operational Resilience plans across health and social care, supporting both improved flow through the hospital and providing a service in Accident and Emergency departments to support both admission avoidance and diversion to other more appropriate services. This has involved Social Work support working across the 7 days and at peak periods of demand, commissioning increased community based support packages, interim placements and a 'take home and settle service' provided via Age UK.
- 2.2 In key areas such as in the provision of community based crisis response, planned activity levels and the intensity of support to individuals was anticipated to increase,

and this would have been unsustainable without the availability of additional Operational Resilience funding. However it is clear that demand during December and January has been significantly higher than planned with the hospitals under acute pressure and discussion is underway with the CCG to ensure the local authorities are able to continue to fund these pressures in 2014/15.

- 2.3 The JADs contribution to Operational Resilience (winter pressures) planning is to reduce the pressure upon acute bed stock by 15 which along with community based provision contributes to the 25 beds saved for the JAD, and the 3 local authorities. For the JAD and LBB community, 24 beds were saved in December 2014 against an operational resilience plan requirement of 15.

3. Other programmes

- 3.1 The service is fully operational across 7 days – supporting a Better Care Fund national outcome for the provision of 7 day working. It is however, noticeable that discharges are reduced at weekends due to the reduced levels of clinical staff with whom discharge planning is necessary.

4. Governance

- 4.1 Whilst the development and implementation of the JAD has been overseen by the Integrated Care Coalition and the Urgent Care Board regular Executive Steering Group meetings with senior representation from each participating organisation have been established chaired by LBB.
- 4.2 The Steering Group has played a crucial role in reviewing progress against milestones established within the individual work streams in the original project plan, providing oversight of performance and acting as a point of resolution of key issues. The Steering Group has closely supported the development of our S.75 agreement, considering in turn each partner organisations requirements and our overall vision for this integrated service.
- 4.3 Following the formal sign off of the partnership agreement the Steering Group will for a formal executive function in governing the service.

5. Performance

- 5.1 The latest performance against agreed metrics is provided with Appendix 2. These were considered and steered by the JAD Steering Group as the agreed point of governance for the JAD Service.
- 5.2 Performance to date evidences that despite high and sustained numbers of S.2's (referrals) and S.5's, DTOC numbers of days delayed via responsibility shows a marked decline (improvement). For example, there has been a 35% reduction in Delayed Transfers of Care (attributable to social care) for the first six months of the JAD.
- 5.3 However it is also evident that commitment to service support hours has markedly increased as we approach the winter period. For example for LBB we have seen numbers of new support packages increase from 262 in August to 530 in October with this increase sustained across November with 680 support packages in November. Spend is significantly supported via the availability of additional funding

via Operational Resilience and would otherwise be unable (within resources available to the council) to be sustained.

- 5.4 Whilst work is underway to develop a robust methodology for establishing user experience, there has been significant feedback from service users and their carers identifying their positive experiences of support via the JAD. Examples have included, the benefits of families being able to come in at weekends and talk to a worker, and earlier discussion about how an individuals support needs might best be met ahead of any discharge.
- 5.5 The indicators provided within the Appendix 2 confirm a surge in activity, notably packages of care and support at home which both avoid unnecessary admissions and support people to remain at home after a period in hospital. Performance in this respect remains within top quartile and is a significant contributory factor in supporting system demand and shifting our reliance upon bed based services to those based closer to home.
- 5.6 The Service has now won an award sponsored by Health Education- North Central East London 'Quality Awards' for training under the category of 'Collaboration and Partnership Education'.



6. Discharge Workshop

- 6.1 The Urgent Care Board has committed LBBDD to lead a workshop to consider in more detail some of the issues that have come to light in the discharge pathway and allow a broader consideration of contributing processes and services. It is proposed to combine this with learning from the Operational Resilience experience which has been marked by significant culture shift in working together at an operational level, particularly with BHRUT and NELFT staff.
- 6.2 This workshop is planned to be held in May when the pressures subside and will include both operational and commissioning staff from:
- The CSU and CCGs
 - BHRUT – clinicians and managers
 - NELFT – CTT, IRS and CHC teams
 - LB Havering
 - LB Redbridge

- GPs and primary care and
- Joint Assessment and Discharge service

7. Implications

7.1 Health and Wellbeing Strategy

The service has been developed and implemented to positively impact upon the health and well being of people who have received acute care and require support, information and advice to leave hospital in a timely and safe way.

The Service is supported by a range of performance outcomes for the service which both align to existing measures – such as the number of people remaining at home after 91 days of discharge, number of discharges and numbers entering long term bed based care. We are also critically developing a measure that will provide the service with direct feedback from service users and their families determining both their experience of support and the extent to which they consider that their individual outcomes have been met.

7.2 Joint Strategic Needs Assessment

At this time there is the necessity, the motivation and momentum to transform the entire organisation and delivery of health and care services to the extent that has not existed throughout the existence of the NHS. The Joint Assessment and Discharge service is part of the transformation agenda providing a single point of access. Its creation was underpinned by the JSNA. The JSNA recommends that this need encompasses primary, community, hospital and social care services and is driven by the need to ensure that meeting the needs of the population goes hand in hand with services that are of high quality, sustainable and affordable.

7.3 Integration

The delivery of the Joint Assessment and Discharge has successfully delivered a single, integrated discharge function across BHRUT involving hospital discharge staff, LBBB SW staff, LB Havering hospital SW team and staffing resources from NELFT.

7.4 Financial Implications

Implications completed by: Roger Hampson, Group Manager Finance

The service has been modelled on existing staffing budgets and operational commissioning budgets and there are no financial issues. The pooled implementation pot is considered sufficient at this stage, and partners are continuing to manage additional one-off implementation costs from within their own budgets.

The S.75 provides for delegated authority to the service in respect to social care budgets and processes related to Continuing Health Care. Further work has been completed from finance teams to ensure there are simplified approaches to funding flowing between organisations and satisfactory reporting mechanisms and draft monitoring and reporting arrangements receive consideration by the Steering Group on a monthly basis.

7.5 Legal Implications

Implications completed by: Allan Donovan, Legal Services

The delivery of the JAD requires a formal S.75 to be in place to properly support the arrangements, allowing staffing and resources to be managed within the service. We have developed a S.75 which has been subject to support from the Councils legal services and in turn partner organisations contributing to the JAD seeking parallel input from their legal representatives. The agreed S.75 is now provided with Appendix 2.

7.6 Risk Management

The S.75 provides for the management of risk between the partners to the JAD and includes provisions in the event of exit from the service by the partners.

7.7 Customer/ Patient/ service user Impact

The provision of the JAD is supporting improvements in collaborative working with decisions moved closer to the service user and their families as planning for discharge is begun within the wards at the point of admission.

Alongside a range of performance measures the conclusion of our approach to gaining direct feedback from individuals and their families will provide further steer in the development of the service continues.

Public Background Papers Used in the Preparation of the Report:

Previous reports to the HWBB:

04 June 2013 <http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MId=7074&Ver=4>

17 June 2014 <http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MId=7551&Ver=4>

17 Sept 2013 <http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MId=7076&Ver=4>

Appendices:

Appendix 1: Performance measures

Appendix 2: JAD Section 75 Agreement

Appendix 1: JAD Performance Indicators

JAD Performance Indicators – Monthly							
	Item	LBH		LBBB		LBR	
		BHRUT	Other hospitals	BHRUT	Other hospitals	BHRUT	Other hospitals
1.	DTOC - Number of people with a delayed discharge recorded as at the last Thursday of the month						
2.	DTOC - number of delayed days in reporting month via responsibility : a) LA b) CHC c) Rehab d) Hospital e) NHS f) Shared						
3.	<u>NB: Not to be reported at this stage</u> Sickness days by ward group: Ward Group 1 Ward group 2 Ward Group 3 Ward Group 4 Ward group 5	<u>NB: Not to be reported at this stage</u> By ward group		<u>NB: Not to be reported at this stage</u> By ward group		<u>NB: Not to be reported at this stage</u> By ward group	
4.	a) No. of Section 2s b) No. of Section 2s withdrawn c) No. of Section 5s d) No. of Section 5s withdrawn e) No. of non delayed discharges						
5.	CHC	Total number in monthly period		Total number in monthly period		Total number in monthly period	

Appendix 1: JAD Performance Indicators

	<ul style="list-style-type: none"> • Number of CHC placements • Numbers of people supported at home via CHC 			
6.	<p>Number of LA placements (care home) in reporting month by borough</p> <ul style="list-style-type: none"> • Permanent • Short term 			
7.	<ul style="list-style-type: none"> • Number of people supported at home by Las in monthly period • Number of hours committed in monthly period to Crisis response/ re-ablement 			

Appendix 1: JAD Performance Indicators

Performance and measures:

JAD 2014/15

DTOC-Patients	June	July	August	September	October	November
LBBB	19	28	29	32	12	15
LBH	25	39	34	33	35	24
LBR	32	16	13	13	14	23

DTOC-number of days	June	July	August	September	October	November
LBBB						
LA	5	14	7	14	4	4
CHC	30	28	36	40	7	29
Rehab:	1	16	14	23	14	0
General	1	16	3	16	0	0
Neuro	0	0	11	7	14	0
'slow stream'	0	0	0	0	0	0
Hospital	1	0	36	2	0	1
NHS	0	13	0	0	0	0
Shared	48	26	46	70	33	14
Totals	85	97	139	149	58	48

DTOC-number of days						
LBH						
LA	9	23	21	10	12	11
CHC	40	10	15	35	37	18
Rehab:	23	43	51	19	0	0
General	9	17	21	0	0	0
Neuro	14	26	20	19	0	0
'slow stream'	0	0	10	0		
Hospital	0	0	6	9	27	5
NHS	8	0	0	0	8	11
Shared	25	40	52	48	38	38
Totals	105	116	145	121	122	83

DTOC-number of days						
LBR						
LA	0	0	0	0	0	0
CHC	39	15	23	50	5	61

Appendix 1: JAD Performance Indicators

Rehab:	70	28	15	7	0	0
General	21	0	15	0	0	0
Neuro	49	27	0	0	0	0
'slow stream'	0	7	0	0	0	0
Hospital	0	1	1	1	3	0
NHS	33	7	0	0	38	0
Shared	7	14	26	4	8	20
Totals	149	65	65	62	54	88

Sections 2&5						
LBB						
No of Section 2's	150	137	188	186	173	183
No. of Section2s withdrawn	0	0	0	0	0	0
No. of Section 5's	121	119	129	147	121	104
No. of Sections 5's withdrawn	12	30	37	44	28	37
No.on non delayed discharges	119	98	91	115	114	121

Sections 2&5						
LBH						
No of Section 2's	303	313	298	325	344	302
No. of Section2s withdrawn	0	0	0	0	0	0
No. of Section 5's	211	256	208	248	254	213
No. of Sections 5's withdrawn	73	41	54	73	71	59
No.on non delayed discharges	215	181	186	192	212	208

Sections						
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Appendix 1: JAD Performance Indicators

2&5						
LBR						
No of Section 2's	124	144	131	157	136	145
No. of Section2s withdrawn	0	0	0	0	0	0
No. of Section 5's	84	105	96	119	95	100
No. of Sections 5's withdrawn	35	17	26	41	28	27
No.on non delayed discharges	88	87	86	105	77	

Appendix 1: JAD Performance Indicators

JAD 2014/15

2014/2015	June	July	August	September	October	November
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Support service hours commissioned

LBBB	385:07:00	311:25:00	262:05:00	553:00:00	564:75:00	680:05:00
LBH	635:30:00	472:30:00	395:15:00	423:30:00		938:45:00
LBR						

Number of residential/ nursing care placements

LBBB	4	4	9	3	4	0
LBH	8	10	6	7	9	2
LBR						

Appendix 1: JAD Performance Indicators

JAD 2014/15

all figures in £

**M5 - August
2014**

2014/2015	LBBD	LBH	BHRUT	NELFT	JOINTLY FUNDED POSTS	TOTAL
-			£592,50	£178,40		£2,144,2
Aligned annual budget	£573,300	£800,000	*	0	0	£0
Actual spend to date as per respective general ledgers	£259,800	£325,000	*	£188,80	*	£830,700
Outstanding items that need to be settled to date between partner organisations	(£41,300)	£30,400	*	0	£13,400	**
Estimated to spend from current date to year end (including recharges)	(£33,900)	£25,800	*	£25,800	£19,000	(£33,900)
Total Estimated Year End Outturn	£372,200	£530,000	*	£364,40	*	£1,370,9
	£590,700	£885,400	*	0	£92,200	**
				£579,00	£124,60	£21,900
Estimated year end favourable/(adverse) variance	(£17,400)	(£85,400)		0	£53,800	(£21,900)
						(£57,400)

Notes:

* Budget figure advised by LBH Finance is £800,000, TBC. Establishment shown as

Appendix 1: JAD Performance Indicators

£744,600

** Actual spend to end of month 5 had not been confirmed by LBH Finance (not from the GL) - calculated from a spreadsheet produced by the Operational Manager's Office.

Uncertainty over whether the figures given include overheads or not.

Estimated to year end on the same basis as the actuals to date, not confirmed by LB Havering Finance.

*** Figures obtained from information provided by the JAD Manager - NELFT Finance have not confirmed figures.

Each partner organisation to submit the above data - with details as will be agreed at the JAD Finance meeting on 11 Sept 2014 to the host organisation for consolidation,

Recharges

	Partner making the charge (from)	Partner receiving the charge (to)	Q1 actual	M4 actual	M5 actual	Total Actual recharges at M5	M6 est.	Q3 est	Q4 est	Total year end
1. LBBB to partners										
A. Jointly funded posts										
	LBBB	LBH	9,900	3,300	3,300	16,500	3,300	9,900	9,900	39,600
	LBBB	BHRUT	7,950	2,650	2,650	13,250	2,650	7,950	7,950	31,800
	LBBB	NELFT	2,500	840	840	4,180	820	2,460	2,460	9,920
			20,350	6,790	6,790	33,930	6,770	20,310	20,310	81,320
B. Other staff costs										
Staff member 1	LBBB	LBH	12,140	4,050	4,050	20,240	4,050	12,150	12,150	48,590
Staff member 2	LBBB	BHRUT	9,370	3,150	3,100	15,620	3,120	9,360	9,360	37,460
Staff member 3	LBBB	BHRUT	-	-	-	-	1,750	5,250	5,250	12,250
3 agency staff	LBBB	NELFT	-	14,100	14,100	28,200	14,100	42,300	42,300	126,900
			21,510	21,300	21,250	64,060	23,020	69,060	69,060	225,200
TOTAL RECHARGES OUT			41,860	28,090	28,040	97,990	29,790	89,370	89,370	306,520

Appendix 1: JAD Performance Indicators

2. Partners to LBBB										
Staff member 4	LBH	LBBB	-	5,000	5,000	10,000	5,000	15,000	15,000	45,000
Staff member 5	BHRUT	LBBB	7,650	2,550	2,550	12,750	2,500	7,650	7,650	30,550
TOTAL RECHARGES IN			7,650	7,550	7,550	22,750	7,500	22,650	22,650	75,550
(already included in LBBB projections)										
3. Partners to partners										
Staff member 1	BHRUT	NELFT	4,460	4,460	4,460	13,380	4,460	13,380	13,380	44,600
Staff member 2	LBH	BHRUT	-	1,850	1,850	3,700	1,850	5,450	-	11,000

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Summary	To M5			To year end		
	In	Out	Net	In	Out	Net
LBBB	22,750	97,990	75,240	75,550	306,520	230,970
LBH	36,740	13,700	23,040	88,190	56,000	32,190
BHRUT	32,570	26,130	6,440	92,510	75,150	17,360
NELFT	45,760		45,760	181,420		181,420
TOTAL	37,820	137,820	-	37,670	37,670	-

JAD 2014/15

2014/2015	April	May	June	July	August	September	October	November
C. STAFFING								
LBB								
D								
Vacancies			3	2	1	0	0	1
Agency staff								
(count)			3	6	8	7	4	4
FTE posts (count)			12	12	12	12	12	12
LBH								
Vacancies			6.5	5.5	5.5	3	3	2
Agency staff								
(count)			7	8	9	6	6	6
FTE posts (count)			15.5	15.5	15.5	15.5	15.5	15.5
BHR								
UT								
Vacancies			5	4	6	6	5	5
Agency staff								
(count)			2	3	3	4	3	3
FTE posts (count)			16	16	16	16	16	16
NEL								
FT								
Vacancies			3	3	3	3	3	3
Agency staff								
(count)			0	0	3	3	3	3
FTE posts (count)			4	4	4	4	4	4

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Appendix 2: JAD Section 75 Agreement

- (1) The Mayor and Burgesses of the London Borough of Barking and Dagenham
- (2) The Mayor and Burgesses of the London Borough of Havering
- (3) The North East London NHS Foundation Trust
- (4) Barking, Havering and Redbridge University Hospitals Trust
- (5) Barking and Dagenham NHS Clinical Commissioning Group
- (6) Havering NHS Clinical Commissioning Group
- (7) Redbridge NHS Clinical Commissioning Group

DEED TO ESTABLISH A PARTNERING AGREEMENT PURSUANT TO SECTION 75 OF THE NATIONAL HEALTH SERVICE ACT 2006 TO DELIVER A JOINT ASSESSMENT AND DISCHARGE INTEGRATED SERVICE

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This Agreement is made by **DEED** this day of 2015

BETWEEN

- (1) **The Mayor and Burgesses of the London Borough of Barking and Dagenham** of the Civic Centre, Dagenham, RM10 7BN (LBBD & the Host Borough)
- (2) **The Mayor and Burgesses of the London Borough of Havering** of Town Hall, Main Road, Romford, Essex, RM1 3BD (LBH & a Partner Organisation)
- (3) **The North East London NHS Foundation Trust** of Trust Head Office, Goodmayes Hospital, Barley Lane, Ilford, Essex. IG3 8XT
- (4) **Barking, Havering and Redbridge University Hospitals Trust** of Queens Hospital, Rom Valley Way, Romford. Essex. RM7 0AG
- (5) **Barking and Dagenham NHS Clinical Commissioning Group** of Barking Community Hospital, Upney Lane, Barking, Essex. IG11 9LX
- (6) **Havering NHS Clinical Commissioning Group** of 3rd Floor, Imperial Offices, 2-4 Eastern Road, Romford, Essex. RM1 3PJ
- (7) **Redbridge NHS Clinical Commissioning Group** of 5th Floor, Becketts House, 2-14 Ilford Hill, Ilford Essex. IG1 2QX

Each a Party and together the Parties

WHEREAS

A. By Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (SI 617) (as amended) certain Local Authorities and NHS Bodies are able to enter into partnering arrangements offering combined NHS and Local Authority community, social, and health related services.

B. Having consulted with all persons who would appear to be affected, the Parties have agreed, pursuant to the legislation detailed above to establish and deliver a Joint Assessment and Discharge Service (JAD) for the benefit of all eligible residents within their area.

C. The Parties consider that such a partnership will improve and enhance the way such services are delivered.

D. The purpose of establishing this section 75 Agreement is to allow all of the Parties to work collaboratively in delivering the JAD Service as envisaged by the relevant legislation and in accordance with their respective constitutions and at all times subject to relevant legislative and constitutional governance provisions.

IT IS NOW AGREED

1. Definitions and Interpretations

1.1 Where the context so permits, the following words and expressions, where used, shall have the following meanings throughout this Agreement and any Schedules or Annexure hereto.

Adult: a person who has attained the age of 18 years

Agreement: this Deed of Agreement comprising these terms and conditions together with any Schedule or Appendices or any other attachment.

Aligned Budget: means a Budget which is NOT a Pooled Budget and is comprised of two or more distinct budgets (the budgets of each Partner Organisation) managed and utilised by each Partner in accordance with their own internal budgetary arrangements but for the purposes of the JAD Service as provided for by this Agreement.

Authorised Officer: the individual person(s) named by each Party as their nominated contact for the day to day management of this Agreement and the Service(s) to be provided hereunder.

Appendix 2: JAD Section 75 Agreement

Board: “the Board” as defined in the 2000 Regulations (as amended) means the National Health Service Commissioning Board

Change in Law: the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgement of a relevant court of law which changes binding precedent in England in each case after the date of this Agreement.

CCG: Clinical Commissioning Group as established and defined by the Health and Social Care Act 2012

CHC: Continuing Health Care as understood and contained in the National Framework for Continuing Health Care reissued November 2012 available from the Department of Health.

Commencement Date: the date from which the provision of the JAD Services commences, specifically 1st June 2014

Commissioning Partner: any of the three Clinical Commissioning Groups named herein responsible for commissioning the JAD or any part thereof on behalf of Service Users within their respective areas.

Confidential Information: means any information which has been designated as confidential by any Party in writing or that ought to be considered as confidential (however it is conveyed or on whatever media it is stored) including information which relates to the Services, the business, affairs, properties, assets, trading practices, developments, trade secrets, Intellectual Property Rights, know-how, personnel, customers and suppliers of any Party, all personal data and sensitive personal data (within the meaning of the DPA)

Data: is a generic term to include all information and data of any description and howsoever held, recorded, or stored and where used throughout this Agreement the expressions Data and Information are synonymous.

Data Protection Legislation: this includes; the Data Protection Act 1998 (DPA); Directive 95/46/EC on the protection of individuals with regard to the processing of personal data and on the free movement of such data; the Regulation of Investigatory Powers Act 2000; the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699); Directive 2002/58/EC concerning the processing of Personal Data and the protection of privacy in the electronic communications sector; the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2003/2426); and all applicable laws and regulations relating to processing personal data and privacy, including the guidance and codes of practice issued by the Information Commissioner, where applicable.

DTOC: Delayed Transfer of Care

Eligibility Criteria: the criteria used to establish the eligibility of persons who will benefit from the provision of the JAD as set out in Schedule 8.

EIR: the Environmental Information Regulations 2004 together with any amending regulations

ESG: the Executive Steering group; a body comprising representative members from each Party to oversee the implementation and operation of the JAD and the Services

Force Majeure: any cause materially affecting the performance by any Party of its obligations under this Agreement arising from any act beyond its reasonable control and affecting any or all other Parties, including without limitation: acts of God, war, industrial action not related to Partners, protests, fire, flood, storm, tempest, epidemic, explosion, acts of terrorism and national emergencies.

Appendix 2: JAD Section 75 Agreement

FOIA: the Freedom of Information Act 2000 together with any amending legislation and related regulations

HWB: Health and Well Being Board as established and defined by The Health and Social Care Act 2012

Host Borough: the Host Borough will be responsible for the management and monitoring of the delivery of the JAD service including the accounting and audit arrangements of the Aligned Budget, HR arrangements, disputes, and performance. As at the Commencement Date the Host Borough shall be the London Borough of Barking and Dagenham subject to review as set out herein.

Information Sharing Protocol: the agreed system and method for sharing information that is of common interest and necessary for the continued operation of the JAD and incorporates the North East London Sharing Protocol as defined elsewhere.

IPR: Means all intellectual and industrial property rights in including (but not limited to) patents, know-how, trademarks, registered designs, utility models, service marks, logos, design rights (whether registrable or otherwise), applications for any of the foregoing, copyright, database rights, rights to prevent passing off for unfair competition, rights in any invention, discovery or process, domain names, trade or business names, moral rights and other similar rights or obligations whether registrable or not in any country in each case in the United Kingdom and all countries in the world and together with all renewals and extensions.

ISP: Information Sharing Protocol as set out in Schedule 2.

JAD: the Joint Assessment and Discharge Integrated Service

Joint Executive Management Committees: The Joint Executive Management Committees are Committees of the Clinical Commissioning Groups and Local Authorities. They will function as a Joint Committee of both legal entities. The Joint Committee will report directly to the CCG Governing Body and the Health and Wellbeing Board and or Cabinet where required of the Local Authorities.

Legislation: any Act of Parliament, sub-ordinate legislation within the meaning of section 21(1) of the Interpretation Act 1978, exercise of the Royal Prerogative, instruments, rules, orders, regulations, notices, bye-law, regulatory policy, permissions and plans for the time being deriving validity from them, guidance or industry code, judgement of a relevant court of law, or directives or requirements of any Regulatory Body, or any European Directives and Regulations enforceable in England and Wales. Specifically;

1970 Act:	The Local Authorities Social Services Act 1970.
1985 Act:	Hospital Complaints Procedures Act 1985.
1990 Act:	The National Health Service and Community Care Act 1990
1999 Act:	The Health Act 1999.
1999 Act Circular:	Circular HSC2000/010; LAC (2000) 9 made Pursuant to the 1999 Act.
1999 Act Circular Guidance:	Guidance issued relating to the above Circular.
2000 Regulations:	The NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (S1 2000/617) as amended.

Appendix 2: JAD Section 75 Agreement

2003 Act:	The Community Care (Delayed Discharges etc) Act 2003 and associated guidance.
2006 Act:	The National Health Service Act 2006.
2007 Act:	The Local Government and Public Involvement in Health Act 2007.
2009 Regulations:	Social Services and National Health Service Complaints (England) Regulations 2009.
2012 Act:	The Health and Social Care Act 2012.
2012 Regulations:	The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012

Minor: a person yet to attain the age of 18 years

NE London Information Sharing Protocol: an over-arching protocol providing a framework Information Sharing Protocol for the secure and confidential sharing of personal information within a consortium of North East London Local Authorities and National Health Service bodies.

Partner: Refers to all Partner Organisations including the “Host Borough” who are signatories to this Agreement each of whom is a “Party” and collectively the “Parties” and all such terms are synonymous.

Performance Metrics: Indicators used to measure performance of delivery of the Services and as set out in Schedule 10

Services: the Services to be delivered pursuant to this Agreement as part of the Joint Assessment and Discharge Integrated Service

Service Manager: the person so identified and notified to each Partner as the person responsible for overseeing the day to day operation of the Services

Service Users: an individual meeting the relevant Eligibility Criteria who is about to be or recently discharged from hospital where circumstances require the provision of the JAD

Term: the duration of this Agreement as set out in clause 3 below.

Working Day: It is anticipated that the JAD will be delivered 7 days a week (Monday – Sunday) including bank and public holidays

1.2 Interpretations:

1.2.1 All references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any clauses attaching thereto;

1.2.2 References to:-

- masculine include the feminine
- singular include the plural
- persons include companies and corporations and vice versa;

1.2.3 The headings of the Clauses of this Agreement are for reference only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant clauses to which they relate;

1.2.4 References made to clauses sub-clauses schedules and annexes are to clauses sub-clauses schedules and annexes of this Agreement;

Appendix 2: JAD Section 75 Agreement

1.2.5 This Agreement is intended to be binding on any successor body to any of the Parties which is created during the Term by or under primary or secondary legislation;

1.2.6 Where reference is made to a body which is abolished by statute it is the intention of the Partners that the Agreement shall be interpreted as if it referred to whichever body takes over the function performed by the body which has been abolished and all references in this Agreement to a body which has been abolished shall be construed as if the reference was to the successor body concerned.

1.2.7 Unless otherwise expressly defined in these terms and conditions, the words used in these terms and conditions shall bear their natural meaning.

1.2.8 Where a term of these terms and conditions provides for a list of items following the word “including” “include”, “included” or “includes” then such list is not to be interpreted as being an exhaustive list. Any such list shall not be treated as excluding any item which might have been included in such list having regard to the context of the contractual term in question. General words are not to be given a restrictive meaning where they are followed by examples intended to be included within the general words.

1.2.9 Subject to the contrary being stated expressly in these terms and conditions, all communication between the Parties shall be in writing.

1.2.10 All monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.2.11 All Schedules, Appendices, and Annexure are intended and shall be deemed to be read and construed as part of this Agreement and shall be given full force as if they appeared in the main body of this Agreement.

2. Purpose, Scope, and Objectives

2.1 This section 75 partnering agreement is established for the purpose of attaining the following objectives;

2.1.1 To facilitate an integrated health and social care support service where required upon discharge from King George Hospital and Queens Hospital for patients with social and/or complex medical needs which may be either short or longer term care;

2.1.2 To identify end of life patients who wish to be looked after at home and ensure that they receive expedited discharge with the right health and social care support

2.1.3 To minimise delays arising from problems with inter-agency liaison;

2.1.4 To focus decision making with the service user at the centre of processes;

2.1.5 To harmonise the assessment and discharge from both hospitals and to improve the quality and efficiency of the service for the relevant Service Users

2.2 This Agreement is a partnering agreement allowing each of the Parties to collectively fulfil their aims and statutory obligations in respect of social, health, and

Appendix 2: JAD Section 75 Agreement

community care for the combined area. It does not and is not intended to create a partnership as defined by the Partnership Act 1890 (as amended).

2.3 This Agreement does not affect the liability of any of the Partners for the exercise of their respective statutory functions and all Partners shall continue to be responsible for observing all applicable laws and regulations in the discharge of their statutory functions.

2.4 Whilst this Agreement is made between the signatories appearing herein the Parties acknowledge the requirements of section 82 of the 2006 Act for NHS Bodies and Public Bodies to co-operate with one another to secure and advance the health and welfare of people within their areas and the need for any partnering agreement to be flexible.

2.5 In the circumstances, the Parties acknowledge that the composition of the Partners who are to deliver the JAD, as well as the location for the delivery of the services, and the services themselves may be varied or amended from time to time as recognised by clause 2.4 above and in accordance with the Variation provisions of clause 5 herein.

2.6 Notwithstanding the arrangements set out in this Agreement it is hereby agreed and declared by the Partners that nothing contained or implied in this Agreement shall prejudice or affect the rights powers duties and obligations of any Partner in the exercise of their functions as a local authority and / or an NHS body as the case may be and their rights powers duties and obligations under all public and private statutes, bye-laws and regulations may be as fully and effectually exercised as if they were not Partners to this Agreement.

2.7 Insofar as any legislation deals specifically with hospital discharge procedures and particularly delayed discharges the Parties agree they will be bound by any such legislation and subsequent amendments.

2.8 The Commissioning Partners named herein, having hitherto commissioned assessment and discharge services on behalf of Service Users from NELFT and BHRUT shall henceforth co-operate and work with all Partner Organisations to commission the JAD Services for all eligible Service Users within their respective areas.

3. Commencement and Term

3.1 This Agreement shall be effective at the date of signing by all Parties. Provision of the JAD Service commences on the Commencement Date of 1st June 2014 and shall continue for an initial period of three (3) years until 31 May 2017 subject to a review by the ESG at 18 months from the Commencement Date.

4. Governance

4.1 Each Partner represents and warrants to the other Partners that at the Commencement Date and continuing thereafter it has full and proper power and authority (including all necessary delegated authority in accordance with their respective Schemes of Delegation) to enter into and perform its obligations under this Agreement and that such authority is available for inspection and audit purposes upon reasonable request.

4.2 The Parties have established an Executive Steering Group (ESG) comprising representative members from each Party to this s.75 Agreement as envisaged by regulation 10(2) of the 2000 Regulations.

4.3 The ESG has overall responsibility for the proper functioning of the partnership and delivery of the JAD. The hierarchy / governance of the ESG is set out in Schedule 1 hereto.

Appendix 2: JAD Section 75 Agreement

4.4 The ESG authority to take decisions regarding the JAD is derived from the combined delegated authority given by each of the Parties to this s.75 Agreement in accordance with their respective schemes of delegation. For the Clinical Commissioning Groups the ESG will report formally to the Joint Executive Management Committees (Barking and Dagenham (1) and Havering (2)). For the avoidance of doubt the Joint Executive Management Committees are formal committees of the CCG Governing Body.

4.5 The function of “Host” and leadership of the ESG shall be reviewed at eighteen months from the Commencement Date and if necessary, variations may be made to this Agreement.

4.6 For the avoidance of doubt, the reference to proper authority in clause 4.1 above includes obtaining any necessary consents from any relevant Health Authority.

4.7 Without prejudice to any other governance or reporting procedures contained herein the Parties shall report both quarterly and annually on the exercise of any health related functions that form part of this Agreement.

5. Variations

5.1 If any Partner proposes a variation to any of the terms of this Agreement that Partner shall initially report its proposal (in writing) to a meeting of the ESG.

5.2 Variations will only be effective if agreed by all Partners through the ESG and if agreed will be evidenced by a document confirming the details of the variation signed on behalf of each Partner by the senior of its representatives on the ESG.

5.3 In the event that a variation is required by virtue of any emergency or unforeseen circumstances such that it is not possible to present a prior written report the ESG shall have the power to make any such variation that might be deemed necessary, provided always that any such variation shall be recorded in writing and notified to all interested parties as soon as practicable thereafter.

6. Insurances

6.1 Each Partner shall at the commencement and throughout the term of this Agreement warrant and affirm that they have adequate insurance policies as may be necessary for their participation in the provision of the JAD and shall provide documentary evidence of the same on request by any of the Parties.

6.2 The insurance policies referred to above shall include as a minimum but may not be limited to Employers Liability, Public Liability, Occupiers Liability, and Professional Indemnity cover Each Partner shall further warrant and affirm they have notified their relevant insurance departments about this Partnership arrangement.

6.3 In respect of liabilities arising under any indemnity in this Agreement, the CCG Commissioning Partners shall effect through the National Health Services Litigation Authority, alternative arrangements in respect of NHS schemes, in lieu of commercial insurance, including maintaining membership of the Liabilities to Third Parties Scheme or equivalent, the Clinical Negligence Scheme for Trusts or such other scheme as may be operated from time to time by the National Health Service Litigation Authority.

6.4 Each Partner shall be responsible for insuring the premises and assets it contributes to the Partnership Arrangement.

6.5 Each Partner acknowledges and affirms that all liabilities howsoever arising that predate the commencement date of this Agreement will be managed by the individual Partner(s) as being distinct and separate and of no effect to this Agreement.

7. Indemnities

7.1 Each Partner (the indemnifying Partner) shall indemnify and keep indemnified the other Partner(s) (the indemnified Partner(s)) against all claims, costs and

Appendix 2: JAD Section 75 Agreement

liabilities arising directly or indirectly from any events, acts or omissions in relation to their respective functions occurring prior to the Commencement Date.

7.2 Each of the Partners confirms that it has informed all other Partners of any material or potential liabilities of which it is aware as at the Commencement Date, arising directly or indirectly from any events, acts or omissions of the indemnifying Partner in relation to those of its respective functions which are relevant to the arrangements set out in this Agreement.

7.3 This Clause 7 shall apply where one of the Partners (“the indemnified Partner”) incurs direct expense or loss, or is subject to claims from third parties as a result of the negligent actions or omissions of one or more of the other Partners or their employees or agents (“the negligent Partner(s)”) and the indemnified Partner reasonably settles any such claim or is found liable at law in respect of such a claim having reasonably opted to defend such a claim

7.4 In the circumstances outlined in Clause 7.3 the negligent Partner(s) shall indemnify the indemnified Partner against any such expenses or claims to the extent which such expenses and claims result directly from the negligence of the negligent Partner(s) with the amount indemnified being apportioned according to each Partner’s share of responsibility where two or more Partners admit or are found to be negligent Partners

7.5 The indemnified Partner shall not be entitled under this Clause 7 to recover from an indemnifying Partner any loss of income or any indirect or consequential loss suffered by the indemnified Partner.

7.6 Each Partner agrees:

7.6.1 to notify all other Partners in a timely manner of the details of any Claim

7.6.2 if it considers that this Clause 7 may apply to any Claim to consult with and have reasonable regard to any views expressed by the indemnifying Partner(s) as to the conduct and handling of that Claim and in particular shall not settle dispose or compromise that Claim without the prior written consent of the indemnifying Partner(s) provided that if such consent is unreasonably withheld or delayed the indemnified Partner(s) may proceed to settle dispose or compromise that Claim if in the reasonable opinion of the indemnified Partner(s) it is necessary to so do.

7.7 Each Partner agrees to co-operate and provide all such advice, assistance and information to the other Partners as may be reasonably required in respect of any claim or the conduct of any such claim in a timely manner.

7.8 Where:

7.8.1 any claim by or against a Partner or

7.8.2 any claim or losses in respect of which a Partner is or it appears may become entitled to indemnification under this Clause 7 relates solely to the exercise of the statutory functions of one Partner, then that Partner shall be entitled at any time to commence or resist the Claim and shall have the conduct of any defence, dispute, compromise or appeal of the Claim and of any incidental negotiations and the other Partners will give that Partner all reasonable co-operation, access and assistance for the purposes of considering and resisting such Claim (including promptly taking all steps necessary to transfer the conduct of such Claim to that Partner) and that Partner shall consult with and keep the other Partners informed of the progress of the Claim.

8. Dispute Resolution

8.1 Save where any dispute resolution procedure is governed by specific legislation, regulation or guidance, (and, for the avoidance of doubt this includes disputes relating to CHC eligibility decisions which will be resolved in accordance with procedures governed by the CHC National Framework), any other dispute between the Parties relating to this Agreement, shall in the first instance be referred to the Executive Steering Group who shall endeavour to resolve such dispute within 28 days of such notification. If it has not been possible to satisfactorily resolve the dispute within 28 days the dispute shall be referred to the Chief Executives of the Partners affected who shall endeavour to resolve the dispute within a further 14 days.

8.2 In the event that a dispute between two or more Partners (the Disputing Partners) has not been resolved pursuant to Clause 8.1 the Partners agree that without restricting the ability of any Partner to terminate this Agreement in accordance with Clause 9 below, the Disputing Partners may by agreement refer the dispute to mediation, the mediator if not agreed by the Disputing Partners to be appointed by the Chief Executive of NHS England or their replacement as determined by the Department of Health from time to time. The mediation procedure shall be in accordance with the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure or such other model mediation procedure as the Disputing Partners may agree.

9. Termination and Consequences of Termination

9.1 This agreement shall continue for the duration of the initial period and any subsequent extension period as identified in clause 3 above unless terminated early in accordance with these provisions.

9.2 This Agreement shall terminate where:

9.2.1 Any Partner gives at six (6) months written notice to the ESG that they wish to terminate this Agreement for whatever reason, provided that no such notice may be given before 31 March 2015. .

9.2.2 A Partner ceases or threatens to cease to carry on all or any part of its undertakings as constituted at the date of this Agreement where this would in the reasonable opinion of the ESG have a material effect on the ability of the Partners to comply with this Agreement

9.2.3 Any Partner considers that reasonable circumstances at any time arising as a result of new and unforeseen legislation or policy requirements of central Government results in the terms of this Agreement no longer being tenable and gives the other Partners at least six months' written notice

9.2.4 Where there has been service failure as a consequence of which the continuation of the Agreement would be detrimental to client services or a Partner and at least three months' written notice is given

9.2.5 The Partners are unable to agree the resourcing of this Agreement either in respect of financial contributions or the available staff to provide the services or the accommodation services to be made available, with the result that the joint arrangements are no longer functional. Where such a situation arises the Partners will first have fully discussed the implications through the ESG and agreed on a joint exit strategy for the dissolution for the Agreement. Thereafter a minimum of three months written notice will be required to determine the Agreement under this Clause.

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9.3 Where this Agreement is terminated the Partners agree to cooperate fully in ensuring that Partnership is dissolved without harm to clients or Services and there is an orderly transition to the arrangements that are to supersede this Agreement in accordance with the Exit Strategy contained in Schedule 7 herein.

9.4 Any costs resulting from the termination of the Agreement shall be paid for:

9.4.1 Where the termination is a no fault termination and agreed by all of the Partners, on a pro rata (based upon each of the Partners' financial contribution to the JAD) or similar basis to be agreed by the Partners. For the avoidance of doubt this clause 9.4.1 shall not apply to any of the Commissioning Partners.

9.4.2 Where one or more Partners decides, without the agreement of the remaining Partners, to cease providing part or all of the Services, by that Partner or Partners;

9.4.3 Where termination is caused by one or more Partners having acted unreasonably (which in the case of dispute shall be determined by the ESG or following the dispute resolution procedure at clause 8 above) by that Partner or Partners.

9.5 Ongoing costs which arise as a consequence of the termination of the Agreement and its replacement with new arrangements shall be borne separately by the Partners.

10. Intellectual Property Rights

10.1 Ownership of all IPR shall remain with the respective owner but each Party hereby grants all other Parties a perpetual, irrevocable, royalty free licence to use such of its IPR as is necessary to enable it to fulfil its functions under this Agreement only.

10.2 Future IPR shall belong absolutely to the Party that creates it from the moment it is created, but that Party hereby grants to all other Parties a perpetual, irrevocable, sub-licensable licence to use the future IPR for the purposes of this Agreement only.

11. Force Majeure.

11.1 No Party to this Agreement shall be liable for failure to perform its obligations hereunder if such failure results from Force Majeure.

11.2 If the delivery location for the performance of the Services is affected by circumstance of Force Majeure, the ESG shall meet to consider whether the Service or any part thereof should be totally or partially suspended until the circumstances of the Force Majeure have ceased. In all cases, the decision of the ESG shall be final and in such circumstances no Partner shall have any claim for damages or loss against any other Partner nor be entitled to terminate the Agreement or any part of the Service thereunder except in accordance with this clause 11.

11.3 In circumstances where the event of Force Majeure is ongoing the ESG shall meet as often as they deem necessary and should the situation continue for more than two (2) consecutive months the ESG may in their absolute discretion give written notice to all the Partners to terminate the JAD and this Agreement forthwith or on a set termination date.

11.4 If the Agreement is terminated in accordance with clause 11.3 above no Partner will have any liability to the other Partners except that any rights and liabilities which accrued prior to termination and will continue to exist.

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11.5 For the avoidance of doubt, industrial action, illness, or unavailability for work by any Partners' own staff, employees, or agents shall not be regarded as an event of Force Majeure.

12. Change in Law

12.1 On the occurrence of a Change in Law which may have a material effect upon the operation of the Services the ESG shall meet at the earliest opportunity to consider any such change.

12.2 Where the ESG decide unanimously that the delivery of the JAD is capable of continuing with or without modifications or amendments in compliance with any Change in Law the ESG shall decide what, if any, modifications or amendments are required and this Agreement shall be varied accordingly.

12.3 Subject to any other rights of any of the Parties if, (in the opinion of the ESG), the effect of any Change in Law is such that the continuation of this Agreement and the delivery of the JAD is no longer feasible the ESG shall meet and agree an orderly dissolution process in accordance with the Termination and Exit Strategy provisions of this Agreement.

13. Severance

13.1 In the event of any provision or part of this Agreement being held to be illegal, invalid, or un-enforceable the remainder of this Agreement shall not thereby be affected.

13.2 In the event that any provision in this Agreement is held to be illegal, invalid, or unenforceable the Partners shall negotiate in good faith to amend or replace the provision concerned with an alternative which is legal valid and enforceable and which achieves to the greatest extent possible the Partner's original intention on entering into this Agreement or as subsequently varied in accordance with Clause 5 above, as the case may be.

14. Waiver

14.1 The rights and remedies of any Partner in respect to this Agreement shall not be diminished, waived or extinguished by the granting of any indulgence, forbearance or extension of time by such party to the other nor by failure or delay by the said party in ascertaining or exercising of any such rights or remedies.

14.2 Any waiver by any Partner of any breach of this Agreement shall not prevent the subsequent enforcement of any subsequent breach of that provision and shall not be deemed to be a waiver of any subsequent breach of that or any other provision.

14.3 No waiver shall be effective unless it is communicated in writing to the other Partners

15. Entire Agreement

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15.1 Save to any extent expressly provided for in this Agreement, this Agreement constitutes the entire agreement and understanding between the Parties in respect of the matters dealt with in it and supersedes, cancels or nullifies any previous agreement between the Parties in relation to such matters.

15.2 Each Party confirms that in entering into this Agreement it does not rely on, and shall have no remedy in respect of, any statements, warranties, representations, or understandings (whether negligently or innocently made) of any person (whether party to this Agreement or not) other than as expressly set out in this Agreement. However nothing in this Agreement purports to exclude liability on the part of either party for fraudulent misrepresentation.

16. Information and Data Sharing

16.1 By entering into this Agreement each Partner warrants and affirms that their respective organisation has in place a robust and DPA compliant system for the gathering, retention, processing, use, and sharing of all Data and information.

16.2 Each Partner further warrants and affirms that all individuals who have or are likely to have responsibility for the gathering, retention, processing, use, and sharing of all Data insofar as it relates to their roles within the provision of the JAD are fully aware of their obligations in relation to Data protection under all Data Protection Legislation.

16.3 Each Partner and all individuals involved in the delivery of the JAD shall have regard to and be bound by the Information Sharing Protocol appearing herein as Schedule 2 .

17. Prevention of Corruption

17.1 Every Partner shall have adequate policies and procedures in place (that shall be shared with any of the other Partners upon request) to ensure that relevant controls, assurance, probity and professional standards are met throughout the Term of this Agreement and the delivery of the JAD.

17.2 Every Partner shall comply with all applicable laws, regulations and sanctions relating to anti-bribery and anti-corruption including but not limited to the Bribery Act 2010 and each and every Partner warrants they will not, by their employees, servants, agents or consultants engage in any activity, practice or conduct which would constitute an offence under the Bribery Act 2010.

17.3 Every partner shall promptly report to the other Partners any request or demand for any undue financial or other advantage of any kind received in connection with the performance of this Agreement.

18. Safeguarding Policy

18.1 Pan London safeguarding policies for Adults and Minors (Children) are in place and continually reviewed and updated. Every Partner is deemed to be aware of all such policies as may be applicable to their function and delivery of the JAD and all such safeguarding policies shall be followed accordingly.

19. Law and Jurisdiction

19.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter shall be governed by and construed in accordance with the law of England and Wales, and the Partners irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

20. Counterparts

Appendix 2: JAD Section 75 Agreement

20.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all the counterparts shall together constitute the one agreement.

20.2 Transmission of an executed counterpart of this agreement together with the signature page(s) executed by all Parties to this Agreement by e-mail (in PDF or other agreed format) shall take effect as delivery of an executed counterpart of this agreement.

IN WITNESS of which the Parties have executed and delivered this Agreement as a DEED the day and year first before written

EXECUTED as a Deed by or)	
for and on behalf of	)	DIRECTOR
)	
	)	DIRECTOR/SECRETARY
And signed by a director and)	
Secretary / another director)	
or signed by a sole director	)	WITNESS PRINT NAME
and witnessed)	
		WITNESS SIGNATURE
		WITNESS ADDRESS

The Common Seal of the Mayor)	
and Burgesses of the London))
Borough of Barking and)	
Dagenham)	
was hereunto affixed in)	
the presence of:)	

.....
Being an officer of the Council of the London Borough of Barking and Dagenham, duly authorised to attest the Common Seal thereof

Minute Number:
Sealing Register:

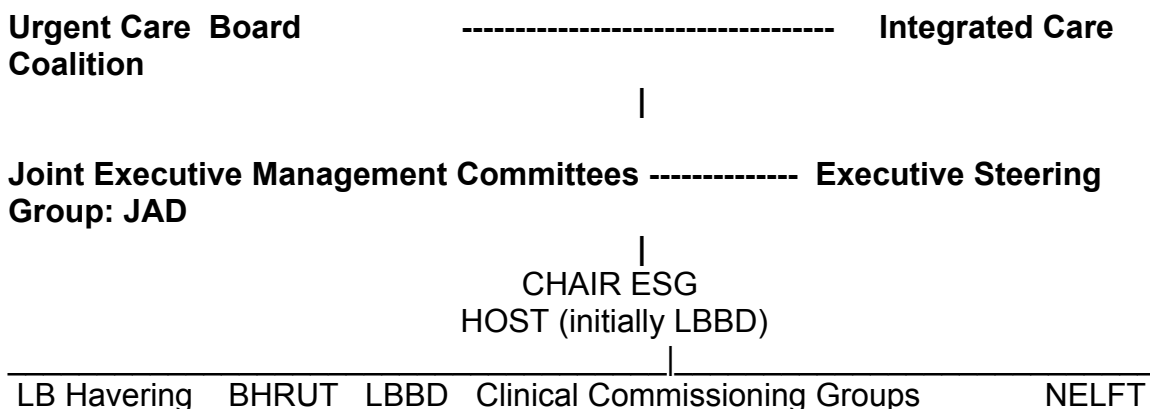
The Common Seal of the Mayor)	
and Burgesses of the London))
Borough of Havering)	
was hereunto affixed in)	
the presence of:)	

_____ Mayor

_____ Authorised Officer

SCHEDULE 1

EXECUTIVE STEERING GROUP AND GOVERNANCE



1. The Executive Steering Group (ESG) shall comprise senior members of the Partners as set out above. The CCG will report directly to the two CCG Executive Committees (Barking and Dagenham (1) and Havering (2)) formally. The Joint Executive Management Committees are formal committees of the CCG Governing body.

2. The Chair of the ESG shall be determined from time to time by the ESG and shall be one of the senior representatives of each party in rotation. The Chair shall not have a casting vote in relation to any item of business transacted by the ESG. The term of office of each Chair shall be 12 months.

3. The Partners agree that the purpose of the ESG's is, inter alia:-
 - 3.1 To provide high level management in respect of the services and to be responsible for agreeing the approach to all relevant issues arising from the provision and procurement of the services, including commissioning reports on the provision of the services and making recommendations on their procurement and management.
 - 3.2 To identify, where appropriate, senior managers employed by the partners to manage the services.
 - 3.3 To consider reports from the Service Manager (including performance reports and risk management) ensuring that the reports take account of the respective reporting cycles of both partners; having regard to the contents and recommendations of such reports, to take all actions which the ESG considers appropriate.

- 5 A decision of the ESG must be unanimous in order to bind the Partners.

5. The quorum required for the ESG shall be one representative of each of the Partners represented on it. Where the designated ESG member of any

Appendix 2: JAD Section 75 Agreement

Partner is unable to attend any meeting for whatever reason a substitute attendee of sufficient seniority to take decisions on behalf of that Partner organisation may be nominated and such substitution shall be sufficient to contribute towards the quorum.

6. The ESG will ordinarily meet at least quarterly, save that for the first three months from the Commencement Date it shall meet at least twice each month. In exceptional circumstances or as the need arises the current chair of the ESG shall have the power to convene further meetings by giving reasonable notice to all ESG members as required. Any member of the ESG can request an exceptional meeting of the ESG via the chair.
7. Practical arrangements to support the ESG will be reviewed from time to time, with initial agreement as follows:-
 - Secretarial support will be provided by LBBD or the current Host Partner
 - Papers and Agendas will be distributed not less than 7 days before each meeting;
 - Reports to the ESG should be written reports, unless of an urgent nature. In such cases any urgent reports presented verbally will be minuted.

SCHEDULE 2
INFORMATION SHARING PROTOCOL

1. Introduction

1.1 This Information Sharing Protocol (ISP) is made pursuant to regulation 8 of the NHS Bodies and Local Authority Partnership Regulations 2000 as amended by regulation 12 of the NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health, and Local Healthwatch) Regulations 2012 which requires all s.75 Agreements to contain provisions for the sharing of information.

1.2 The aim of this ISP is to facilitate the sharing of all personal, sensitive, and non personal data between all of the Partners responsible for delivering the JAD so that service users and members of the public receive the services they need and peace of mind they deserve.

1.3 Public bodies involved in providing services to the public have a legal responsibility to ensure that their use of personal data is lawful, properly controlled, and safe and that individual rights are respected.

1.4 Each Partner to this s.75 Agreement shall ensure that all persons engaged in the delivery of the JAD are aware of their individual and collective responsibilities in relation to the collection, processing, use, and sharing of all data.

1.5 This ISP will be reviewed periodically or as often as the ESG deem necessary. Any revision or amendment to this ISP must be approved by the ESG but the responsibility for disseminating any such change throughout the Partner Organisations shall remain with each Partner Organisation.

2. SCOPE

2.1 This ISP sets out the rules that all persons working for or with the Parties to this Agreement must follow when collecting, processing, using, and sharing information.

2.2. This protocol applies to all information shared by the Partners and not solely information classified as Personal Data by the Data Protection Act 1998. This includes all information processed by the organisations, howsoever obtained and stored in whatever format including electronic, or manual records and any anonymised, including aggregated data.

2.4 This ISP is subject to the overarching and governing protocol which is the North East London Information Sharing Protocol (the NELISP) as amended from time to time. Each Partner to this Agreement are either signatories to and bound by the principles set out in the NELISP or, shall be deemed to be aware of its contents and by entering into this Agreement also deemed to agree to abide and be bound by the principles contained therein.

2.5 The specific purpose for use and sharing information will be defined in the Information Agreements that will be specific to the Partners sharing information, for example Subject Specific Information Sharing Agreements.

3. The Legal Framework

3.1 In addition to the Data Protection Legislation as defined herein each Partner Organisation and every individual involved in the delivery of the JAD and responsible for information and data sharing will be familiar with the principal legislation

Appendix 2: JAD Section 75 Agreement

concerning the protection and use of personal information. This may include but shall not be limited to:

- Article 8 of The Human Rights Act 1998
- The “Caldicott Principles”
- The 8 principles of The Data Protection Act 1998
- The Common Law Duty of Confidence
- Computer Misuse Act
- Civil Contingencies Act 2004

3.2 Other legislation may be relevant when sharing specific information.

4. Information covered by this ISP

4.1 All Information, including personal data and sensitive personal data as defined in the Data Protection Act 1998 (DPA). In order to reduce the risks of DPA compliance and security breaches it is recommended that, where possible, anonymised data should be used.

5. Individual and Collective Responsibility

5.1 Each Partner Organisation is responsible for ensuring that their internal organisation and security measures protect the lawful use of information shared under this ISP.

5.2 Every individual working for the organisations listed in this Partnership Agreement is personally responsible for the safekeeping of any information they obtain, handle, use and disclose.

5.3 The Service Manager for the JAD (directly employed by LBBD) will line manage managers and staff, some of whom will be directly employed by LBBD and some who retain their existing employment with their originating employer. The Service Manager, in consultation with other Partner Organisations will determine a unified approach to the sharing of information that will require adherence to this ISP and the NELISP.

5.4 The Partner Organisations will work together to establish any further procedures, forms or additional agreements that may be necessary from an operational perspective for compliance with this ISP. This may include the development of forms, agreements, subject specific information sharing agreements, and any other policies, examples of which can be found at Annexure 1 to this Schedule.

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SCHEDULE 2 INFORMATION SHARING PROTOCOL ANNEXURE 1

Who	Type of information	Reasons
Service Manager and other managers (ward managers and any deputies)	HR data relating to individual staff who may not share the same employer as their manager	To manage staff, supervision, performance, sickness and leave etc...
Practitioners working within the JAD (including SWs, Nurses etc..)	Individual patient records	To undertake assessment of need (as required by NHS & CC Act)
Practitioners working within the JAD (including SWs, Nurses etc..)	Assessment information undertaken by other agencies	To undertake assessment of need (as required by NHS & CC Act) and determine eligibility.
Practitioners working within the JAD (including SWs, Nurses etc..)	Access to databases which will include: <ul style="list-style-type: none"> • Rio • Carefirst • Health analytics 	To undertake assessment of need (as required by NHS & CC Act) and determine eligibility.
	Information from other agencies which will include information from: <ul style="list-style-type: none"> • UK Border Agency • Housing Departments 	To undertake assessment of need (as required by NHS & CC Act) and determine eligibility.
Staff and managers	Information and data relating to organisational performance, some of which will relate to action planning to improve current performance which may be sensitive were this to be more broadly available.	To understand the services role in delivering whole system performance and in meeting service specific measures.
Managers	G.P registration services (<i>tbc- final iteration</i>)	
Managers	Datex database – recording of incidents & risks (<i>tbc- final iteration</i>)	
Administrative staff	<ul style="list-style-type: none"> • HR data • Individually identifiable data for patients and service users. • Performance reporting and database access 	<p>To support management function and core business of the service.</p> <p>To receive referrals and track onward management of volumes and those people who may be pending discharge</p>

DETAILS OF STAFF PERMITTED TO ACCESS SENSITIVE PERSONAL INFORMATION RELEVANT TO SSISA.

Appendix 2: JAD Section 75 Agreement

SCHEDULE 3 FINANCIAL GOVERNANCE AND FUNDING

1. The Parties have agreed that the financial contributions from each Partner will form the Aligned Budget.
2. Each Partner organisation that contributes to the Aligned Budget will retain the monies in their respective internal budgets. The amounts that have been agreed will be “ring fenced” for the specific purpose of funding the JAD.
3. Under no circumstances may any of the Partner Organisations use any part of their respective internal budget for use with the JAD except for that part which has been “ring fenced” for that specific purpose.
4. All Partner Organisations that contribute funding to the JAD shall keep documented records for audit purposes and such records shall be made available for inspection by any of the Partner Organisations or any other interested party upon reasonable notice.
5. Financial tracker / monitor tracker attached.

JAD Financial Tracker 2014/2015
ALL FIGURES IN £'000

2014/2015	LBBB	LBH	BHRUT	NELFT	JOINTLY FUNDED POSTS	TOTAL
Aligned Annual Budget						
Actual spend to date as per respective general ledgers						
Outstanding items that need to be settled to date between Partner organisations						
Estimated to spend from current date to year end						
Total estimated year end outturn						
Estimated year end favourable / unfavourable variance	0	0	0	0	0	0

Notes: Each Partner organisation to submit the above data to the JAD Service Manager by 21st of each month. The JAD Service Manager will then liaise with the host finance team.

SCHEDULE 4
HR, STAFFING, SECONDMENT

SECONDMENT AGREEMENT

THIS SECONDMENT AGREEMENT is made on 14 June 2014 between: -

- (1) **London Borough of Barking and Dagenham ("the Host")**
- (2) **London Borough of Havering ("Partner organisation")**
- (3) **Barking, Havering and Redbridge University Hospitals Trust ("Partner organisation")**
- (4) **North East London NHS Foundation Trust ("Partner organisation")**

1. INTRODUCTION

- 1.1 This Secondment Agreement is entered as a consequence of an Agreement between the Host, and the Partner organisations under section 75 of the National Health Service Act 2006 ("the s75 Agreement") for the provision of a joint Assessment and Discharge Service.
- 1.2 Partner organisations have agreed to second their Employees to the Host on the terms of this Agreement.

2. SECONDMENT

- 2.1 With effect from 14 June 2014 Partner Organisations shall second Employees to the Host on the terms of this Agreement. Subject to earlier termination as provided for in this Agreement, the secondment is reviewable annually during the period of the s75 Agreement provided that the Employee remains employed by the Partner organisation
- 2.2 During the Secondment, the Employee shall be co-located within the Joint Assessment and Discharge service, located at Queens' Hospital, Romford or King George Hospital, Goodmayes, where he/she shall act and perform the duties as set out in the Employee's contract of employment with the Employer. However it is recognised that in order to meet changes in service provision this location and role may change over time. The Employee will be consulted in relation to any further proposed changes to either location or role.

3. CONDITIONS OF SECONDMENT

- 3.1 The Employee's Terms and Conditions of Employment with the Partner organisation shall remain in force during the Secondment period.
- 3.2 Employees shall be issued with a revised, generic, job description which will be subject to consultation with the Employee and Trade Unions.
- 3.3 Employees shall remain an employee of the Partner organisation at all times and shall not be deemed to be an employee of the Host by virtue

of the Secondment and shall not be entitled to any salary, pension, bonus or other fringe benefits of the Host.

- 3.4 The Employee's continuity of service with the Partner organisation will be preserved for both statutory and contractual purposes during the period of secondment.

4 LIABILITY AND INDEMNITIES

- 4.1 The Partner organisation shall indemnify and keep indemnified, the Host in relation to any claims, charges or liabilities for (including but not limited to) any income tax, Employee National Insurance or similar contributions (including costs interests and penalties), or other statutory charges or remuneration or other compensation arising from or in relation to the services by the Employee under this Agreement or the Employee being found to be an Employee of the Host or otherwise. The Host agrees to notify the Partner organisation of any such claims charges or liabilities received by the Host.
- 4.2 The Host shall not be liable for any act or omission on the part of the Employee during the Secondment and shall incur no liability for loss, damage or injury of whatever nature sustained by the Employee during the Secondment.
- 4.3 The Partner organisation hereby indemnifies the Host against any and all claims, liabilities, actions, proceedings, costs (including legal fees), losses, damages and demands arising out of or resulting from breach of this Agreement or any act or omission or default of the Employee including without limitation:
- 4.3.1 Any loss of or any damage to any property;
 - 4.3.2 All financial loss;
 - 4.3.3 Those resulting from any breach by the Employee of any intellectual property rights owned by the Partner organisation or a third party;
 - 4.3.4 Injury to or death of any person caused by any negligent act or omission or wilful misconduct of the Employee, whether resulting in material or financial loss or damages or death or injury to persons or any other loss or damage whatsoever;
 - 4.3.5 Any and all liability arising from any breach of the provisions of the Data protection Act 1998 by the Employee.
- 4.4 The Partner organisation hereby indemnifies the Host against any and all claims, liabilities, actions, proceedings, costs (including legal fees), losses, damages, demands, penalties, fines or expenses suffered or incurred by the Partner organisation which are attributable to any act or omission by the Partner organisation any other person for whom the Partner organisation are liable arising out of:-
- 4.4.1 The employment or termination of employment of the Employee during the Secondment; or
 - 4.4.2 The engagement or termination of engagement of the Employee under the terms of this Agreement during the Secondment; or
 - 4.4.3 Any breach by the Partner organisation of any collective

Appendix 2: JAD Section 75 Agreement

agreement with a trade union, staff association or employee representatives in respect of the Employee including for the avoidance of doubt without limitation liability for personal injury, accident or illness suffered or incurred in whole or in part during the Secondment, breach of contract or in tort, unfair dismissal, redundancy, statutory redundancy, equal pay, and discrimination of any kind or under any legislation applicable in the United Kingdom.

- 4.5 The Host shall indemnify the Partner organisation against any and all claims, liabilities, actions, proceedings, costs (including legal fees), losses, damages, demands, penalties, fines or expenses suffered or incurred by the Partner organisation which are attributable to any act or omission by the Host or any other person for whom the Host are liable arising out of:-
 - 4.5.1 Any breach by the Host of any collective agreement with a trade union, staff association or employee representatives in respect of the Employee
 - 4.5.2 Any breach by the Host of any disciplinary, grievance or other employee related rules and procedures during the Secondment including for the avoidance of doubt without limitation liability for personal injury, accident or illness suffered or incurred in whole or in part during the Secondment, breach of contract or in tort, unfair dismissal, redundancy redeployment costs, statutory redundancy, equal pay, discrimination of any kind or under any legislation applicable in the United Kingdom.

5 CONDUCT OF CLAIMS

- 5.1 If the Host becomes aware of any matter that may give rise to a claim against the Employee and/or the Partner organisation, notice of that fact shall be given as soon as possible to the Partner organisation.
- 5.2 Without prejudice to the validity of the claim or alleged claim in question, the Host shall allow the Partner organisation and its professional advisors to investigate the matter or circumstance alleged to give rise to such claim and whether and to what extent any amount is payable in respect of such claim, and for such purpose, the Host shall give subject to being paid all reasonable costs and expenses, all such information and assistance, including access to premises and personnel, and the right to examine and copy or photograph any assets, accounts, documents and records, as the Partner organisation or its professional advisors may reasonably request provided that nothing in this clause shall be construed as requiring the Host to disclose any document or thing the subject of any privilege. The Partner organisation agrees to keep all such information confidential and only to use it for such purpose.
- 5.3 No admission of liability shall be made by or on behalf of the Host and any such claim shall not be compromised, disposed of or settled without the consent of the Partner organisation.

- 5.4 The Partner organisation shall be entitled in its absolute discretion to take such action as it shall deem necessary to avoid, dispute, deny, defend, resist, appeal, compromise or contest any such claim or liability (including, without limitation, making counterclaims or other claims against third parties) in the name of and on behalf of the Host and to have the conduct of any related proceedings, negotiations or appeals.

6 LEAVE

- 6.1 The Host will inform the Partner organisation of any absence, including but not limited to sickness absence, industrial injury or other disability as soon as is reasonably practicable. It is the Employee's responsibility to follow the Partner organisation's sickness absence reporting procedures at all times. The Host will abide by the partner organisations leave policy including sickness absence management, leave and other absence related policies.
- 6.2 The Employee shall be entitled to holiday during the period of secondment in accordance with the Employee's terms and conditions of employment with the Partner organisation.

7 HEALTH AND SAFETY

- 7.1 The Host shall ensure that the Employee observes its health and safety policies and procedures and maintains a safe method of working.
- 7.2 The Employee is required under Section 7 of the Health and Safety at Work Act 1974, to take reasonable care for his/her own Health and Safety and that of others who may be affected by his/her acts or omissions at work.

8 CONFLICTS OF INTEREST

- 8.1 The Employee must declare and seek agreement from the Partner organisation and his/her line manager regarding any interests, financial or otherwise, which may give rise to a conflict of interest during the course of the secondment. Such interests include other employment, business interests and positions of authority in a charity or voluntary body in the field of health and social care and in connection with a voluntary or other body contracting for NHS services.

9 RESPONSIBILITY FOR RESOURCES

- 9.1 **Where applicable:** Where the Employee is responsible for the management of the Host budgets and/or the procurement of equipment and services the Employee should follow the Host's Standing Financial Instructions and associated procedures.
- 9.2 In undertaking such duties the Employee should be mindful to ensure efficient and transparent financial management. This will include financial probity, the management of financial risk and achievement of value for money.

10. PAYMENT OF SALARIES AND EXPENSES

- 10.1 The Employee will continue to be paid by the Partner organisation in accordance with the Employee's terms and conditions of employment for the duration of the secondment.
- 10.2 It is agreed that the Partner organisation shall be solely responsible for all income tax liability and National Insurance contributions or other statutory charges in respect of any payment to the Employee for the

provision of services by the Employee to the Host under this Agreement.

- 10.3 Any salary increments applicable to the Employee's substantive post with the Partner organisation will continue to apply subject to the Partner organisation's Pay Review.

11. HUMAN RESOURCES SERVICES

11.1 Replacement of seconded staff

After 13 June 2014 the administrative services to support the recruitment and selection of seconded staff will be led by the Host, supported by the Partner organisation as appropriate.

11.2 Employee Relations

- 11.2.1 After 13 June 2014 the Partner organisation will continue to provide advice to the Employee on the Partner organisation's policies including but not limited to disciplinary, grievance, ill health, maternity leave and general terms and conditions of service. The Partner organisation's Human Resources Policies are available internally on the Partner organisations' Intranet.

- 11.2.2 The Partner organisation will be responsible for ensuring the Employee is kept updated with all changes in the Partner organisation's policies and procedures, although this may be communicated to the Employee through the Host staff.

11.3 Policies and Procedure

11.3.1 During the Secondment Period, the Host, in consultation with the Partner organisation's Human Resources Department shall implement the Partner organisation's policies and procedures in respect of the Employees, so far as they comply with current employment legislation.

- 11.3.2 The Partner organisation authorises the Host to take action in respect of the

Employees pursuant to the Partner organisation's Disciplinary Policy save for any action, which could result in the dismissal of an Employee. In such circumstances the Partner organisation shall take appropriate steps in accordance with its Disciplinary Policy and Procedure.

- 11.3.3 The Host may, should it consider necessary to do so, suspend Employees from

duty in accordance with the Partner organisation's Disciplinary Policy and in consultation with the Partner organisation's Human Resources Department and responsible officer provided that such a suspension shall be notified to the partner no later than the following working day.

- 11.3.4 The Partner organisation authorise the Host to deal with any grievances raised by

the Employee against the Host in accordance with the Partner organisation's grievance policy. The Host will notify the Partner organisation of any grievances received by the Host including those against the Partner organisation within 3 working days or as soon as reasonably possible

- 11.3.5 For the avoidance of doubt, nothing in clause 11 shall be construed or have

Appendix 2: JAD Section 75 Agreement

effect as construing any relationship of Partner organisation or Employee between the Host and the Employee.

11.4 Workforce Information

Workforce information regarding seconded staff will continue to be collected and retained by the Partner organisation. However, it is recognised that the Host will require data concerning seconded staff in order to support the planning and delivery of services. The Partner organisation in accordance with the format and deadlines identified by the Host will provide this information as required. The Host organisation will also be required to provide workforce information to the partner organisation in order to maintain accurate records

12 MANAGEMENT DURING THE SECONDMENT

12.1 The Employee shall be supervised by and directly accountable to a designated line manager in the Host's organisational structure during the secondment and the Partner organisation will provide access to professional supervision for qualified social workers.

13 PROFESSIONAL DEVELOPMENT

13.1 The Partner organisation will work with the Host to ensure the Employee's professional and developmental needs are identified and met. Performance Development Review's, Performance Management processes, and training of the Employee will be undertaken by the Host In line with the partner organisations policy.

14 MANAGEMENT OF CHANGE

14.1 It is recognised that the Host and the Partner organisation in delivering and developing services will face organisational restructuring and changes in employment levels. In the event that the Employee is affected by organisational change, the Host and the Partner organisation will ensure that changes happen following full consultation with his/her union representative and that changes comply with the Partner organisation's employment policies.

15 DATA PROTECTION

15.1 The Employee and the Partner organisation consent to the Host holding, disclosing, using or otherwise processing any information about them which they provide to the Host on which the Host may acquire as a result of the Secondment.

15.2 The Partner organisation and the Host agree to protect any personal data held in relation to the Employee in accordance with the Data Protection Act 1998.

16 CONFIDENTIALITY

16.1 In addition to the provisions regarding confidentiality in the Employee's Contract of Employment, the Employee will not disclose during or after the secondment any confidential information to which the Employee became privy during the course of the secondment, including but not

limited to all trade secrets, lists or details of customers, suppliers or patients, information relating to the working of any process or invention carried on or used by any subsidiary or associate, research projects, prices, discounts, mark-ups, future business strategy, marketing, tenders, any price sensitive information, and any proprietary Host information.

17 TERMINATION

- 17.1 In the event of termination of the s75 Agreement howsoever arising, this Secondment Agreement will automatically terminate. In such circumstances, the appropriate redeployment and / or redundancy of the Partner organisation will apply. There will be no presumption for Host organisation to redeploy staff other than those staff employed on the Hosts' terms and conditions.
- 17.2 The Employee may terminate the Secondment by giving not less than (one) month's notice in writing (or the Employee's contractual notice period if this is greater) simultaneously to the Host and the Partner organisation. Any notice of termination will, after the appropriate notice period, terminate employment with the Partner organisation.
- 17.3 Should, at any time, an employee secure alternative employment with the employing Partner organisation through that organisations recruitment and selection processes, the secondment will terminate. Subject to the policies and procedures of the employing Partner, continuous service will be maintained.

18 REVIEW AND VARIATION

- 18.1 Subject to clause 2 above, this secondment agreement will remain the subject of periodic review and amendment as necessary in light of changing service needs and legislative developments.
- 18.2 The parties agree that any amendments or variations to this Agreement must be in writing and signed by authorised representatives of the parties

19 GENERAL

- 19.1 If any provision or term of this Agreement shall become or be declared illegal invalid or unenforceable for any reason whatsoever, including without limitation, by reason of provisions of any legislation or by reason of any decision of any court or other body having jurisdiction over the parties, such terms or provisions shall be divisible from this Agreement and shall be deemed to be deleted in the jurisdiction in question provided always that if any such deletion substantially affects or alters the commercial basis of this Agreement, the parties shall negotiate in good faith to amend and modify the provisions or terms of this Agreement as may be necessary or desirable in the circumstances.
- 19.2 This Agreement does not create any partnership or agency relationship between the Partner organisation and the Host.

Appendix 2: JAD Section 75 Agreement

- 19.3 This Agreement shall supersede any previous letters of appointment, agreements or arrangements, whether written, oral or implied, relating to the Secondment of the Employee.
- 19.4 This Agreement shall be governed by and construed in accordance with English law. The Partner organisation and the Host agree that any dispute arising under this Agreement or in connection with it shall be decided in the English Courts, which shall have the sole jurisdiction in any such matter.

SCHEDULE 5
CONTINUING HEALTH CARE

1. Introduction:

1.1 The JAD is the Joint Assessment and Discharge Integrated Service. From 1 June 2014 the Partner Organisations and LBBB are providing the JAD to the Commissioning Partners. The decision maker as to the eligibility of Continuing Healthcare remains with the appropriate Commissioning Partner if and until the relevant Commissioning Partner (being the relevant Clinical Commissioning Group) who have accountability for decisions regarding Continuing Health Care, are satisfied that the systems and processes are in place to ensure robust decision making, and for quality assurance of these decisions.

1.2 If and until the Commissioning Partners are so satisfied the Partner Organisations and LBBB will simply recommend Continuing Healthcare eligibility to the Commissioning Partners in accordance with the prevailing and accepted process:

1.3 The Partners have agreed that existing dispute resolution procedures, which shall include but may not be limited to the CHC National Framework, will apply to the provision of the JAD.

1.4 This scheme of delegation shall apply to the Service Manager and the Discharge Managers within the JAD. It determines the level of financial decision-making and quality assurance permissible in the allocation of health resources to facilitate discharges from acute care.

1.5 The key principle is seek to move decision making closer to the front line and for all staff to be clear about the level of authority held and to deliver consistency and equity.

2. Implementation:

2.1 The Parties have agreed below a scheme of delegation which will apply to this Agreement if and when the relevant Clinical Commissioning Groups, who have accountability for decisions regarding Continuing Health Care, are satisfied that the systems and processes are in place to ensure robust decision making, and for quality assurance of these decisions. The Commissioning Partners may decide in their absolute discretion whether they are so satisfied.

3. The Scheme of delegation:

3.1 Verification of the Multidisciplinary Team Continuing Health Care Recommendation is transferred from the CCG Commissioning Partners to trained and competent Continuing Health Care assessors within the Joint Assessment and Discharge service Management Team.

a) Ratification of the Multidisciplinary Team's recommendation and financial approval for Continuing Health Care will be provided by the JAD Service Manager and a JAD Discharge Managers

b) Joint Assessment & Discharge Managers will make decisions for Continuing Health Care Nursing Home placements and packages of care for up to and including £700 per week. Where the cost is more than £700 per week, the case will be referred to the Clinical Commissioning Group for financial approval.

c) The Joint Assessment and Discharge service will also be responsible for assuring high quality Continuing Health Care applications are made. Quality Assurance of Continuing Health Care paperwork will be undertaken by a Discharge Manager and the Service Manager, before the final eligibility decision is made. To ensure objectivity, Quality Assurance will be undertaken

Appendix 2: JAD Section 75 Agreement

by a Discharge Manager from a different Ward Group to the one where the assessment is undertaken. The Service Manager will also carry out regular audits to make sure that high standards are maintained.

3.2 The Joint Assessment and Discharge Service Manager shall review all commitments entered into by the Service and shall ensure the provision of regular budgetary information and reporting to support the CCG to monitor its spend and commitment.

4. Review:

4.1 This Scheme of delegation shall be regularly reviewed by the ESG to ensure it continues to provide a framework for the operation of efficient and effective discharge arrangements for patients who require continuing health care.

SCHEDULE 6 EXIT STRATEGY

1. In the event of termination of this Agreement (or any part of it) the Partners agree to work together in good faith to ensure an orderly wind down of the Partnership Arrangements and minimum disruption to the commissioning and/or provision of the Services.

2. The Partners shall provide all reasonable co-operation and assistance and provide to the other Partners all information and documentation as might reasonably be requested.

3. The Partners shall agree a lead out plan within such reasonable timescale as agreed by the Partners on anticipation of the coming to the end of the Partnership Arrangements which will include project management of any consultation process and the transfer of the Services or any part of them as appropriate to achieve a controlled and timely transfer of Services with as little disruption to Service Users as possible.

SCHEDULE 7

COMPLAINTS PROCEDURES

NB This Schedule deals with complaints received from Service Users and third parties in relation to the delivery of the Service(s). Internal staffing disputes or complaints from within the Partnership relating to governance or performance are dealt with elsewhere in this agreement. At all times, all prevailing legislation and regulations shall take precedence and be adhered to wherever there is any inconsistency with these guiding key principles.

1. Complaints (key principles):

1.1 The JAD and each Partner will maintain or adopt, as the case may be, complaints procedures internal to their organisations which enable service users or patients to be heard in respect of any complaint concerning any element of the Services which are provided by or on behalf of a particular Partner organisation. Policies must adhere to local authority Social Services and National Health Service complaints (England) regulations 2009, the parliamentary health service ombudsman and the NHS constitution.

1.2 The JAD (or in the case of a receiving Partner Organisation) shall consider and determine the most appropriate complaints procedure to be followed in discussion with partners contributing to the JAD and shall be with the agreement of the complainant

1.3 For Social Care the local authority Social Services and National Health Service Complaints (England) Regulations came into force in April 2009. The regulations require that arrangements for dealing with complaints must ensure that:

1.3.1 complainants and their families or carers are listened to

1.3.2 complaints are dealt with efficiently

1.3.3 complaints are properly investigated and a range of interventions are able to assist resolution

1.3.4 complainants are treated with respect and courtesy and involved in the process.

1.3.5 complainants receive, so far as is reasonably practicable, assistance to enable them to understand the procedure in relation to complaints or advice on where they may obtain such assistance

1.3.6 complainants receive a timely and appropriate response

1.3.7 complainants are told the outcome of the investigation or their complaint and

1.3.8 action is taken if necessary in the light of the outcome of the complaint

1.4 Complaints by third parties in respect of the provision of Services to service users or patients will also be dealt with initially by the JAD or the relevant Partner within its own complaints procedures

1.5 The JAD and contributing partners shall have regard to such legislation or guidance as may from time to time be issued in respect of complaints, including the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and guidance issued in connection with those regulations

Appendix 2: JAD Section 75 Agreement

1.6 In the event that the JAD (or a partner organisation) receives an enquiry from an elected representative or a complaint relating to the Services which the JAD or the Partner considers falls within the remit of another Partner or pertains to the budget or resources committed to the Partnership by another Partner, it shall without delay notify that other Partner and the Partners concerned shall agree which of the Partners shall deal with the complaint or enquiry concerned.

2. Joint Complaints which involve one or more Partner Organisations

2.1 Complaints will be acknowledged by the JAD or the receiving organisation within three working days.

2.2 In the event of several organisations receiving the complaint at the same time, contact will be made with the other organisations and an agreement made as to which will be the 'lead organisation' via an initial risk assessment being undertaken to identify the seriousness of the concerns being raised. The lead organisation will acknowledge within three working days on behalf of all organisations involved and will clarify the complaint and explain the role of the other organisations.

2.3 In the event that the complaint is sent to only one organisation (who will be known as the receiving organisation) but involves other organisations, that receiving organisation will seek consent from the complainant and copy the complaint to the other organisations involved. Consent must be obtained so that records can be accessed by the teams involved.

2.4 On receipt of consent, a copy of the complaint letter will immediately be sent to the other organisations involved in the complaint and a discussion undertaken to agree which organisation should be the lead.

2.5 Where a complaint is shared across organisations, the lead organisation will confirm to the complainant a named person, address and telephone number to identify where each part of the complaint is being investigated

2.6 Each Partner Organisation will investigate in accordance with its own procedure, keeping the lead organisation informed of progress. Ideally, all responses should be completed simultaneously and reports delivered to the complainant together. There may be occasions when this time frame cannot be achieved and on these occasions the timeframe discussion will be noted by all parties with a decision taken and duly agreed with the complainant.

2.6 The lead organisation will obtain responses from all the organisations involved and coordinate them into a final response to the complainant, unless the complainant indicates otherwise. The coordinated response must identify which issues relate to which organisation and the advice/step up details of the next stage for each process should be included if the complainant/s want to pursue.

2.7 It is the responsibility of each Partner Organisation to identify any conflict in input with the other organisations involved and to ensure this is discussed and resolved between the Organisations concerned, or with the relevant Directors if necessary.

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2.8 The lead organisation will not have editorial licence to alter the content of the responses from those responding without their explicit and 'confirmed' agreement. The final response from the lead organisation to the complainant **MUST** be approved, within an agreed timescale, by respondent organisations before being dispatched.

2.9 If a comprehensive response is not possible, due to delayed information from one or more organisations, the lead organisation will complete a response with the available information, indicating that the outstanding response(s) will follow separately and directly from those organisations. Those subsequent responses will be copied to all other organisations involved. The complainant will be made aware of this and given the opportunity to decide on either accepting the response in two parts or waiting for the joint response.

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SCHEDULE 8 ELIGIBILITY CRITERIA

Eligibility for individuals to benefit from the delivery of the JAD will include the following criteria:

1.1 To benefit from services commissioned by the Local Authority, the Service User will:

- 1.1.1 be aged 18 years or over
- 1.1.2 be a resident of the London Borough of Barking and Dagenham or Havering
- 1.1.3 be a resident outside the London Borough of Barking and Dagenham as a result of a placement made by the Clinical Commissioning Group and/or the Council to meet their statutory obligations
- 1.1.4 be registered with a Barking & Dagenham or Havering GP
- 1.1.5 be the subject of the authority's statutory support and care responsibilities as defined by the London Borough of Barking and Dagenham's Fair Access to Care (FACS) Eligibility Criteria (taking into account the pending eligibility criteria in the Care Bill when it is enacted)
- 1.1.6 be a Carer of somebody eligible under the above conditions

1.2 To benefit from services commissioned by health, the service user will:

- 1.2.1 be over 18 years or over
- 1.2.2 be resident in the UK
- 1.2.3 eligible for Continuing Health Care as assessed by the CCG or their representatives
(Unless it is determined that the individual is ineligible for receiving on-going healthcare)

2. Exclusions

2.1 The JAD will not undertake the following:-

- 2.1.1 Rehabilitation assessments/care planning. Any community intermediate care assessments for patients who require admission to a community bed provided by NELFT. These assessments will be completed by NELFT
- 2.1.2 Any Specialist neuro Rehabilitation assessments/care planning as these shall be undertaken by the receiving provider.
- 2.1.3 Fast Track Continuing Health Care Assessments/care planning

Within the resources at its disposal, the JAD Service team should ensure that Service Users and their Carers are not disadvantaged on the grounds of age, disability, gender, language (including sign language), race, ethnic origin, sexual orientation, social class, political beliefs or religion.

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ASSESSMENT ARRANGEMENTS

JAD Workers will work collaboratively with Ward Multi-disciplinary staff to complete assessments and discharge plans for the following pathways:

- Continuing Health Care – Full and Funded Nursing Care (not Fast Track)
- Packages of Care
- Residential Care

JAD will also broker a pathway for those who are medically fit but not able to be discharged.

JAD will undertake Safeguarding Investigations

The JAD Operational Procedures set out the detailed processes and timescales for each pathway. JAD, ward staff and therapies staff will use Care Applications (CAPS) to log and track the patient's progress along a pathway.

SCHEDULE 9
ACCOMMODATION and SERVICES

1. Pursuant to Section 75 (2)(d) of the 2006 Act and Regulation 10(1) of the Regulations the Partners will from the Commencement Date provide in connection with the JAD such accommodation, goods, and services as are agreed and required for the proper and efficient delivery of the JAD.

2. The Partners will cooperate over the Term of the Agreement to utilise the accommodation, goods, and services in an integrated manner and periodically to review the needs of the JAD additional or substituted accommodation, goods or services available by agreement in the light of such periodic review.

3. The Partners shall make available for the purposes of the Partnership and for the purposes of the Services at any time after the Commencement Date the following support services which will include inter alia but not exclusively the following functions

- Finance
- Human resources
- Contracts and procurement
- Performance and management functions
- Business support (including Public Relations and Communications)
- IT
- Legal services

provided that the functions may change from time to time, and service level agreements will be drawn up between the Partners and amended as appropriate in accordance with Schedule 8 and further provided that the cost to each Partner of the provision of such support services shall not count as any part of that Partner's contributions.

SCHEDULE 10
PERFORMANCE MONITORING

1. The Partners will, through the Executive Steering Group and with close regard to the Performance Metrics and the local priorities for Health and Social Care, develop a performance management framework for the partnership arrangements with relevant indicators for measuring effectiveness. In so doing, the Partners will have regard to the 1999 Act Circular.

2. The performance measures will demonstrate:

- How far the aims of the Partnership Agreement are being achieved;
- The extent to which outputs including timescales and milestones are being met, as defined in clauses.
- The extent to which agreed outcomes are being fulfilled and targets met, as defined in clauses Budget monitoring for all staffing and Partnership budgets.
- **The targets used to measure quality will primarily relate to those contained in the**
key NHS and L.A. performance indicators.

In relation to any targets set, the Partners agree that it shall be the responsibility of the JAD Service Manager to manage the delivery of such targets, in particular:

- the JAD Service Manager will take the lead in ensuring action plans are prepared in response to Delivery and Improvement Plans, NHS and L.A. Indicators and targets
- to put in place and monitor a clearly identifiable performance monitoring process

The JAD Service Manager shall provide all partners with information / data and reports on a monthly basis to enable compliance with its statutory management requirements

All Partners will ensure that any changes to the data required in light of new guidance / legislation by Central Government are communicated and changes made in accordance with the new requirements.

3. The JAD Service Manager shall initiate and maintain all JAD policies and procedures necessary for the safe and efficient delivery of the JAD. These will include but may not be limited to Risk Management (e.g. service user issues such as safeguarding and inappropriate discharges) and Incident Reporting procedures (e.g. staff injury). All such reports to be recorded centrally as part of the JAD system in addition to being reported to the relevant Partner Organisation.

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HEALTH AND WELLBEING BOARD**10 FEBRUARY 2014**

Title:	Sub-Group Reports	
Report of the Chair of the Health and Wellbeing Board		
Open Report	For Information	
Wards Affected: NONE	Key Decision: NO	
Report Authors: Louise Hider, Health and Social Care Integration Manager, LBBD	Contact Details: Telephone: 020 8227 2861 E-mail: Louise.Hider@lbbd.gov.uk	
Sponsor: Councillor Maureen Worby, Chair of the Health and Wellbeing Board		
Summary: At each meeting of the Health and Wellbeing Board each sub-group, excluding the Executive Planning Group, report on their progress and performance since the last meeting of the Board.		
Recommendations: The Health and Wellbeing Board is asked to: <ul style="list-style-type: none"> • Note the contents of sub-group reports set out in the Appendices 1 - 5 and comment on the items that have been escalated to the Board by the sub-groups. 		

Public Background Papers Used in the Preparation of the Report:

None

List of Appendices

- Appendix 1: Integrated Care Sub-group
- Appendix 2: Mental Health Sub-group
- Appendix 3: Learning Disability Partnership Board
- Appendix 4: Children and Maternity Sub-group
- Appendix 5: Public Health Programmes Board

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Integrated Care Group

Chair:

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

Items to be escalated to the Health & Wellbeing Board	
<ul style="list-style-type: none"> ▪ The Health and Wellbeing Board is asked to note progress of the integrated care sub group 	
Meeting Attendance	
24 November 2014:	47% (9 of 19)
22 December 2014:	32% (6 of 19)
Performance	
<p>Please note that no performance targets have been agreed as yet; going forward the group will review progress against Barking and Dagenham targets delivered through achievement of milestones in Better Care Fund (BCF) schemes. Further national Better Care Fund guidance has now been issued which will inform development of the BCF outcomes.</p>	
Action(s) since last report to the Health and Wellbeing Board	
<ul style="list-style-type: none"> • The previous two meetings of the Integrated Care Group (November & December 2014) have been dedicated to review the development of the Programme update report. • A workshop was organised on 11 December 2014 to look at the next phase for community health and social care which took views of broader outcomes for BCF developments for the next year. Actions from the workshop are in working progress. • The group received update on the development of the Joint Executive Management Committee • The group discussed the project plan for Prevention and falls. Work is being done to link Mental Health to the prevention work. • The group discussed developing a B&D specific strategy for falls pathway. • The group noted the revised Carers strategy will be presented back at the March HWBB meeting. • The group supported the proposal for the Mental Health outside hospital scheme and this was presented at the Mental Health Subgroup of the HWBB. • The group was presented with the Engagement Plan updates. • The group received update on the Joint assessment and discharge service, further development is being made on the discharge model. • The group was advised of the outcome on the Intermediate Care Consultation since the three Governing Bodies met on 11 December 2014. • The group reviewed and commented on the admissions data dashboard and risk update reports. 	
Action and Priorities for the coming period	
<ul style="list-style-type: none"> • Further develop the risk register • Link mental health and community teams to the community health and social care work. • Coordinate work under the prevention and falls project and identify work linking to other projects in the system. • Ongoing liaisons with council officers in discussing the estates issue post Intermediate Care Consultation decision. • Further develop the discharge model as part of the work on Joint assessment and discharge service 	

Contact: Jackeya Quayam, Project Officer, Strategic Delivery, BHR CCGs
 Tel: 0208 822 3079; Email: Jackeya.Quayam@onel.nhs.uk

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Mental Health sub-group

Chair: Gillian Mills, Integrated Care Director (Barking and Dagenham), NELFT

<p>Items to be escalated to the Health & Wellbeing Board</p> <p>(a) None to note.</p>
<p>Performance</p> <p>Please note that no performance targets have been agreed as yet.</p>
<p>Meeting Attendance</p> <p>3 December 2014: 62.5% (10 of 16)</p>
<p>Action(s) since last report to the Health and Wellbeing Board</p> <p>(a) Mental Health Needs Assessment (MHNA) - final report feedback presented by Delta Consulting. Quality assurance of data still to be completed before report ready for circulation. Findings from the Mental Health Needs Assessment were used to inform the Mental Health Sub Group development day on 19 January 2015 focusing on future service commissioning and provision priorities. This session encompassed the central and local policy and scrutiny priorities identified within 'Closing the Gap', the Mental Health Crisis Concordat and the HASCC Welfare Reforms and Austerity Impact review.</p> <p>(b) Presentation from Big White Wall regarding the use of digital early intervention service within Barking and Dagenham.</p> <p>(c) Update received regarding the roll out of Mental Health First Aid that has taken place over last 2 years. 1000 front line staff have received the training to date. Third year of training being developed with aim to consolidate this from 2 days to 1 day.</p> <p>(d) Verbal update received following recent London launch of the Mental Health Crisis Concordat response. B&D CCG to sign declaration by 15th December and action plan to be developed by March 2015.</p>
<p>Action and Priorities for the coming period</p> <p>1. Using the outcomes of the development session on 19 January 2015, the sub group will focus on developing a single overarching, 'synthesised' action plan to incorporate the actions within the MHNA, 'Closing the Gap', the Mental Health Crisis Concordat and the HASCC Welfare Reforms and Austerity Impact review action plans.</p>

Contact:

Julie Allen, PA to Integrated Care Director (NELFT)

Tel: 0300 555 1201 ext 65067; **E-mail:** Julie.allen@nelft.nhs.uk

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Learning Disability Partnership Board

Chair: Glynis Rogers, Divisional Director Commissioning and Partnerships, London Borough of Barking and Dagenham

Items to be escalated to the Health & Wellbeing Board None.
Meeting Attendance 16 December 2015: 50% (9 out of 19 attendees) a number of apologies were received due to illness and clashing commitments as well as annual leave. Decision to not hold future meetings so close to festive break.
Action(s) since last report to the Board <ul style="list-style-type: none">(a) Received an informative presentation regarding the implications of the Care Act for people with a learning disability relating to the provision of Information and Advice.(b) Received an update on the Carers Strategy(c) Received an update on the Independent Living Strategy plan and a request for involvement in this from LDPB members(d) Received the final version of the Autism Strategy and discussed the mechanisms for monitoring the plan(e) Received an update on the supported living tender(f) Feedback from the subgroups
Action and Priorities for the coming period <ul style="list-style-type: none">(a) At future meetings the LDPB will discuss the Care Act, Winterbourne view update, transitions, the Learning Disability Self Assessment Framework (SAF) and the Autism SAF which will now be incorporated into an Independent Living Strategy for the Council.

Contact: Karen West-Whyllie, Group Manager – Learning Disabilities

Tel: 020 8724 2791 **Email:** karen.west-whyllie@lbdd.gov.uk

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Children and Maternity Sub-Group

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

<p>Items to be escalated to the Health & Wellbeing Board</p> <p>None</p>
<p>Meeting Attendance</p> <p>13 January 2015: 66% (10 out of 15)</p>
<p>Performance</p> <p>Prevalence of children in reception year that are obese or overweight – above England average and increased on 12/13</p> <p>Prevalence of children in year 6 that are obese or overweight - above England average and increased on 12/13</p>
<p>Action(s) since last report to the Board</p> <p>The CMG at its meeting on 13 January:</p> <ul style="list-style-type: none"> • Discussed the ongoing review of the borough’s Health and Wellbeing Strategy • Received a report from the Director of Public Health on Childhood Obesity and discussed the summit on obesity planned for April/May 2015. • Received the breastfeeding action plan, presented by the Director of Public Health • Received the Healthwatch work plan
<p>Action and Priorities for the coming period</p> <ul style="list-style-type: none"> • Maternity dashboard to be reviewed at next meeting • CAMHS formal process to be reviewed for next meeting • Teenage pregnancy scoping paper to be reviewed at future meeting • LAC and early years development to be reviewed at next meeting • CMG work plan summaries priorities.

Contact: Mabel Sanni, Executive Assistant, Barking and Dagenham CCG
 Tel: 0203 644 2371 mabel.sanni@barkingdagenhamccg.nhs.uk

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Public Health Programmes Board

Chair: Matthew Cole Director of Public Health

<p>Items to be escalated to the Health & Wellbeing Board</p> <p>None</p>
<p>Performance</p> <p>Whilst the Public Health Programmes Board has not met in this period, Council Officers had an internal meeting on 9th December to discuss the performance of the non NHS Public Health Contracts. Recommendations were made to the Portfolio holder for commissioning and de-commissioning as part of the budget preparation process for 2015/16.</p> <p>A full paper on the discussions will be presented to the next Public Health Programmes Board meeting on 11th March 2015 to allow the Public Health Programmes Board to consider the way forward.</p> <p>The Obesity Task and Finish Group met in December 2014</p> <p>Health Protection Committee met in November 2014.</p> <p>Integrated Sexual Health and Reproductive Board met in January 2015.</p>
<p>Meeting Attendance</p> <p>Attendance at the Health Protection Committee, Obesity Task and Finish Group and Public Health Programmes Board was good . Integrated Sexual Health & Reproductive Board was good.</p>
<p>Action(s) since last report to the Health and Wellbeing Board</p> <ul style="list-style-type: none"> • Full paper on Public Health Programmes in March to the Public Health Programmes Board • Health and Wellbeing Commissioning Intentions paper to the Health & Wellbeing Board in March • Performance framework for Board is now finalised. Up to data being provided against each indicator to allow target setting to take place at the next Board meeting. • Concerns raised around the cessation of THT's contract to oversee the Pan-London C-Card Scheme locally in April. Plans for after this have not been discussed with the Board. • Implications of Local Authority Sexual Health Epidemiology Report for the borough (published by PHE) discussed, with suggestions for improvement fed back to PHE. • Commissioning Intentions paper from NHS England for screening and immunisation to be presented to the February Health and Wellbeing Board. • Paper on progress of the transition for the 0-5 healthy child commissioning and FNP to be presented to the Children's Trust in March 2015.
<p>Action and Priorities for the coming period</p> <p>(a) Agree the spend on the Public Health Grant 2015/16</p> <p>(b) Transition of the 0-5 Healthy Child commissioning</p>

Contact: Pauline Corsan

Tel: 0208 227 3953 **Email:** pauline.corsan@lbbd.gov.uk

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HEALTH AND WELLBEING BOARD

10 FEBRUARY 2014

Title:	Systems Resilience Group Update		
Report of the Systems Resilience Group			
Open Report		For Information	
Wards Affected: ALL		Key Decision: NO	
Report Author: Louise Hider, Health and Social Care Integration Manager, LBBD		Contact Details: Tel: 020 8227 2861 E-mail: louise.hider@lbbd.gov.uk	
Sponsor: Conor Burke, Accountable Officer, Barking and Dagenham Clinical Commissioning Group			
Summary: This purpose of this report is to update the Health and Wellbeing Board on the work of the Systems Resilience Group. This report provides updates on the Systems Resilience Group meetings held on the 19 December 2014 (Appendix 1). Operational Resilience planning and delivery, primarily through the Joint Assessment and Discharge Service and community services have been key in supporting system capacity over the key winter months where pressure upon the hospital, presentation and admission rates are at their peak. Monies drawn down from NHS England via the CCG have supported additional activity which has included increased provision of Crisis Response, interim bed based placements and take home and settle services provided with a voluntary sector partner, alongside increasing 7 day working enhancing capacity at points of key pressure and at the front end of the hospital. Social care have seen a doubling of activity in key areas such as those of crisis response which rose from 280 packages in August to 580 in December, such increased activity would ordinarily have been unsustainable without additional funding being in place.			
Recommendation(s) The Health and Wellbeing Board is recommended to: <ul style="list-style-type: none"> • Consider the updates and their impact on Barking and Dagenham and provide comments or feedback to Conor Burke, Accountable Officer to be passed on to the Systems Resilience Group. 			
Reason(s): There was an identified need to bring together senior leaders in health and social care to drive improvement in urgent care at a pace across the system.			

1 Mandatory Implications

1.1 Joint Strategic Needs Assessment

The priorities of the group is consistent with the Joint Strategic Needs Assessment.

1.2 Health and Wellbeing Strategy

The priorities of the group is consistent with the Health and Wellbeing Strategy.

1.3 Integration

The priorities of the group is consistent with the integration agenda.

1.4 Financial Implications

The Systems Resilience Group will make recommendations for the use of the A&E threshold and winter pressures monies.

1.5 Legal Implications

There are no legal implications arising directly from the Systems Resilience Group.

1.6 Risk Management

Urgent and emergency care risks are already reported in the risk register and group assurance framework.

2 Non-mandatory Implications

2.1 Customer Impact

There are no equalities implications arising from this report.

2.2 Contractual Issues

The Terms of Reference have been written to ensure that the work of the group does not impact on the integrity of the formal contracted arrangements in place for urgent care services.

2.3 Staffing issues

Any staffing implications arising will be taken back through the statutory organisations own processes for decision.

Public Background Papers Used in the Preparation of the Report:

None

List of Appendices

Appendix 1: System Resilience Group Briefings, 19 December 2014

System Resilience Group (SRG) Briefing	Meeting dated – 19 December 2014
	Venue – Conference room, Barking Learning Centre
Summary of paper	This paper provides a summary of the key issues discussed at the System Resilience Group meeting. The meeting was chaired by Conor Burke (Chief Accountable Officer, BHR CCGs) and attended by members as per the Terms of Reference.

Agenda	Key issues raised
UCB dashboard	Members were updated on the key areas from the dashboard report.
Trust improvement plan	Members received an update on the Trust Improvement Plan.
Programme Board	Members were briefed on the establishment of the Programme Board.
S1 schemes	Leads provided an update on the progress of their schemes.
S2 schemes	Members received a brief update on the progress of the S2 schemes.
Flu planning update	Members were updated on the progress of flu planning.
HR update	Members received a report from the Trust's HR lead on workforce.
Proactive Surge Escalation Framework	Members were briefed on the surge escalation framework and cover arrangements over the Christmas period.
RTT Improvement Plan:	Members received a brief update on the RTT Improvement Plan.
Cancer Improvement Plan:	Members received a brief update on the Cancer Improvement Plan.
AOB	None.
Next meeting	Monday 19 th January 2015 2pm – 4pm, Board room A, Becketts House, Ilford.

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HEALTH AND WELLBEING BOARD

10 FEBRUARY 2014

Title:	Chair's Report	
Report of the Chair of the Health and Wellbeing Board		
Open Report	For Information	
Wards Affected: ALL	Key Decision: NO	
Report Author: Louise Hider, Health and Social Care Integration Manager	Contact Details: Tel: 020 8227 2861 Email: louise.hider@lbbd.gov.uk	
Sponsor: Councillor Maureen Worby, Chair of the Health and Wellbeing Board		
Summary: Please see the Chair's Report attached at Appendix 1.		
Recommendation(s) The Health and Wellbeing Board is recommended to:		
a) Note the contents of the Chair's Report and comment on any item covered should they wish to do so.		
b)		

Appendices:

Appendix 1: February 2015 Chair's Report

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In this edition of my Chair's Report I talk about making a pledge as part of our 'Make a Change' campaign and the Borough's 50th anniversary celebrations. There is also information on the stakeholder event hosted by Healthwatch which saw consultation on the Health and Wellbeing Board Strategy refresh and service planning. I would welcome Board Members to comment on any item covered should they wish to do so.

Best wishes,

Cllr Maureen Worby, Chair of the Health and Wellbeing Board

Make a Change

We're looking for Barking and Dagenham's movers and shakers in health and adult social care to be at the forefront of practicing what we preach: making changes for a healthier lifestyle.

"Do what I do, not what I say!"

We're running a 'people like me' inspirational campaign, created with and for people from all walks of life. So far, we have just a few pledges from Councillors and residents, and we need to inspire more people to get in touch. We need Councillors, chief executives, directors, doctors, dentists, physios, nurses, and... you know who you are! What are you doing, or planning to do, that sets a good example?! Every story, tweet, poster and flyer will be signposting people to our borough's health and wellbeing services and resources.

Spread the word...

We need you to tell us what you do to keep healthy, and/or what you plan to do to improve your health and wellbeing. We also need you to nominate colleagues and service users. No problem if participants want anonymity, but even better if they'd like to be on posters and in the press! Please contact Ellen Doran at ellen.doran@lbbd.gov.uk to make **YOUR** pledges and nominations.

50th Anniversary celebrations

We're also finalising the borough's 50th anniversary programme, celebrating Barking and Dagenham's existence as a single London borough; a series of events highlighting our heritage, our successes, and our future plans. Your #makeachange pledges will form part of those celebrations.

We're asking everyone to make a mark now with a personal celebration of health and wellbeing; enjoying our positive points, and asking the question 'Is there anything I'd like to change for the better?'. We'd like **YOU** to help lead the way.

News from NHS England

Increase in patients accessing medical records online

As of September 2014, 21 per cent of patients in England have been able to access their medical records online, a significant increase on 2 per cent this time last year. The number of patients able to book appointments and request repeat prescriptions has jumped to 91 per cent and 88 per cent respectively. The Patient Online programme team has been working with practices across England to ensure they have the support needed to offer these online services.

Cancer Drug Fund

The NHS [Cancer Drugs Fund \(CDF\)](#) have published the outcome of its review of cancer drugs. The budget will grow from £200 million in 2013/14, to £280 million in 2014/15, and an estimated £340 million from April 2015. This represents a total increase of 70 per cent since August 2014. This will also create projected savings of approximately £80 million through a combination of negotiated price reductions and improved clinical effectiveness. As part of the review 59 of the 84 most effective currently approved indications (clinical 'uses') of drugs will rollover into the CDF next year, and new drug indications will be funded for the first time. These include a treatment for bowel cancer, a treatment for Mantle cell lymphoma (a type of non-Hodgkin lymphoma) and Ibrutinib for use in chronic lymphocytic leukaemia (CLL).

'Have your say on health and services': a public event for residents and all stakeholders

A public event was held in January at the Ripple Centre in Barking to get residents' input in to our Health and Wellbeing Strategy, commissioning intentions and service planning. The event was hosted by Healthwatch in partnership with Barking and Dagenham CCG. We had a packed house for the event and got some great feedback. We were able to chat with residents and all stakeholders, as well as get their written thoughts and ideas, and quite a few (highly popular) video interviews.

Presenters included Matthew Cole - Director of Public Health, Marie Kearns - CEO of Harmony House and the Healthwatch contract Manager, Dr Jagan John - one of the CCG Clinical Directors, and Sharon Morrow - Chief Operating Officer of the CCG. All of the presenters chatted with residents to get their direct feedback. There were some positive comments, and also quite a few comments and questions that we'll need to respond to in our future planning and incorporate into our refreshed Health and Wellbeing Strategy.

Feedback and questions included:

- Why has the CCG decommissioned alternative therapies?
- General Practice needs to change its hours to be more accessible.
- We don't always need to see a GP - often a practice nurse.
- Why doesn't Barking and Dagenham, Havering and Redbridge have a single commissioning team for consistency?
- The value of volunteers must always be recognised - health champions, etc.
- Maybe GPs and other professionals aren't social prescribing enough?
- Concern about walk in appointments and long waits for physical therapy (August to May).
- The Alzheimer Society would like to support trainees/offer training to GPs.
- Could volunteers within practices to help signpost people?
- Aids and equipment are not being reused as no system to return them.
- Translation services are not readily accessible.
- Positive feedback for the community treatment team.
- Is health and social care integration really working on the ground? JAT working well - how can we build on successes?
- Changing hearts and minds of local population - how do we support people to take more responsibility for their own health?
- Personal health budgets - we need to go back and look at the choice available.
- Good feedback from one resident who can see their GP on Saturdays.
- Accessing a psychologist in secondary care means a year's wait.
- Good communication at all stages is key to people's experience of care.
- Healthwatch - need to make sure that we close the feedback route.
- Need greater efficiency with the supply of equipment such as wheelchairs & commodes.
- Professionals need training to better understand autism and learning disabilities - the Sycamore Trust can provide it.
- Learning Disability passports - are not recognised or used by services effectively.
- Diagnosing cancer late, but can people see their GP when they need to?
- Mental health - children and young people; there's much focus on physical health, but stigma needs to be tackled a lot earlier.

New Medical Director

Dr Nadeem Moghal has been appointed as the new executive Medical Director at Barking, Havering and Redbridge University Hospitals NHS Trust. With a strong track record in leading quality improvements, the Trust has welcomed Nadeem to the team. Chief Executive Matthew Hopkins said: "I am delighted that Nadeem is joining us. He is committed to working across the local health economy to provide high quality, compassionate care for the patients and families that rely on us." Nadeem is currently the Director of Strategy and Knowledge Management, and Associate Medical Director, at George Eliot Hospital in the West Midlands. He built a team that transformed and delivered a unique, high quality service model for children and families. He also led one of the transformation teams that collectively brought the organisation out of special measures. He said: "I am looking forward to working with the staff at BHRUT who drew me to the organisation through their passion for the patient, responsibility to improve services, fearless want to innovate and drive to be the best, becoming empowered to face the challenges ahead."

Better Care Fund

Following the Nationally Consistent Assurance Review (NCAR) process NHS England has now formally approved the Better Care Fund plan following the publication of the 2015/16 Mandate. NHS England has said that our plan is clear and ambitious and they fully support it. They agree that it puts us in a strong position for delivering the change required to transform local services and improve the lives of people in your community. The full value of the element of the Fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. CCGs may only release the full value of this funding into the pool if the admissions reduction target is met. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. A review of this target for the 2015/16 contracting round will need to include appropriate involvement from local authorities and be approved by the H&WBB. NHS England will assess the extent to which any proposed change has been locally agreed in line with BCF requirements, as well as the risk to delivery of the ambition, as part of its assurance of CCGs' operational plans.

0 – 5 Transfer of Health Visitors

The 0-5 children's health services (health visitors and family nurse partnership) transfers to Local Authorities in October 2015. This is on a 'lift and shift' basis for 2015-16 with additional funding to ensure that Local Authorities do not take on additional financial burdens. The proposed allocation for Barking and Dagenham for the 6 month period from October 2015 to March 2016 is £2.41m. This is made up of £2.395m on a 'lift and shift' basis and £15k for commissioning support. A funding floor has been provided on the amount of resource transferred such that no local authority is funded below an adjusted spend per head (0-5 year olds) of £160, based on full year allocations. In addition, it is proposed that local authorities are given £15k for 2015-16 (£30k on a full year basis) equivalent to the 0.5 full time equivalent of commissioning resource. The Council has challenged the Department of Health's Baseline Agreement Exercise in respect of a circa 300k funding gap in overhead funding in respect of the expansion of future parts of the service. This includes the wider costs of implementing Call to Action growth. In short, NHSE provides Call to Action funding for Health Visitors only and has made no expansion funding available for other posts surrounding the new Health Visitors.

The Council has responded in writing to the Department of Health on 16 January 2015, that it does not accept the baseline allocations as adequate to meet the financial demands of the of the 0-5 children's public health service. In our opinion the funding at the proposed levels will not be adequate to commission the service at the level required without putting additional pressures on the Council's Public Health Grant. Other concerns included:

- Clarity is needed on what the arrangements for staff will be with regard to supervision and management. There is no funding to support this so current terms and conditions will not be able to be sustained.
- We also understand that it is likely that boroughs will be expected to demonstrate more rigorous performance management of the contracts, and yet there is no commissioner's management fee factored in.
- In addition not all boroughs have had their MASH staff taken from their health visitor allocations; we would like further information before we agree to this.

The Department of Health will confirm the allocation in the coming weeks.

Ebola – The National Situation

On 29 December the UK reported its [first confirmed case](#) of Ebola when a healthcare worker returning from Sierra Leone was diagnosed in Glasgow. The HCW is currently receiving treatment at the Royal Free Hospital in London where her condition is described as critical. Public Health England has completed the [contact tracing](#) of passengers who were on the same flight as the confirmed case from Casablanca to London Heathrow. Although the risk of infection to other passengers on the flight was considered extremely low, all 117 UK based passengers on the flight have been contacted and advised directly by Public Health England. Health Protection Scotland carried out a similar exercise for the 71 passengers on the Heathrow to Glasgow flight, and has also contacted all passengers. Health Secretary, Jeremy Hunt, made a [statement](#) in the House of Commons on Monday 5 January, on Ebola preparedness in the UK. Enhanced screening for travellers who have recently returned from Liberia, Sierra Leone and Guinea continues at Heathrow, Gatwick, Birmingham and Manchester airports and at St Pancras (Eurostar) railway station. Public Health England is continuously reviewing the airport screening programme and has made a number of improvements to practice since it was first introduced. It is important to note that the assessment of the UK public health risk from Ebola has not changed – it continues to be very low.

Adult Social Care Survey for 2014/2015

All Councils with Adult Social Services Responsibilities (CASSRs) are required to conduct a postal survey of their service users and the results are sent to the Health and Social Care Information Centre (HSCIC) by mid May 2015. This survey is repeated annually and provides the basis of analyses that are included in national level Official Statistics reports.

The survey, will inform the Department of Health and the Health and Social Care Information Centre, at a national level how well services are meeting service user needs. At a local level, the results will be used to inform policy and decision-making and to improve care, services and outcomes for local residents.

Currently, there are 3361 clients with services recorded on the social care database. Based on the methodology prescribed to us, questionnaires will be sent to a total of 658 clients. We require 298 completed questionnaires to be returned in order to meet the minimum margin of error as set by HSCIC. The survey will be sent out week commencing 26 January and reminders will be sent out 4 weeks later to those who have not responded.

We have sent out communications with a copy of the questionnaire to internal staff, external stakeholders and partners, Councillors and MPs should any resident approach them regarding the survey. We also have a dedicated number that those receiving the survey can call if they need help or advice (0208 227 5464). Alternatively contact Teresa Coe, 0208 227 2155 teresa.coe@lbbd.gov.uk for further information.

Dates for your Diary

Health and Wellbeing Board Meeting Dates:

17 March 2015, 6pm, Barking Learning Centre

Learning Disabilities Valentines Ball:

14 February, 7.30 to midnight, Relish Café in Barking, Town Square, IG11 7NB. Tickets are £10 and can be purchased by calling 0208 275 5660.

Health and Wellbeing Board Development Afternoon:

Thursday 17 April 2015, 2 – 6pm.

HEALTH AND WELLBEING BOARD

10 February 2015

Title: Timing of Future Meetings															
Report of the Monitoring Officer															
Report Author: Tina Robinson Democratic Services Officer, Legal and Democratic Services	Contact Details: Tel: 020 8227 3285 E-mail: tina.robinson@lbbd.gov.uk														
Accountable Divisional Director: Fiona Taylor, Head of Legal and Democratic Services and Monitoring Officer															
Accountable Director: Chief Executive															
Summary															
<p>A report will shortly be presented to the Assembly on proposed changes to the Constitution in respect of the default start time and cut-off time of Council committee meetings. The proposals are:</p> <ol style="list-style-type: none"> 1) The default start time for evening meetings shall be 7.00pm, unless alternative arrangements are agreed by the majority of the Members of the Committee; and 2) All meetings should be concluded after 2 hours (currently 2½ hours), subject to the usual provisions to extend meetings for a reasonable period. <p>This Committee currently has a start time of 6.00pm and Board Members are asked to decide whether to keep to this time or move to the recommended time of 7.00pm.</p> <p>To assist the Board, the schedule of dates for future meetings of the Health and Wellbeing Board is below.</p> <table border="1"> <thead> <tr> <th>2015</th> <th>2016</th> </tr> </thead> <tbody> <tr> <td>Tuesday, 17 March</td> <td></td> </tr> <tr> <td>Tuesday, 12 May</td> <td>Tuesday, 26 January</td> </tr> <tr> <td>Tuesday, 7 July</td> <td>Tuesday, 8 March</td> </tr> <tr> <td>Tuesday, 8 September</td> <td>Tuesday, 26 April</td> </tr> <tr> <td>Tuesday, 20 October</td> <td>Tuesday, 14 June</td> </tr> <tr> <td>Tuesday, 8 December</td> <td></td> </tr> </tbody> </table>		2015	2016	Tuesday, 17 March		Tuesday, 12 May	Tuesday, 26 January	Tuesday, 7 July	Tuesday, 8 March	Tuesday, 8 September	Tuesday, 26 April	Tuesday, 20 October	Tuesday, 14 June	Tuesday, 8 December	
2015	2016														
Tuesday, 17 March															
Tuesday, 12 May	Tuesday, 26 January														
Tuesday, 7 July	Tuesday, 8 March														
Tuesday, 8 September	Tuesday, 26 April														
Tuesday, 20 October	Tuesday, 14 June														
Tuesday, 8 December															
Recommendation(s)															
The Committee is asked to agree the start time of future meetings.															
Reason(s)															
To accord with the Council's Constitution.															

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

List of appendices: None

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HEALTH AND WELLBEING BOARD

10 FEBRUARY 2015

Title:	Forward Plan		
Report of the Chief Executive			
Open		For Comment	
Wards Affected: NONE		Key Decision: NO	
Report Authors: Tina Robinson, Democratic Services		Contact Details: Telephone: 020 8227 3285 E-mail: tina.robinson@lbbd.gov.uk	
Sponsor: Cllr Worby, Chair of the Health and Wellbeing Board			
Summary: Attached at Appendix A is the Draft March 2015 issues of the Forward Plan for the Health and Wellbeing Board. The Forward Plan lists all known business items for meetings scheduled for the 2015/16 municipal year and is an important document for not only planning the business of the Board, but also ensuring that we publish the key decisions to be taken at least 28 days notice of the meeting. This enables local people and partners to know what discussions and decisions will be taken at future Health and Wellbeing Board meetings.			
Recommendation(s) The Health and Wellbeing Board is asked to: a) Note the draft forward plan and to advice Democratic Services of any issues of decisions that may be required so they can be listed publicly in the Board's Forward Plan, with at least 28 days notice of the meeting; b) To consider whether the proposed report leads are appropriate; c) To consider whether the Board requires some items (and if so which) to be considered in the first instance by a Sub-Group of the Board. d) To note that the next issue of the Forward Plan will be published on 16 February 2015. Any changes or additions to the next issue should be provided before 6.00p.m, on 11 February.			

Public Background Papers Used in the Preparation of the Report:

None

List of Appendices

Appendix A – Draft Forward Plan

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HEALTH and WELLBEING BOARD FORWARD PLAN

Draft March 2015 Edition

Publication Date: 16 February 2015

THE FORWARD PLAN

Explanatory note:

Key decisions in respect of health-related matters are made by the Health and Wellbeing Board. Key decisions in respect of other Council activities are made by the Council's Cabinet (the main executive decision-making body) or the Assembly (full Council) and can be viewed on the Council's website at <http://modern.gov.barking-dagenham.gov.uk/mgListPlans.aspx?RPId=180&RD=0>. In accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 the full membership of the Health and Wellbeing Board is listed in Appendix 1.

Key Decisions

By law, councils have to publish a document detailing "Key Decisions" that are to be taken by the Cabinet or other committees / persons / bodies that have executive functions. The document, known as the Forward Plan, is required to be published 28 days before the date that the decisions are to be made. Key decisions are defined as:

- (i) Those that form the Council's budgetary and policy framework (this is explained in more detail in the Council's Constitution)
- (ii) Those that involve 'significant' spending or savings
- (iii) Those that have a significant effect on the community

In relation to (ii) above, Barking and Dagenham's definition of 'significant' is spending or savings of £200,000 or more that is not already provided for in the Council's Budget (the setting of the Budget is itself a Key Decision).

In relation to (iii) above, Barking and Dagenham has also extended this definition so that it relates to any decision that is likely to have a significant impact on one or more ward (the legislation refers to this aspect only being relevant where the impact is likely to be on two or more wards).

As part of the Council's commitment to open government it has extended the scope of this document so that it includes all known issues, not just "Key Decisions", that are due to be considered by the decision-making body as far ahead as possible.

Information included in the Forward Plan

In relation to each decision, the Forward Plan includes as much information as is available when it is published, including:

- the matter in respect of which the decision is to be made;
- the decision-making body (Barking and Dagenham does not delegate the taking of key decisions to individual Members or officers)
- the date when the decision is due to be made;

Publicity in connection with Key decisions

Subject to any prohibition or restriction on their disclosure, the documents referred to in relation to each Key Decision are available to the public. Each entry in the Plan gives details of the main officer to contact if you would like some further information on the item. If you would like to view any of the documents listed you should contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@lbbd.gov.uk).

The agendas and reports for the decision-making bodies and other Council meetings open to the public will normally be published at least five clear working days before the meeting. For details about Council meetings and to view the agenda papers go to <http://moderngov.barking-dagenham.gov.uk/ieDocHome.asp?Categories> and select the committee and meeting that you are interested in.

The Health and Wellbeing Board's Forward Plan will be published on or before the following dates during the 2014 / 2015 Council year, in accordance with the statutory 28-day publication period:

Edition	Publication date
March 2015 edition	16 February 2015

Confidential or Exempt Information

Whilst the majority of the Health and Wellbeing Board's business will be open to the public and media organisations to attend, there will inevitably be some business to be considered that contains, for example, confidential, commercially sensitive or personal information.

This is formal notice under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 that part of the meetings listed in this Forward Plan may be held in private because the agenda and reports for the meeting will contain exempt information under Part 1 of Schedule 12A to the Local Government Act 1972 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it. Representations may be made to the Council about why a particular decision should be open to the public. Any such representations should be made to Alan Dawson, Democratic Services Manager, Civic Centre, Dagenham, Essex RM10 7BN (telephone: 020 8227 2348, email: committees@lbbd.gov.uk).

Key to the table

Column 1 shows the projected date when the decision will be taken and who will be taking it. However, an item shown on the Forward Plan may, for a variety of reasons, be deferred or delayed.

It is suggested, therefore, that anyone with an interest in a particular item, especially if he/she wishes to attend the meeting at which the item is scheduled to be considered, should check within 7 days of the meeting that the item is included on the agenda for that meeting, either by going to <http://modern.gov.barking-dagenham.gov.uk/ieListMeetings.aspx?CIId=669&Year=0> or by contacting contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@lbbd.gov.uk).

Column 2 sets out the title of the report or subject matter and the nature of the decision being sought. For 'key decision' items the title is shown in **bold type** - for all other items the title is shown in normal type. Column 2 also lists the ward(s) in the Borough that the issue relates to.

Column 3 shows whether the issue is expected to be considered in the open part of the meeting or whether it may, in whole or in part, be considered in private and, if so, the reason(s) why.

Column 4 gives the details of the lead officer and / or Board Member who is the sponsor for that item.

Decision taker/ Projected Date	Subject Matter Nature of Decision	Open / Private (and reason if all / part is private)	Sponsor and Lead officer / report author
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Health and Wellbeing Board: 10.2.15	<p>Health and Young Offenders</p> <p>The Board will receive a report that outlines the health needs and challenges for young offenders as a cohort. The Board will discuss gaps in service provision and how health inequalities can be addressed for this group.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>
Health and Wellbeing Board: 10.2.15	<p>Joint Assessment and Discharge Service Section 75 : Community,; Financial</p> <p>The Board will receive a report on the progress and proposed agreement between the Council and partner organisations to support the operational delivery of a Joint Assessment and Discharge Service. The proposed agreement will also be considered by (London Borough of Havering, Barking, Havering and Redbridge University Trust, North East London Foundation Trust and Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups).</p> <p>The Board will be asked to delegate authority to the Corporate Director of Adult and Community services to finalise the Section 75 agreement on behalf of the Board.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Bruce Morris, Divisional Director, Adult Social Care (Tel: 020 8227 2749) (bruce.morris@lbbd.gov.uk)</p>

Health and Wellbeing Board: 10.2.15	<p>Primary Care Strategic Commissioning Framework</p> <p>The Primary Care Strategic Commissioning Framework aims to support the transformation of primary care in London and sets out a new vision for general practice, including a new 'patient offer' of high quality care for all Londoners.</p> <p>The Barking and Dagenham Health and Wellbeing Board will discuss the draft Strategic Commissioning Framework and provide feedback to Barking and Dagenham, Havering and Redbridge CCGs and NHS England before the final Framework is implemented from April 2015.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Mark Tyson, Group Manager, Integration & Commissioning (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)</p>
Health and Wellbeing Board: 10.2.15	<p>Quarter 3 Performance</p> <p>The Quarter 3 performance dashboard and Better Care Fund (BCF) update will be presented to the Board for the Board to analyse and discuss.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>
Health and Wellbeing Board: 10.2.15	<p>Care Act: Compliance of NHS Partners</p> <p>On 9 December 2014 the Health and Wellbeing Board (H&WB) agreed that the CCG and NHS Trusts would report back on 10 February 2015 to give assurance to the H&WBB that each organisation had considering the implications of the Care Act and was working towards full compliance with the Act from 1 April 2015.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Ian Winter CBE, Care Act Programme Lead (ian.winter@lbbd.gov.uk)</p>
Health and Wellbeing Board: 10.2.15	<p>New Psychoactive Substances - Legal Highs</p> <p>The report will highlight the current situation regarding the use of New Psychoactive Substances (legal highs) in the Borough.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Glynis Rogers, Divisional Director, Community and Partnerships (Tel: 020 8227 2827) (glynis.rogers@lbbd.gov.uk)</p>

Health and Wellbeing Board: 10.2.15	<p>Public Health Commissioning Intentions</p> <p>NHS England will update the Board on public health commissioning intentions including immunisations, screening and health in the justice and military.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>
Health and Wellbeing Board: 17.3.15	<p>Procurement Plan 2015/16</p> <p>Under the Council's Contract Rules (Rule 25) there a requirement to report the Procurement Plan for all new contracts (including extensions, additions and renewals) with a Contract Value of £500,00 or above scheduled to start in the next financial year, which are funded in part or in whole from the Public Health Grant or from within social care budgets.</p> <p>The Board will be presented with Procurement Plan and be asked to agree the proposed Plan in its entirety or identify any individual procurements / contracts which the Board requires separate more detailed Procurement Strategy Reports to be submitted to it for closer consideration.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>
Health and Wellbeing Board: 17.3.15	<p>Learning Disability Section 75 Agreements - Update</p> <p>The Board will be updated on the Learning Disability Section 75 Agreements, including the results of consultation that has been undertaken with service users and the Learning Disability Partnership Board.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Glynis Rogers, Divisional Director, Community and Partnerships (Tel: 020 8227 2827) (glynis.rogers@lbbd.gov.uk)</p>

<p>Health and Wellbeing Board: 17.3.15</p>	<p>Carers Strategy and Commissioning of Carers Services : Community</p> <p>The Board will be asked to agree:</p> <ul style="list-style-type: none"> (i) The final Carers' Strategy. (ii) The proposed commissioning intentions for carers services. (iii) To delegate authority to the corporate Director of Adult and Community Services, in consultation with the Head of Legal and Democratic Services, to commence a tender for these services and award the contracts. <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Mark Tyson, Group Manager, Integration & Commissioning (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)</p>
<p>Health and Wellbeing Board: 17.3.15</p>	<p>Joint Health and Social Care Self Assessment Framework : Community</p> <p>The Annual Joint Health and Social Care Self Assessment was carried out on how the Council meets the needs of People with a Learning Disability and their Carers. The assessment focussed on the period 1 April 2013 to 31 March 2014. The final submission was agreed by the Learning Disability Partnership Board.</p> <p>This report outlines the background, the findings and agreed actions for improvement.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Glynis Rogers, Divisional Director, Community and Partnerships (Tel: 020 8227 2827) (glynis.rogers@lbbd.gov.uk)</p>
<p>Health and Wellbeing Board: 17.3.15</p>	<p>Prevention Strategy : Framework</p> <p>To meet Care Act duties relating to prevention the statutory guidance requires the Council to develop a prevention strategy on behalf of the borough. In keeping with the Council's corporate priority of encouraging social responsibility the Programme Board has agreed a framework which builds preventative support around the individual with an emphasis on self-help and access to universal service provision. This Strategy will be developed in the context of the refresh of the Health and Wellbeing Strategy and presented to the Board for agreement.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Ian Winter CBE, Care Act Programme Lead (ian.winter@lbbd.gov.uk)</p>

Health and Wellbeing Board: 17.3.15	<p>Arrangements for Advocacy provision in 2015/16 and future years</p> <p>The Care Act 2014 expands the duties on local authorities with regard to arranging independent advocacy for service users and carers. In response to this it is necessary to review our current arrangements and make plans to ensure adequate provision of independent advocacy locally.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Mark Tyson, Group Manager, Integration & Commissioning (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)</p>
Health and Wellbeing Board: 17.3.15	<p>The provision of a Section 75 Agreement for the Better Care Fund between the Council and Barking and Dagenham's Clinical Commissioning Group : Community</p> <p>It is a requirement of the Better Care Fund that a pooled fund be in place for April 2015.</p> <p>The Board will be asked to consider and agree the Section 75 Agreement and its key schedules relating to financial management arrangements, risk sharing and performance requirements.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Corporate Director of Adult & Community Services</p>
Health and Wellbeing Board: 17.3.15	<p>Director of Public Health Annual Report</p> <p>The Director of Public Health Annual Report identifies key issues, flags up problems, and reports progress. The Annual Report will also be a key resource to inform local inter-agency action.</p> <p>The Board will be asked to note the 2014/15 Annual Report.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>

Health and Wellbeing Board: 17.3.15	<p>Information and Advice Strategy for Adult Social Care and Support : Framework</p> <p>To meet the duties within the Care Act 2014 the Council will need to have in place a Plan for providing and maintaining an information and advice service for adult social care and support.</p> <p>The Board will be asked to agree the Information and Advice Strategy as the first step in meeting this new duty.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	Mark Tyson, Group Manager, Integration & Commissioning (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)
Health and Wellbeing Board: 17.3.15	<p>Pharmaceutical Needs Assessment All Issue Categories</p> <p>Following presentation to the Board on 9 December 2014, the draft Pharmaceutical Needs Assessment commenced its 60 day consultation process on 19 December 2014. The consultation is due to end on 16 February 2015.</p> <p>The Board will be asked to sign off the PNA for publication by the statutory deadline of 1 April 2015.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
Health and Wellbeing Board: 17.3.15	<p>Children's Autism Strategic Plan : Community</p> <p>The Children's Autism Strategy is being presented to the Board as the Children's Strategy has been reviewed and revised to reflect the Adult Autism Strategy.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	Ann P Jones, Group Manager Education Inclusion, Children's Services (Ann.p.Jones@lbbd.gov.uk)

Health and Wellbeing Board: 12.5.15	<p>Quarter 4 Performance</p> <p>The Quarter 4 performance dashboard and Better Care Fund (BCF) update will be presented to Board for the Board to analyse and discuss.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>
Health and Wellbeing Board: 12.5.15	<p>Health and Wellbeing Board Strategy Refresh (Final) : Community</p> <p>One of the key roles of the Health and Wellbeing Board is to oversee the development, authorisation and publication of the Health and Wellbeing Strategy. The Health and Wellbeing Strategy is the mechanism by which the Board addresses the needs identified in the Joint Strategic Needs Assessment (JSNA), setting out agreed priorities for collective action by the commissioners. The current Health and Wellbeing Board Strategy is due to be refreshed in 2015.</p> <p>The final refreshed version of the Health and Wellbeing Strategy will be presented for approval.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>
Health and Wellbeing Board: 7.7.15	<p>Annual Health Protection Profile <i>[Annual Item]</i></p> <p>Representatives from Public Health England are invited to the Board to present and discuss Barking and Dagenham's Health Protection Profile which is compiled annually.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>
Health and Wellbeing Board: 7.7.15	<p>Primary Care Transformation Programme - Update</p> <p>The Board will be presented with an update on the Primary Care Transformation Programme in Barking, Havering and Redbridge (BHRUT).</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Conor Burke, Cheif Officer (Tel: 020 8926 5238) (conor.burke@onel.nhs.uk)</p>

Membership of Health and Wellbeing Board:

Councillor Maureen Worby, Cabinet Member for Adult Social Care and Health (Chair)
Councillor Laila Butt, Cabinet Member for Crime and Enforcement
Councillor Evelyn Carpenter, Cabinet Member for Education and Schools
Councillor Bill Turner, Cabinet Member for Children's Social Care
Anne Bristow, Corporate Director for Adult and Community Services
Helen Jenner, Corporate Director for Children's Services
Matthew Cole, Director of Public Health
Frances Carroll, Chair of Healthwatch Barking and Dagenham
Dr Waseem Mohi, Chair of Barking and Dagenham Clinical Commissioning Group (Deputy Chair of the H&WBB)
Dr Jagan John, Clinical Director (Barking and Dagenham Clinical Commissioning Group)
Conor Burke, Accountable Officer (Barking and Dagenham Clinical Commissioning Group)
Jacqui Van Rossum, Executive Director Integrated Care (London) and Transformation (North East London NHS Foundation Trust)
Stephen Burgess, Interim Medical Director (Barking Havering and Redbridge University Hospitals NHS Trust)
Sean Wilson, Deputy Borough Commander (Met Police)
John Atherton, Head of Assurance (NHS England) (non-voting Board Member)