Notice of Meeting

HEALTH & WELLBEING BOARD

Tuesday, 12 May 2015 - 6:00 pm
Conference Room, Barking Learning Centre, 2 Town Square, Barking, IG11 7NB

Date of publication: 1 May 2015

Chris Naylor
Chief Executive

Contact Officer: Tina Robinson
Tel. 020 8227 3285
E-mail: tina.robinson@lbbd.gov.uk

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 Services and 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 Nadeem Moghal	(Barking Havering & Redbridge University NHS Hospitals Trust)
Sultan Taylor	(Metropolitan Police, Borough Commander)
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 17 March 2015 (Pages 3 - 16)**

BUSINESS ITEMS

4. **Draft Refresh of the Joint Health and Wellbeing Strategy Including Delivery Plan and Outcomes Framework (Pages 17 - 193)**

5. **Prevention Strategy: A Local Framework for Preventing, Reducing and Delaying Care and Support Needs In Adults (Pages 195 - 220)**

6. **Mental Health Needs Assessment (Pages 221 - 236)**

7. **Health and Wellbeing Outcomes Framework Performance Report - Quarter 4 (2014/15) (Pages 237 - 280)**

8. **Review of Learning Disability and Autism Health and Social Care Self Assessments (Pages 281 - 306)**

9. **Review of Governance Arrangements Of The Sub Structure Of The Health And Wellbeing Board (Pages 307 - 313)**

STANDING ITEMS

10. **Systems Resilience Group - Update (Pages 315 - 321)**

11. **Sub-Group Reports (Pages 323 - 333)**

12. **Chair's Report (Pages 335 - 340)**

13. **Forward Plan (Pages 341 - 350)**

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

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

Private Business

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

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

This page is intentionally left blank

London Borough of Barking & Dagenham
lbbd.gov.uk

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

This page is intentionally left blank

MINUTES OF
HEALTH AND WELLBEING BOARD

Tuesday, 17 March 2015
(6:00 - 8:07 pm)

Present: Cllr Maureen Worby (Chair), Dr Waseem Mohi (Deputy Chair), John Atherton, Anne Bristow, Dr Nadeem Moghal, Chief Superintendant Sultan Taylor, Conor Burke, Cllr Laila Butt, Cllr Evelyn Carpenter, Frances Carroll, Matthew Cole, Helen Jenner and Jacqui Van Rossum

Also Present: Sarah D'Souza, Cllr Adegboyega Oluwole and Kenny Gibson

Apologies: Cllr Bill Turner and Sarah Baker

104. Declaration of Members' Interests

Jacqui Van Rossum, Executive Director Integrated Care (London) and Transformation, NELFT, declared a pecuniary interest in Agenda Item 11 'Section 75 Arrangements for the Provision of Learning Disability Services' and Agenda Item 14 'Update on the preparation for transfer of the 0-5 year Healthy Child Programme (Health Visiting) Service and Family Nurse Partnership Programme from NHS' and took no part in the discussions or decisions of those items.

There were no other declarations of interest.

105. Minutes - 10 February 2015

The minutes of the meeting held on 10 February were confirmed as correct.

106. Carers Strategy and Commissioning of Carers Services

Further to Minute 63, 20 October 2014, Mark Tyson. Group Manager, Integration and Commissioning, LBBD, presented the strategy for improving support to carers in the Borough. The Strategy 2015 to 2018 and the detailed Action Plan, covering the first year, had been compiled following consultation events with carers and service.

The strategy had taken into account the need for correct commissioning and the need to look at what and how we do things and also preventative work that could be done to remove the need for care in the future.

The market position statement would also be refreshed in the summer and further consultation would be undertaken on those aspects at that time.

Mark Tyson explained that, the Safeguarding Adults Board had recently considered a serious case review and this had resulted in recommendations which would be added to the Strategy.

Prompts were also being developed to ensure that Social Workers consider and deal with the needs of young carers.

In response to a question from Councillor Carpenter, Cabinet Member for Education and Schools, Mark Tyson confirmed the milestones, set out in page 23 of the Strategy, were all on track for April and May 2015.

Councillor Carpenter asked how we could tell if the actions were having a real impact and if there would be any problems obtaining data to assess the impact. Mark Tyson confirmed that it would be possible to measure the impact against the data flows and that could be easily collected direct from health partners.

The Chair, Councillor Worby, Cabinet Member for Adult Social Care and Health, indicated she was concerned that the vision ''A carer-conscious community, working together to create innovative and sustainable support for carers, where carers are viewed as 'everybody's business' and feel valued' was too long and felt a shorter more customer friendly strap line was needed. Councillor Carpenter agreed and suggested 'Let's Care for the Carers'.

The Chair commented that she still felt concerned that we could have understated the number of carers, especially young carers, and the impact on resources that could have. Mark Tyson advised that a review had been factored in half way through the first year to take stock of the situation and make any reassessments necessary.

Having considered the report and discussed the issues, the Board:

(i) Approved the Strategy attached to the report as the basis for future joint work on the development of carers' services in Barking and Dagenham;

(ii) Agreed the new vision strap line should be 'Let's Care for the Carers'.

(iii) Delegated authority to the Corporate Director of Adult and Community Services to work with partners including carers, carer service providers and health partners in the development of proposals of a specification for future carers' services; and

(iv) Delegated authority to the Corporate Director of Adult and Community Services in consultation with the Cabinet Member for Adult Social Care and Health, Divisional Director of Legal Services, Chief Finance Officer, and partners through the Carers Strategy Group and Joint Executive Management Group for the Better Care Fund, to proceed to tender for carers' support services for April 2016 onwards, in line with the intentions set out in the Carers' Strategy.

107. Arrangements for Advocacy Provision in 2015/16 and Future Years

Ian Winter CBE, Care Act Programme Lead, presented the report, which explained that the Care Act states that an independent advocate must be appointed to support and represent a person for the purpose of assisting their involvement in the care and support process where a person had substantial difficulty in being involved and had no appropriate individual to support them. Ian Winter stressed the difference between general advocacy support and the more specific issues for those who would have communication difficulties.

Ian Winter explained that the report set out the interim service provision for the first twelve months and the future from 2016 and how this would enable an understanding of service

need and mechanisms to be put into place as well as the correct training to be undertaken in the market place. The interim arrangements would also be monitored.

The Chair advised that both colleges in the Borough had been approached and Barking and Dagenham Adult College had already responded that it would be looking into provision of training.

In response to a question from Helen Jenner, Corporate Director of Children's Services, Ian Winter CBE, Care Act Programme Lead, advised that further discussions were to be held with Children's Services in due course on the statutory children's mental health act advocacy needs.

The Board:

(i) Noted that the current advocacy services would be extended for one year and brought up to 'Care Act compliance' from 1 April 2015 to enable the Council to achieve an interim position to comply with the requirements of the Care Act over the next 12 months and a review of services to ensure a longer term approach which will meet local need as required and ensure full Care Act compliance.

(ii) Requested a report to the December Health and Wellbeing Board meeting on:

(a) The use of individual advocacy covering the first six months of the extended service; and,

(b) The options for a revised service approach from 1 April 2016.

108. Information and Advice Plan for Adult Social Care and Support

Karen West-Whylie, Group Manager-Learning Disabilities, LBBD, presented the report on the Barking and Dagenham's statutory duty under the Care Act 2014 to provide high quality information to the local population, whether they were in need of services or not at the moment, and the strategic approach to meeting those requirements. The Plan covered Council provided and commissioned information as well as advice and signposting to other local and national sources of information.

Karen West-Whylie drew the Board's attention to the details in the report and the proposed priorities and also explained that a response to enquiries could no longer be the provision of general fact sheets but would require a letter with advice tailored to the individual's needs. In addition, from April 2016 advice about the financial aspects of care and support would also be required.

Councillor Carpenter queried the accuracy of the figures of people with mental health problems, on page 91 of the agenda, as they seemed rather low. Anne Bristow, Corporate Director of Adult and Community Services, felt that the figures may be those with significant mental health problems, rather than less acute or shor- term issues, such as low level anxiety. The Chair asked NELFT for clarification and Jacqui Van Rossum advised that the service user figures were not those she recognised and also felt they could be higher and she would work with Mike Tyson to ensure these were correct.

Anne Bristow informed the Board of a cross London information initiative that was being investigated at the current time which might provide a digital solution, backed by trained people, and could also be cost effective.

The Chair commented that there was also a need to support and those with lower categories of mental health needs. Matthew Cole, Director of Public Health advised that The Maples needs assessment would be completed shortly, and the details could be fed into the Plan.

Ian Winter and Anne Bristow suggested that GPs and other health professional may find the information hub of particular use as the details will be up-to-date, in one place, well indexed and easily understandable. The hub could be accessed from the Council's webpage. All partners were reminded to report any contact changes etc or problems they encounter so that alterations could be made and to ensure that it seen as a reliable central information point.

The Chair commented that it was important for all the communication teams to make sure that all the links worked and linked together and took people to the information they needed.

Having considered the report and discussed the Information and Advice Plan, which had been developed to provide a strategic approach to meeting the requirements of the Care Act 2014 in relation to providing information and advice, the Board:

(i) Agreed the priorities:

a) Ensure there is a comprehensive range of information and advice about care and support available locally.

b) Ensure all digital and face-to-face information and advice is accurate, up-to-date, easy to understand, and consistent with other sources of information

c) To offer tailored information and advice about care and support (in a variety of formats) whenever possible to help individuals understand their range of options.

d) To work with key information and advice providers from all sectors to improve the co-ordination of information and advice locally.

e) To develop and promote the Care and Support Hub as the Borough's web based local directory.

f) To transform information and advice provision in line with the Council's 'digital by design' approach to ensure quick, efficient and localised signposting.

(ii) Noted and supported the Action Plan for 2015/16, attached as Appendix 4 to the report, which provided details of the key activities during the coming year to deliver those priorities.

109. Care Act 2016 - Consultation on draft regulations and guidance to implement the cap on care costs and policy proposals for a new appeals system for care and support

Ian Winter CBE, Care Act Programme Lead, presented the report on the consultation being undertaken by the Department of Health on the changes of the Care Act that would come into effect in April 2016. The consultation was in two parts, the first sought stakeholders' views on funding issues and the guidance that would introduce the cap on care costs and the second part was on an appeals policy and process. This consultation would close on the 30 March 2015 and a draft response from the Council had been set out in Appendix 1 to the report.

Connor Burke, Chief Accountable Officer, Barking and Dagenham, Clinical Commissioning Group, raised concern about the how we could explain the complexity of the changes and financial implications to people. Anne Bristow commented on the risk of the pension changes to future care financing and that it was expected that pension drawdown deposited in a bank may not be looked at as a weekly pension but as a capital sum that could fund care and therefore could affect an individual's weekly income. Anne Bristow stressed that it was important for people to get their own professional financial advice, especially around pensions. Ian Winter responded that the due to the number of changes in April 2016 it was intended to produce a short guide or prompt cards for staff but this would be progressed once the changes have settled down and the further guidance, due to be issued in November, was received.

Helen Jenner, asked if there was a need to obtain clarification around the working age adults especially those who, for various reasons, may not have obtained access to services before age 25. Ian Winter advised that his understanding was that there is no retrospective award, however he accepted Helen Jenner's point that there could be a test of that in court in the future and that the request for clarification should be part of the response. Helen Jenner added that the changes may result in a rush for assessment for under 25s not identified so far.

Having received the report on the consultation and discussed the proposed response of the Council, as set out in the report and in particular Appendix 1, the Board:

(i) Noted the consultation closed on 30 March 2015.

(ii) Agreed that a request for clarification around the working age adults pre age 25 should be included in the response.

(ii) Delegated authority to the Corporate Director of Adult and Community Services, in consultation with the Cabinet Member for Adult Social Care and Health, to finalise the consultation response based upon Appendix 1 to the report.

110. Director of Public Health Annual Report

Matthew Cole, Director of Public Health, presented the Public Health Annual report, which was a statutory requirement under the provision of the Health and Social Care Act 20102. The report provided an assessment of the health of the

population and a focus on some priorities areas where the Council and its partners could either individually or collectively consider where more needs to be done to realise health gain. Matthew Cole drew the Board's attention to the contents of the report and five particular areas he had considered as set out in Chapters 1 to 5.

Frances Carroll, Healthwatch Barking and Dagenham, drew the Boards attention to the number of school nurses and how the number of School Nurses would need to be reviewed as the 0-5 cohort move up through the years. Helen Jenner confirmed that we not have enough school nurses to meet demand in the a few years time. Kenny Gibson Head of Early Years, Immunisations & Military Health NHS England (London Region), advised that NHS England were looking at the numbers of school nurses needed both in the shorter term and projected for the future and it may be that there would be a need for less Health Visitors and more School Nurses and training would need to be geared up to match the projections.

Helen Jenner commented that she was surprised that Child Sex Exploitation had not been included. Matthew Cole responded that he had not covered it in his five areas this year but it would be included next year.

Francis Carroll drew the Board's attention to page 130 and asked what could be done about high strength alcohol and beers and the amount people congregating around the front of Barking Station and drinking and smoking. Matthew Cole responded that the chapter looked at what we can do as a local authority and the only extra option would be a voluntary code on shopkeepers not selling extra strength beers etc. Voluntary codes have had a positive effect in places like Ipswich both on street and in A&E hospital admissions. However, there was often resistance to a voluntary code by smaller shopkeepers. Chief Superintendant Sultan Taylor, Borough Commander Barking and Dagenham, said that he was happy to work with the Council and its partners to drive forward such initiatives.

The Chair commented that the Health and Wellbeing Strategy and commissioning intentions needed to ensure that all the actions are brought together so that we were all doing what we could to have a significant improvement in the lives and life chances of residents. The Chair added that the Public Health Annual Report provided a timely reminder, which would enable partners to take on board the issues in commissioning plans and intentions.

Matthew Cole advised on the work that had been undertaken to develop smoking and alcohol reduction actions and that the Council had been leading the way, in conjunction with the police, to identifying hot spots where excessive or on-street alcohol consumption was related to related crime. It was hoped that neighbouring boroughs may join the initiative.

Dr Nadeem Moghal, Medical Director, BHRUT, gave an update on cancer screening rates and initiatives and the work that was being undertaken with the CCG to encourage patients to present earlier for investigations. Dr Moghal advised that the whole of the BHRUT estate was now smoking free and he was personally challenging people who he saw smoking on the sites.

The Chair reminded all that they were each expected to make a pledge about what they were going to do over the next year to make their health better. The Chair asked that they take the idea of the pledge back to their own organisations and encourage their staff to participate as well.

Frances Carroll drew the Board's attention to page 132 of the agenda and asked if there were any specific actions in regards to air pollution. Matthew Cole explained the role of Environmental Health Team and the Regeneration Division.

Having received and discussed the Director of Public Health's Annual report the Board:

(i) Noted and commented, as shown above, on the observations of the Director of Public Health in his Annual Report.

(ii) Noted the Director of Public Health Annual Report would be used to inform future iterations of the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment.

(iii) Noted Child Sexual Exploitation would be included in next year's Annual Health Annual Report.

111. Pharmaceutical Needs Assessment for Barking and Dagenham 2015

Matthew Cole, Director of Public Health, presented the report and advised that the Pharmaceutical Needs Assessment (PNA) review was a statutory requirement and was undertaken every three years. The PNA provided an assessment of the local need for pharmaceutical services and on this occasion there was no need to make any changes.

Councillor Carpenter raised the current coverage in the media about the potential for pharmacies being sited within GP surgeries and the provision and also the quality of the facilities within pharmacy shops to enable confidential discussions to be held. Matthew Cole advised that pharmacies providing services such as smoking cessation and emergency contraception do require a private area to be available for consultations. However, these may not always be very large rooms in some shops.

Dr Mohi explained that the commissioning of pharmaceutical provision was the responsibility NHS England.

Councillor Carpenter said that overall there was a good level of service from pharmacies but felt the question could have been included for the public to comment on the provision and quality of consultation rooms in the pharmacies.

It was expected that the incoming CQC accreditation of pharmacies would be defining what constitutes an acceptable room size for consultation.

Conor Burke commented that the PNA was a statutory requirement that was a process we used to inform commissioning but we could still use pharmacies and the Health and Wellbeing Strategy to look at how we can do things differently in the future.

Helen Jenner commented that she would have like to have seen the young inspectors used and their views sought more on pharmacies. Matthew Cole agreed to take this on board.

The Chair commented that 91% of pharmacy users say the service they received was good or above. There was also good local coverage.

Francis Carroll asked about pharmacist availability to support the GP out-of-hours service and the GP hubs, for example at Barking Hospital, so that the patients do not have a delay in getting their prescriptions filled. Anne Bristow explained that there were duty pharmacist arrangements. Dr Mohi advised that both the GP hubs and the GP home visiting services prescribe and they do have medications at hand for immediate dispensing if they deemed it necessary.

Having received and discussed the report and PNA, the Board:

(i) Noted the consultation results and findings:

a) Barking and Dagenham HWB had 38 community pharmacies;

b) This equated to about 19.6 community pharmacies per 100,000 population - which was lower than the average for London (22.3/100,000) and England (21.7/100,000);

c) Of these community pharmacies, 79% were open weekday evenings, 97% were open on Saturdays, and 18% were open on Sundays;

d) Half of the pharmacies in Barking and Dagenham were owned by independents, compared to 39% nationally;

e) From a pharmacy user survey taken in the autumn last year (480 responses) 91% rated the service received from pharmacies in Barking and Dagenham as good or excellent; 82% indicated that they did not have a preferred pharmacy they used; 85% said the ease of obtaining medicines was good or excellent; 71% said their journey time to a pharmacy was no more than 10 minutes;

f) Pharmacies in Barking and Dagenham are commissioned to provide services on behalf of NHS England, Barking and Dagenham CCG, and Barking and Dagenham Council;

g) The Pharmaceutical Needs Assessment did not find any gap in provision or access to services provided from community pharmacies in Barking and Dagenham, either now or in the next 3 years;

h) The work that was being undertaken to enable finalisation by 1 April 2015; and,

(ii) Agreed the Pharmaceutical Needs Assessment (PNA), as set out in the Appendix 3 of the report.

112. The provision of a Section 75 Agreement for the Better Care Fund between the Council and Barking and Dagenham's Clinical Commissioning Group

Glynis Rogers, Divisional Director Community Safety and Public Protection, LBBD, presented the report on the provision of a Section 75 Agreement between the Council and the Barking and Dagenham's Clinical Commissioning Group (CCG) for the

Better Care Fund, which aims to provided pooled fund arrangements that would transform local commissioning and services to provide improved integrated care and support and so improve local outcomes.

The Better Care Fund was set to deliver from 1 April and the Section 75 Agreement would regularise the performance and financial management. Whilst the Section 75 Agreement is for one year, it did allow for extension for a further period.

The CCG was expected to ratify the Section 75 Agreement at its meeting on 23 March 2015.

In response to a question from Connor Burke, it was noted that the Corporate Director of Adult and Community Services would not sign on behalf of all the partners but would sign on behalf of the Council and partners would sign on behalf of their organisations.

Having received the report and discussed the issue, the Board:

(i) Noted the Barking and Dagenham, Clinical Commissioning Group (CCG) Governing Body would be considering the same authorisation to enter into the agreement on 23 March 2015; and,

(ii) Delegated authority to the Corporate Director of Adult and Community Services, acting on advice from the Divisional Director of Legal and Democratic Services and the Chief Finance Officer, to enter into the Section 75 Agreement for the Better Care Fund on behalf of the Council, as set out in the report.

113. Section 75 Arrangements for the Provision of Learning Disability Services

Glynis Rogers, Divisional Director Community Safety and Public Protection, LBBD, presented the report on the provision of a Section 75 Agreement for the Provision of Learning Disability Services.

One of the recommendations of the Winterbourne View concordat was that local authorities and health partners put joint and collaborative commissioning arrangements into place. The Board had been provided with reports in March and September 2014 on the intentions for the Section 75 Agreement for learning disabilities. The Section 75 Agreement before the Board set out the provision of an integrated Community Learning Disability Team, which would bring together the services provided by North East London NHS Foundation Trust (NELFT) and the Council. The full details of were set out in the report on how that would be achieved on a practical level, including workforce structure and staffing, monitoring and the operational group membership, outstanding issues.

The Council would be the 'host' organisation and the agreement would be effective for a term of three years from its commencement date, with the option to extend for a further two years.

It was noted that Jacqui Van Rossum had delegated responsibility to sign the agreement and it did not need to go to the NELFT Board.

Having received and discussed the report, the Board:

(i) Delegated authority to the Corporate Director of Adult and Community Services, in consultation with the Chief Finance Officer and the Director for Legal and Democratic Services, to finalise terms and enter into Section 75 Agreements with North East London NHS Foundation Trust for the provision of the integrated learning disability service.

114. Procurement Plan and Commissioning Intentions 2015/16

(The Chair agreed that this item could be considered at the meeting as a matter of urgency under the provisions of Section 100B(4)(b) of the Local Government Act 1972.)

Matthew Cole, Director of Public Health, presented the commissioning intentions for 2015/16. Matthew explained the priorities and strategic framework for commissioning and advised there was also a requirement in the Council's Constitution that the Board was made aware of contracts Board might be asked to let over £500,000 during 2015/16. Children's health services contracts would be reported through the Council's Cabinet.

The Chair commented that this report would enable partners to double check and challenge how we deliver and if we should be undertaking delivery in a different way, as well as the specifications that would be used in commissioning. Anne Bristow added this also flagged-up in one document what each partners would be doing ahead of the financial year and where there might be further opportunities to work together.

Having received the report and discussed the priorities, the Board:

(i) Agreed the strategic framework for commissioning health and wellbeing programmes for 2015/16, as set out in the report

(ii) Noted the list of contracts over £500,000 that were due to expire during the financial year, as identified in section 7 and Appendix A of the report.

(iii) Noted that the next stage was to look at resourced delivery programmes, in respect of what was being done now, what could be stopped or done differently, and what else was needed to make a difference.

115. Barking and Dagenham Clinical Commissioning Group (CCG) Commissioning Plan 2015/16

The Clinical Commissioning Group Barking and Dagenham (CCG) presented the report which gave an indication of the CCG's local requirements and how those fitted into the wider context. The Boards attention was drawn to the work that had been undertaken by the Sub–Groups of the Board in ensuring that the delivery plans of the various partners converge and would be achieved.

The Chair commented that the working relationships had matured between the partners and they were now able to participate in full and frank discussion and to embrace partnership working and different methods of working.

The Board were shown a short video of a stakeholder event that had been held on the 12 January 2015 and it was explained how different media had and would be used to engage the public in consultation and feedback on service delivery.

Chief Superintendant Sultan Taylor commented that he would be happy for his teams to participate and engage in events, especially public facing events. Anne Bristow thanked the Chief Superintendant for the offer and the officers would contact him in regards to the various events that are coming up in 2015.

Dr Mohi stressed that the CCG were now focusing on what patients need and want and not what suits individual organisations.

Having received the report and considered the information, including the development of the CCG commissioning plan for 2015/16, the information in the national NHS planning requirements set out in "The Forwards View into Action: Planning for 2015/16", the CCG operating plan submission and the feedback from the stakeholder engagement session held on 21 January 2015, the Board:

(i) Noted and supported the CCG commissioning plan 2015/16 update and alignment to the Health and Wellbeing Strategy.

116. Update on the preparation for transfer of the 0-5 year Healthy Child Programme (Health Visiting) Service and Family Nurse Partnership Programme from NHS England to London Borough of Barking and Dagenham.

Matthew Cole, Director of Public Health and Kenny Gibson Head of Early Years, Immunisations & Military Health NHS England (London Region) jointly presented the report.

Matthew Cole advised that the original bid put to NHS England had been for £369,000 however they had only agreed to meet 55% of that bid, however that £202,950 (£405,900 full year effect) would take the allocation to circa £5.2m per annum. Matthew Cole indicated that it was his view that this was the best deal that we could obtain at present. Helen Jenner agreed but added that we still needed to keep lobbying because of the growth needs of the Borough and the decision had been based upon data that was two years old.

Matthew Cole indicated that due diligence was needed in regards to service plans and they needed to be focused upon the priority areas.

Kenny Gibson explained the process of moving 0-5 services to the boroughs had been complex and drew the Board's attention to page 466 of the agenda and particularly paragraph 3.4. The model used to set out the transfer terms was two years old and was not near the contemporary status, especially when families are moving into the area to benefit from the lower housing costs. ACRA would be undertaking a needs assessment to realign where young families and children are actually located. Kenny Gibson confirmed that NHS England would not provide any further resources and was not in a position to offer additional funding, over-and-above, that which has already been allocated by the DH Allocation process and DH Floor Adjustment.

The Board wished to place on record its appreciation to all involved in the work in transferring the services.

The Chair commented that we would continue to lobby because of the speed of change and increase in child numbers in the borough. The Chair said that she would recommend that we sign the transfer agreement.

Having received the update on the preparation for transfer of the 0-5 year Healthy Child Programme (Health Visiting) Service and Family Nurse Partnership Programme from NHS England to London Borough of Barking and Dagenham, the Board

(i) Noted the contract position in principal for the transition for the 0-5 commissioning arrangements and that a further report will be presented on this issue in due course.

(ii) Noted the additional £202,950 funding which had been agreed.

(iii) Agreed to formally accept /sign the transfer of the 0-5 year Healthy Child Programme (Health Visiting) Service and Family Nurse Partnership Programme from NHS England to London Borough of Barking and Dagenham.

117. Systems Resilience Group - Update

Connor Burke, Chief Accountable Officer, Barking and Dagenham, Clinical Commissioning Group presented the report and stressed the incredible value that the Joint Assessment and Discharge (JAD) had played in operational resilience and that rate was now the best in the country and was this week down to one across the three sites. Planning work was now starting on the Easter impact. The Chair commended on the work and positive results that were being achieved. Dr Mohi stressed that the new system wide way of working was clearly having results and was making responsibility for decisions clearer and actions swifter.

Conor Burke advised that a CQC inspection of King George and Queen's Hospitals had taken place during 2 to 6 March. Significant improvement had occurred since the previous Inspection and it was hoped that the March 2015 Inspection report would be positive.

Conor advised that Barts Health Trust had been put into special measures today and he would send a briefing note to the partners.

The Board

(i) Received the report from the Systems Resilience Group, which had noted that the Joint Assessment and Discharge (JAD) had played a key part in operational resilience over the winter period and that discharges supported by the JAD had averaged 100 people a week, and that was consistently exceeding the target agreed for the JAD as part of a series of other programmes, for avoidable admissions into acute care. Funding provided through operational resilience planning had enabled a level of activity that would otherwise be unsustainable for Social Care Budgets.

(ii) The Mental Health Sub Group had further developed the sub group work plan and also reviewed the B&D Mental Health Crisis Concordat draft Action Plan, for submission on 31 March 2015.

118. Sub-Group Reports

Noted update reports from:

(i) Mental Health Sub-Group

(iii) Learning Disability Partnership Board

119. Chair's Report

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

(i) **A&E Performance at BHRUT**
The performance for the 4 hour target for the week ending 22 February had met the national standard of 95%.

(ii) **BHRUT CQC Inspection**
This had taken place at King George's and Queens Hospitals during 2 to 6 March.

(iii) **Changes at Barts Health NHS Trust**
The deficit was now being forecast at £93m. There had also been retirements and resignations at senior level. The Trust had now also been placed into special measures on 17 March 2016.

(iv) **Tobacco Control Statement of Support**
BHRUT had recently signed up to the Local Government Declaration on Tobacco Control.

(v) **GP Hub**
The Barking and Dagenham pilot scheme would finish at the end of March 2015. The GP access hub at Barking Community Hospital opened in January 2015 and was working well. There were also plans for increased opening hours and it also was hoped to identify a site for a second hub in Dagenham.

(vi) **NHS Staff Survey and Summary of Key Results**

(vii) **Guidance on New Mental Health Standards**

(viii) **London Calling for GPs – report launch**

(ix) **Care Act 2014 – 14 days to go!**

(x) **Learning Disability Self Assessment Framework**

(xi) **Dates for Diary** - **Health and Wellbeing Board Development Afternoon:**

Thursday, 16 April 2015, 2.00p.m. to 6.00p.m. at Eastbury Manor House, Barking.

(xii) **Teenage Pregnancy Rates**
The Chair advised that she would be commissioning, within the next week or so, a specific piece of work that would look at what is different about this borough to ensure that we target and commission correctly for the future and to identify what we need to do differently.

Helen Jenner welcomed this and commented that LBBD do the same as other boroughs but for some reason the effects in reducing teenage pregnancy rates were not the same as in other boroughs. This would enable us to drill down as to why we were not achieving the same impact as other boroughs.

120. 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 6.00p.m, on 8 April 2015 for them to be considered at the 12 May 2015 meeting or later.

HEALTH AND WELLBEING BOARD

12 MAY 2015

Title: Draft Refresh of the Joint Health and Wellbeing Strategy	
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: All	**Key Decision:** Yes
Report Author: Matthew Cole Director of Public Health	**Contact Details:** Tel: 020 8227 3914 Email: matthew.cole@lbbd.gov.uk

Sponsor:

Anne Bristow Deputy Chief Executive & Corporate Director for Adult & Community Services

Summary:

Our refreshed joint Health and Wellbeing Strategy sets out a vision for improving the health and wellbeing of residents and reducing inequalities at every stage of people's lives by 2018. It aims to help residents improve their health by identifying the key priorities based on the evidence in our Joint Strategic Needs Assessment (JSNA), and what can be done to address them and what outcomes are intended to be achieved.

These priorities will then underpin commissioning plans and other agreements to undertake the actions together, in order to make the greatest impact across the health and social care system and wider Council responsibilities. It also sets out how we will work together to deliver the agreed priorities.

The refresh of the joint Health and Wellbeing Strategy is supported by two key documents. The Health and Wellbeing Outcomes Framework sets out the outcome indicators that will be used to monitor progress toward achieving the priorities set out in the Strategy and the Health and Wellbeing Strategy Delivery Plan 2015-18 that focuses on the key actions that the Board will focus on achieving over the timeframe of the strategy.

Recommendation(s):

The Health and Wellbeing Board is recommended:

(i) To discuss and approve the Joint Health and Wellbeing Strategy

Reason(s):

The Health and Wellbeing Board has a duty to balance needs carefully and to make difficult decisions about strategic priorities given the resources available. The production of the joint Health and Wellbeing Strategy was enshrined in the Local Government and Public Involvement in Health Act 2007 and the Health and Social Care Act 2012 imposes this duty on local authorities and clinical commissioning groups, discharged through the Health and Wellbeing Board.

The Joint Health and Wellbeing Strategy also informs other strategies linked to the Council's priorities for delivering **One borough; one community; London's growth opportunity**.

1. Background

1.1 A requirement of the Health and Wellbeing Board is to produce a Joint Health and Wellbeing Strategy to steer the major strategic work on health and wellbeing in the borough. The refresh is informed by our Joint Strategic Needs Assessment (JSNA), which describes Barking and Dagenham's population and the current and future health and wellbeing needs of residents.

1.2 This refresh of the Joint Health and Wellbeing Strategy (JHWS) will provide a focus for the Board and assist in setting priorities locally. It is not intended to be a detailed plan of action but instead sets out those areas that are of the greatest importance to the health and wellbeing of Barking and Dagenham's population and will be used to inform the setting of priorities including those within local commissioning processes.

2. Introduction

2.1 This paper builds on our current priorities agreed at the Health and Wellbeing Board as well as making a number of new strategic recommendations for improving health through the Council and its partners wider responsibilities. Background information on demographic need and more specific recommendations are available on the website http://www.barkinganddagenhamjsna.org.uk

2.2 The JHWS underpins a range of key documents for delivering the Council's vision and priorities as well as NHS Barking and Dagenham Clinical Commissioning Group's 5 year strategic plan:

- Joint Better Care Fund work programme
- Children & Young People's Plan
- Community Strategy 2013 -2016

3. Priorities

3.1 The Board agreed and prioritised the following for commissioning intentions at its meeting on 14th February 2014:

- Transformation of Health and Social Care
- Improving premature mortality
- Tackling obesity and increasing physical activity
- Improving Sexual and Reproductive Health
- Improving Child Health and Early Years
- Improving Community Safety

- Alcohol and Substance Misuse
- Improving Mental Health
- Reducing Injuries and Accidents.

3.2 These remain the priorities for improving population health and wellbeing. The refresh of the JHWS identifies areas where increased work and focus can support the delivery of outcomes.

4. Key strategic principles for drafting Barking and Dagenham joint health and wellbeing strategy

4.1 The Health and Wellbeing Strategy has strong links to national policies and strategies. In the local context the Health and Wellbeing Board will not seek to replicate the work of existing boards and strategies such as the Housing Strategy and Sport and Physical Activity Strategy. However, we will work with other boards, to ensure the achievement of our outcomes is supported across the whole partnership.

4.2 The Strategy will:

- Set out shared priorities based on evidence of greatest need that puts the emphasis on prevention and early intervention.
- Make health and wellbeing a personal agenda supported by borough based programmes and interventions.
- Set out a clear rationale for the locally agreed priorities and also what that means for the other needs identified in the JSNA and how they will be handled.
- Not try to solve everything, but take a strategic overview on how to address the key issues identified in the JSNA, including tackling the worst inequalities.
- Concentrate on an achievable amount with an outcomes focus – prioritisation is difficult but important to maximise resources and focus on issues where the greatest gains in health and wellbeing can be achieved.
- Address issues through joint working across the local systems and also describe what individual services will do to tackle priorities and give effective solutions to individual problems.
- Enable improved patient and service user engagement in the development of our Strategy and plans.
- Enable increased choice and control by residents who use services with independence, prevention and integration at the heart of how choices can be made

5. Outcomes

5.1 The key outcomes from the delivery of our Strategy in 2015 are to:

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

5.2 These are high level outcomes and under each of the four strategic themes we have established high level outcomes as well as specific annual measures linked to the key actions to be taken.

6. Strategic Themes

6.1 The Health and Wellbeing Board mapped the outcome frameworks for the NHS, Public Health, Adult Social Care and Children and Young People outcomes. We agreed, based on this, to establish four strategic themes that covered the breadth of the frameworks. We then mapped our priorities, outcomes and outcome measures across these four strategic themes:

- **Prevention:** Supporting local people to make lifestyle choices at an individual level which will positively improve the quality and length of their life and overall increase the health of the population.

- **Protection:** Protecting local people from threats to their health and wellbeing. These include:
  - Infectious disease
  - Deaths relating to extreme weather
  - Enablers to protect health include
  - Built environment and housing stock
  - Safeguarding individuals of all ages and identities from abuse, sexual exploitation, crime and ill treatment.

- **Improvement and Integration of Services:** Improving treatment and care by benchmarking against best practice and where we identify that care has failed. Exploring new and different ways of providing health and social care that is more accessible and person centered with particular emphasis on improving this for older people and disabled children.

- **Personalisation:** Ensuring that patients, service users and carers have control and choice over the shape of the care and support that they receive in all care settings.

7. Delivery plan

7.1 Underpinning the high level Strategy and its key actions will be a detailed delivery plans. The recommendation is that this needs to be developed within the governance arrangements for the Health and Wellbeing Board through the Board's sub groups.

8. Mandatory Implications

8.1 Joint Strategic Needs Assessment

This report is grounded on the most recent findings and recommendations of the JSNA.

8.2 Health and Wellbeing Strategy

The Strategy aligns well with the recommendations of the JSNA. The refreshed strategy will continue to serve the borough well as a means to tackle the health and wellbeing needs of local people, as identified in the JSNA.

8.3 Integration

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

8.4 Financial Implications

Financial implications completed by Roger Hampson, Group Manager Finance, Adults and Community Services, LBBD.

The Health and Wellbeing Strategy Delivery Plan and Outcomes Framework provide a focus for existing resources to be targeted at those key priorities that will have a significant impact on the health and wellbeing of residents of the borough. There are no new resources to support implementation.

The Council has agreed a two year budget for 2015/16 and 2016/16; it is likely that additional savings will need to be considered across both the Council and health in 2017/18; the level of resources available will need to be reflected in the annual review of the delivery plan.

With regard to the further integration of services with health and partnership working, this is likely to form part of the development of Better Care Fund planning arrangements beyond the current agreement for 2015/16. These arrangements are dependent on the outcome of the General Election, not known at the time of writing these comments.

8.5 Legal Implications

Legal implications completed by Dawn Pelle Adult Care Lawyer, Legal and Democratic Services, LBBD.

There are no legal implications as the joint Health and Wellbeing Strategy has been aligned with the variety of National Frameworks outlined in the Strategy Frameworks document and the provisions of the Health and Social Care Act 2012, Care Act 2014 and Children and Families Act 2014 has been extensively referred to.

8.6 Risk Management

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

9. Appendices

Appendix 1: Refreshed Joint Health and Wellbeing Strategy 2015-18

London Borough of Barking & Dagenham
lbbd.gov.uk

DRAFT Joint Health and Wellbeing Strategy 2015-18

Author:			Owner:	Approving body:
Matthew Cole Director of Public Health			Matthew Cole	Health and Wellbeing Board
Date:	**Version:**	**Amended by:**	**Change / Reason for Change:**	**Approval status:**
02/04/15	V2	Matthew Cole	First cut – working draft	
24/04/15	V3	Matthew Cole	Included comments from the engagement and support statements from partners	
29/04/15	V3	Matthew Cole	Comments incorporated from Portfolio Holder meeting	
30/04/15	V3	Matthew Cole	Residents info pages added	

Contents

Foreword

Everyone in the borough has a right to good health. The Council have recently agreed a new vision **'One borough; one community; London's growth opportunity'** and our Strategy seeks to make this a reality**.** Residents who feel they belong to and can contribute to their community tend to enjoy better health than people who feel lonely or isolated. There are lots of things that the Council and our partners can, and do, to help make our borough a healthier one in which to live and work.

This 2015 refresh of Barking and Dagenham's Joint Health and Wellbeing Strategy outlines our top priorities for improving the health and wellbeing of all the people who live and work in the borough. The refresh coincides with Barking and Dagenham 50th anniversary of becoming one borough. It will be another defining point in our borough's history and brings with it a once in a generation opportunity to radically transform the relationship between our residents and the Council as well as between patients and the NHS.

This refresh is in response to the changing health and social care needs of the population, as described by the Joint Strategic Needs Assessment 2014. We want this Strategy to give all those who work to improve health and wellbeing and reduce inequalities the focus that will drive the significant improvements needed to achieve the outcomes we seek. It is intended to provide a framework and direction to review commissioning and service delivery planning in order to make the biggest difference over the next few years.

The London Borough of Barking and Dagenham's Health and Wellbeing Board brings together those who buy services across the NHS, public health, social care and children's services, with elected councillors and Healthwatch, to jointly consider local needs and plan the right services for our population. This Strategy will enable the Board and partner organisations to account for how their actions will progress our Joint Health and Wellbeing Strategy. The Board have also carefully considered what local people have said about what health means to them and where their priorities lie. We will keep talking to local groups and individuals about the issues so our Strategy stays relevant and ambitious for our borough.

We will keep this Strategy under review and assess the effectiveness of the overall framework, as well as the continuing relevance of the priorities, as new information, evidence and policies emerge. Progress is regularly reported to the Health and Wellbeing Board.

Councillor Maureen Worby
Chair, Health and Wellbeing Board

What does this strategy mean for you?

You may be reading this as a resident, the owner of a borough-based business or someone who works in Barking and Dagenham. Whoever you are, this strategy means good news for you!

The next three pages illustrate the highlights of what we're doing and how it will impact on you. In our programme to grow the borough we will include measures to make the healthier choice the easer choice. In order to do this we have broken down the messages into three broad stages of life:

- **Starting well** — **We feel that getting off the starting blocks is absolutely essential in improving health and wellbeing. This starts with establishing healthy habits in pregnancy and with our children.**
- **Living well** — **This is a marathon, not a sprint and we intend to make it easier for adults to maintain healthy habits**
- **Ageing well** — **As we approach the finishing line we feel that enabling you to live independently and healthier for longer and making the most of older age is vital for your wellbeing**

Who are We?

When we say 'we' we're including all of the partners on the Health and Wellbeing Board and the many agencies and organisations who provide services in the borough. Many of them are commissioned by Health and Wellbeing Board partners. We're also including anyone who participates in developing and maintaining their own health and wellbeing…. that means you!

Starting well: Establishing healthy habits in pregnancy and with our children

We start working with you for your child's health while you're still planning to become pregnant! This life stage covers you and your child during pregnancy, and includes children and young people up to 18 years old.

Your life:

- Supported pregnancy, delivery and breastfeeding
- Healthier children with a better outlook for developing, learning and achieving
- Children and young people able to make their own healthier choices

What we can do:

- We will support you to have a healthy pregnancy and give your child the best start in life
- Our children's centres and schools will support you in keeping your child healthy and safe
- Our services will be there to advise young people on how to cope with the stress of modern living and peer pressures
- We will safeguard individuals of all ages from abuse, sexual exploitation, crime and ill treatment.
- We will continue to improve our services to ensure you get the right service at the right time in the right place

What you can do:

- Make sure your child has been immunised to protect them and others from disease
- Be vigilant and act on the signs and symptoms of disease – Spot disease and illness early and see your GP
- Make the lifestyle changes now for you and your family that will improve and maintain good health
- Find out about them and use them! We provide a range of services to help you and your family maintain good health from exercise and diet programmes, sexual health and drug services, cooking skills to learning opportunities.
- Help us to stamp out abuse, sexual exploitation, crime and ill treatment and make this borough a safer place
- Make sure your child visits the dentist for regular check-ups and get regular eyesight tests – They are free
- Encourage your child to eat well and move more

Living well: Making it easier for adults to maintain healthy habits

We want to make healthy choices the easiest choice for everyone.

Your life:

- Easy access to free and low cost resources for self care and maintenance
- Alert to any health issues and able to deal with them
- Well informed and empowered
- Living a healthier, longer, more fulfilling life

What we can do:

We will ensure that our services support you to make the smallest changes that will have a huge impact on your health – so we're working to help you help yourself.

What you can do:

- If you receive an invitation from us for bowel/breast or cervical cancer screening or your NHS Health Check. Take it up – its free
- Take on disease be vigilant and act on the signs and symptoms – Spot disease and illness early and act quickly
- If you are invited to have a free seasonal flu injection – Have the jab
- Find out and use them! We provide a range of services to help you and your family maintain good health from exercise and diet programmes, sexual health and drug services, benefits advice to learning opportunities.
- Make sure you visit your dentist once a year and get your eye sight examined every two years
- Sleep well, live longer

Ageing Well: Living healthier for longer and making the most of older age

Helping you to live independently and maintain good health for longer is vital for ageing well. Even if you suffer from long term illness you can still enjoy a good quality of life.

Your life:

- Easy access to care and support
- Early diagnosis of health issues
- Well supported carers
- Prepared for a healthier, longer, more fulfilling older age

What we will do;

- Support those who are caring for people living with dementia
- Support investment in housing, leisure, business and public spaces to enhance your wellbeing
- Provide regular check-ups to ensure you age well
- We will safeguard individuals of all ages from abuse, sexual exploitation, crime and ill treatment.
- We will continue to improve our services to ensure you get the right service at the right time in the right place

What you can do;

- Be vigilant and act on the signs and symptoms of disease – Spot disease and illness early and see your GP
- If you are invited to have a free seasonal flu injection – Have the jab
- Find out and use the extensive range of services from our Active Age centres to our parks and befriending service to keep you independent, healthy and safe
- Make sure you visit your dentist once a year and get your eye sight examined every two years
- Sleep well, live longer

Our Partners

Dr Waseem Mohi
Chair

Conor Burke
Accountable Officer

NHS BARKING AND DAGENHAM CLINICAL COMMISSIONING GROUP: Barking and Dagenham clinical commissioning group (CCG) is committed to improving the health and wellbeing of our patients and residents. As a local GP membership organisation we are acutely aware that this isn't something we can do alone. Working more closely with our partners across health and social care locally and further afield as appropriate, is the only way we will tackle some of the health issue we face here in Barking and Dagenham.

Together with our partners in the local authority, voluntary sector and acute and community and mental health provider organisations, we know that the considerable challenges we face in our health economy demand a system approach to be tackled effectively.

We are a young organisation, but we have already demonstrated our desire and focus to bring about real change and real improvements to the quality of services and the care that local people are receiving. We are enthusiastic members of the Health and Wellbeing Board and see this strategy as a crucial document to help further integrate services and to help us make the best use of the resources available to us.

The priorities identified in this strategy are familiar to all of us. Whether that's a focus on early years, older adults or our most vulnerable groups of residents – we are committed to work in partnership to improve health outcomes for the people we see every single day in our surgeries across Barking and Dagenham. We are delighted to support this strategy document and its priorities to make a real difference for all of our residents.

Our Partners

HEALTHWATCH: Barking and Dagenham has been engaged as a partner in producing the Health and Wellbeing Strategy and welcome the plans to improve the health and wellbeing of those who live in Barking and Dagenham. Through Healthwatch's consultation with borough residents, concerns have been raised by people regarding the many health challenges the borough faces, including lower than average life expectancy and high death rates from heart disease, circulatory diseases and cancer. This is in contrast to our two neighbouring boroughs who share the same acute services.

Healthwatch are aware of the challenges the Health and Wellbeing Board partnership faces in working towards reducing the causes of ill health including smoking, alcohol, low exercise uptake and obesity. This is alongside social and economic deprivation, high unemployment, low incomes, poor housing and other factors which limit opportunities and aspirations. There are also concerns regarding the pressure on services that our changing demographics are having both now and in the future. Healthwatch has worked hard to raise the profile of public opinion and are pleased to see it reflected in this document. We are confident that the strong partnership of the Health and Wellbeing Board will rise to the challenges of local needs and be effective in improving the health and wellbeing of all residents.

Frances Carroll
Chair, Healthwatch

Dr Henrietta Hughes
Medical Director London North Central & East London

NHS ENGLAND: The main aim of NHS England is to improve the health outcomes for people in England. We empower and support clinical leaders at every level of the NHS through clinical commissioning groups (CCGs), networks and senates, in NHS England itself and in providers, helping them to make genuinely informed decisions, spend the taxpayers' money wisely and provide high quality services. As members of the Health and Wellbeing Board, we are committed to working with partners to achieve the vision for making a real difference to the quality and standard of local services. This comprehensive document identifies some key priorities for local services and ensuring equity of access based on local need. The Health and Wellbeing Strategy is an important vehicle that will guide the development of integrated services across health and social care, making the best use of resources for the benefit of local people.

Our Partners

NORTH EAST LONDON FOUNDATION TRUST: I am delighted to endorse the Barking and Dagenham Joint Health and Wellbeing Strategy.

The strategy sets out the framework for achieving the goal of better health and wellbeing in Barking and Dagenham, with a particular emphasis on those who need support most. Being healthy is not just an absence of illness or disability. Health and wellbeing are broad concepts which take a much wider view of what affects a person's quality of life. A feeling of 'wellness' therefore includes all aspects of physical, mental and social wellbeing.

The Health and Wellbeing Strategy includes actions for improving health both within and outside of NHS services, and promoting better integration of services based around people's needs rather than traditional organisational boundaries. The actions in this Strategy are ambitious and challenging. The successful implementation of the Strategy will depend on close working between local public, voluntary and community organisations. This strategy is all about partnership and working together.

With this in mind NELFT staff will be working with others to encourage and support local people to make healthier choices in their lives, to deliver more integrated and accessible health and social care services and to improve the conditions that people in Barking and Dagenham live and work in.

Jacquie Van Rossum
Executive Director Integrated Care London & Transformation

Dr Nadeem Mogal
Medical Director

BARKING HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST: Working with our partners to improve the health of our population is an essential part of our work at Barking, Havering and Redbridge University Hospitals NHS Trust. I am fully supportive of this Strategy; its priority themes mirror our own.

With a growing population it is essential that we look at ways of keeping our community healthy, and provide health and social care in a way that is accessible to all. Improving the links between hospital and social care has already had enormous benefits to patients, with people supported and able to stay in their own homes whenever possible.

The implementation of this Strategy will build on that work, and strengthen the partnerships already in place to benefit our patients, service users and carers. I am particularly pleased that work will continue to encourage people to stop smoking. London Borough of Barking and Dagenham are invaluable in our work to stamp out smoking on our hospital sites, offering tireless support to make our Trust smoke free.

Our Partners

METROPOLITAN POLICE: Being a member of the Health and Wellbeing Board adds value to the local police priorities in the following ways. As a member it enables the police to influence and shape the Strategy to actively work in partnership to improve the community safety and quality of life of our residents. There are many areas whereby the health and well being of our community affect the demand on policing and also presents many opportunities where the police can work more with closely with partners to support, prevent and resolve issues whilst improving health and well being. For example where police come across vulnerable members of our community by us having an awareness of the support available through our partnership, individuals can be quickly referred to our partners to receive the support. From a proactive perspective the police can access service providers through referral systems to prevent individuals entering the criminal justice system and receive the necessary support for example people suffering mental health, substance misuse. By working in partnership there are many areas that add value to our policing priorities such as safeguarding vulnerable adults and children, and also child exploitation issues. By collaboration and working in partnership, policing improves the quality of life for our community.

The police support partners to improve residents health and well being, by firstly giving support to individuals and referring to the service providers, this applies to people who come to notice in the community and also those who are brought into custody for the safety and well being as well as those who have committed offences. The local police are involved in many community engagement activities and by working in partnership with health professionals our community can be made more aware of the help and support they can receive from service providers. The police can support partners by sharing information and develop plans to help protect vulnerable people in our community.

Sultan Taylor
Borough Commander

Introduction

In Barking and Dagenham our residents are not as healthy as they should be. Compared to other parts of the country they don't live as long, with many dying earlier from cancer or heart disease. Our Strategy sets out a vision for improving the health and wellbeing of residents and reducing inequalities at every stage of people's lives by 2018. It aims to help residents improve their health by identifying the key priorities based on the evidence in our Joint Strategic Needs Assessment (JSNA), what can be done to address them and what outcomes are intended to be achieved. These priorities will then underpin commissioning plans and other agreements to undertake the actions together, in order to make the greatest impact across the health and social care system and wider Council responsibilities. It also sets out how we will work together to deliver the agreed priorities within a tighter financial framework. However we need to ensure there are support mechanisms to enable our residents to live more independently, whilst still offering a safety net of support for our most vulnerable.

Through better integration of service planning and improvements in the quality and accessibility service provision, we will continue to build on the resilience in local communities by supporting active citizens, local assets and neighbourhood networks. The Board will continue its determination to capitalise on the opportunity to connect prevention and regeneration to help create a place that supports well-being thereby encouraging residents to make informed choices for a healthy lifestyle and behaviours which improve their own health. This will be realised through bringing together services across the partners, beyond health and social care, to health-related services such as leisure, housing, active age centres and children's centres. It will also consider how the commissioning of these can be joined up with commissioning of health and social care services toimprove the health and wellbeing of residents. The Strategy and JSNA inform the London Health Commission and the NHS England (London) plans and strategies.

It is important that we maintain the key policy driver that "no decision about me, without me". Our Strategy is supported by a detailed delivery plan which provides more specific goals, actions and expected achievements to meet the outcomes. The delivery plan and outcomes are separate documents and accompanies this Strategy.

The Care Act 2014 is the most comprehensive overhaul of social care since 1948, it consolidates and modernises all social care law into a single framework. As well as consolidating the legislation, the Care Act brings social care law into the 21st Century. The Act enshrines in legislation and statutory guidance modern adult social care policy and practice. There is a new focus and direction for social care which centres on prevention, wellbeing, and personalisation.

The Care Act became operational on 1 April 2015. It is therefore a key driver in developing the refresh of the Health and Wellbeing Strategy. The elements of wellbeing and prevention within the Act require a specific response. This takes the form of a locally agreed approach to promoting wellbeing and developing prevention which is a distinct piece of work that is referenced at relevant points in this document.

Our population and its health challenges

The JSNA 2014 draws out the important challenges to our residents' health and can be characterised under the following two key headings 1) Population growth and changes in our local population and 2) Income poverty and employment.

Income poverty and employment result in reduced wellbeing by numerous mechanisms which we also address. These are fuel poverty, excess winter deaths and access to services and many more, including high levels of lifestyle risk linked to smoking, obesity and physical inactivity. The population of the borough has both comparatively high rates of chronic disease and as a consequence high death rates from these diseases, especially heart disease, cancer and chronic lung disease. Additional health and social care needs remain, for example mental health challenges, safeguarding, domestic violence and dementia.

1. Population growth and changes in our local population

There have been significant changes to the demographics of the population in the last decade, most noticeably an increase in the numbers of people living in the borough, a very high birth rate and increase in proportion of the population from black and minority ethnic (BME) communities.

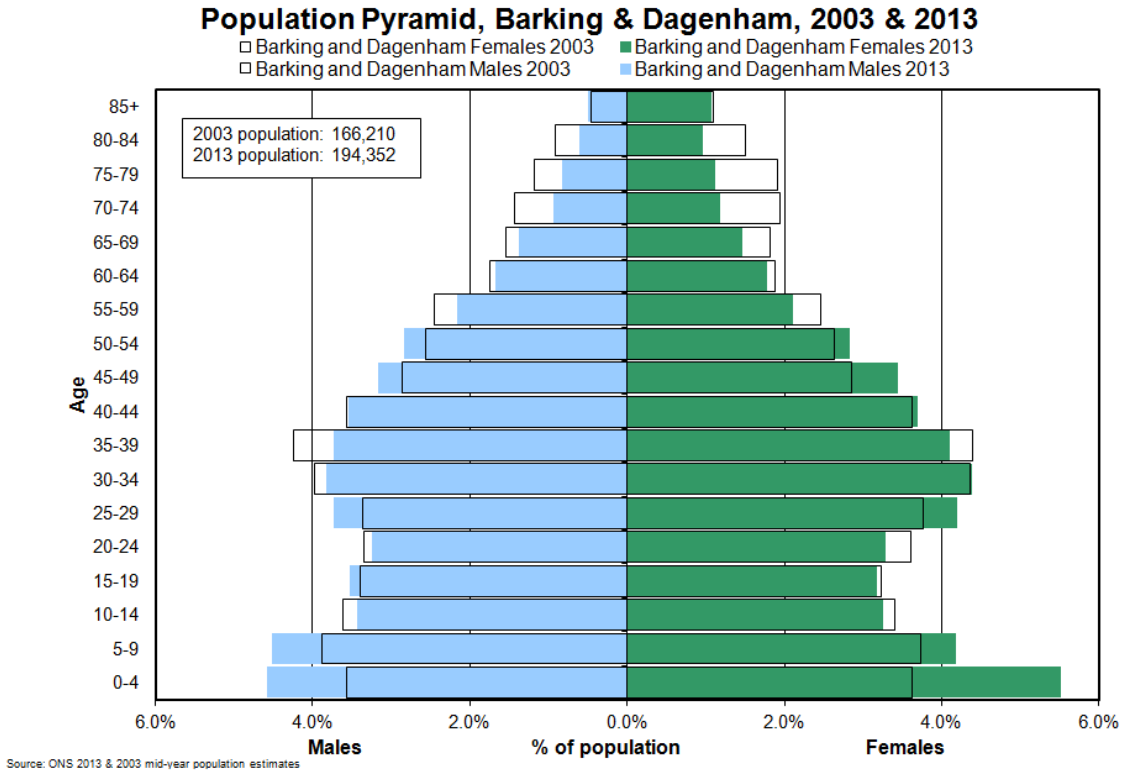
1.1. Population growth

The borough's population is growing at a faster pace than in London and England. The growth rate in the borough is 16.6 per cent and has gone up more than twice that of England's, 8 percent, between 2003 and 2013. Growth is also ahead of that for London which is again 8 per cent.

1.2 High birth rate

Across the age groups, significant increases were in the children population aged 0-4 with figures up by almost 50 per cent, followed by adult working population, 16- 64, especially the younger age groups in this category. In contrast figures were down 14.8% per cent in the 65+ population, compared to London and England which were all up 8.1% and 17.4% respectively. Figure 1 shows the population pyramid for Barking and Dagenham. It should be noted that Barking and Dagenham has a wide base to its population pyramid, which is more typical of a developing country characterised by a high fertility rate. In Barking and Dagenham the older population is expected to decline until at least 2025 when it is projected to start increasing again. This is in stark contrast with the rest of the nation which is experiencing a steady increase in the number of people aged 65 and over. Possible explanations include poor life expectancy and people moving out of the borough as they become older and / or increase their earnings. This movement is known as population 'churn'.

Figure 1: Population pyramid for Barking and Dagenham based on the mid-year estimate (MYE) from the Office for National Statistics.



1.3 Increased proportion of population from BME communities

The population make up has changed significantly with increases in the proportion of the population who are from black and minority ethnic backgrounds such as Nigeria and Pakistan and also from eastern European countries such as Lithuania Proportion of BME groups in the borough is projected to increase by 27.3 per cent between the 2011 census and 2015. In 2016 the BME population will make up 51 per cent of the borough's population. This is projected to keep on rising: by 2020, the BME population is estimated to have increased by 58 per cent.

2. Income poverty and employment through improved life expectancy and health and social care outcomes

This Joint Health and Wellbeing Strategy and the actions and outcomes which are needed to address the priorities for improving the health and wellbeing of local people are based on priorities. These priorities are based on the needs identified in the Joint Strategic Needs Assessment and the national and local priorities identified in the various outcome frameworks (Public Health, Adult Social Care, NHS and the Children and Young People's).

The outcomes contained within the strategy are:

- To increase the life expectancy of people living in Barking and Dagenham;
- To close the gap between the life expectancy in Barking and Dagenham with the London average;
- To improve health and social care outcomes through integrated services.

Three particular challenges continue to dominate our thinking:

(i) The first is the burden of ill health demonstrated by the significant numbers of our population in poor health and the high premature mortality rates especially from coronary heart disease, stroke, cancers and respiratory disease.

(ii) The second is to continue the essential development and investment in primary care provision to deliver the "better care outside the hospital" agenda, without which our hospital services are unsustainable.

(iii) The third is to take account of our rapidly changing population in our commissioning strategies and delivery plans, so that services keep pace with changing needs and numbers.

2.1 Deaths in people under 75 years old

Addressing these three challenges is critical to delivering enhanced life expectancy from birth for our residents. Currently more than half (56.7%) of all deaths under 75 in Barking and Dagenham were from conditions considered amenable to healthcare. Nearly 2200 potential years of life per 100,000 registered patients are being lost through such causes. There is likely to have been economic loss because of sickness absence, inability to work, carer needs and loss of family income. There are also disproportionately high health and social care costs associated with premature chronic disease and disability.

2.2 Premature illness and dependency

People with premature illness and dependency will add need and therefore costs to our commissioned health and social care services and this need may not be fully reimbursed in a simple age-related funding formula. There are opportunities to address this. Firstly, all services (health and social care) need to consider prevention as an essential part of their service delivery model, and secondly, the Board strongly advocated for partners to collaborate more on prevention. The cost of care for adults will continue to rise disproportionately whilst prevention is currently suboptimum. The partners have already started to address these opportunities by including, in the Better Care Fund, a stronger focus on prevention and making integration work effectively for less dependent residents.

2.3 Mental Wellbeing

Whilst two of the three outcomes of our Joint Health and Wellbeing Strategy focused on life expectancy, mental wellbeing is often omitted from consideration and recent policy directives have demanded parity of esteem with physical health. Cancer, CVD and respiratory disease are all associated with a higher risk of depression and people with poor mental health have below average physical health and higher rates of the diseases associated with premature mortality.

2.4 Prevention

In considering our prevention responsibilities, we have to take account not only of the need to influence lifestyles amongst children, young people and adults, but also what actions could prevent the breakdown of people's ability to live independently and precipitate the need for some form of institutionalised care, whether in hospital or a nursing home. For Barking and Dagenham the focus for investment to improve outcomes needs to focus on early years and those of old age as well as those who are in the later stages of long term conditions.

Section 2 of the Care Act 2014 requires that a local authority must provide or arrange for services, facilities or resources which would prevent, delay or reduce individuals' needs for care and support, or the needs for support of carers. Local authorities should develop a clear, local approach to prevention which sets out how they plan to fulfil this responsibility, taking into account the different types and focus of preventative support.

Under the umbrella of the Health and Wellbeing Strategy sits the partnership's agreed approach to prevention which has been developed directly in response to the requirements of the Care Act.

2.5 Social care demand

In respect of demand for child social care the impact of domestic violence on referrals is significant. Programmes to address domestic violence will play an important role in helping to manage demand for child social care. Child Sexual Exploitation is a key issue for all commissioners and providers to address following Government directives following the Rotherham case.

The demand for adult social care services continues to increase, even though the numbers of older people, who are the largest client group, are reducing. Increasingly services users are choosing self-directed support, through the provision of direct payments for their care, supported by a Personal Assistant. With the introduction of the Care Act reforms in April 2015, which will change eligibility, carers' entitlements and self-funding arrangements, predictions about future demand for services arranged by the Council are hard to make although partners have reduced the cost of social care since 2012/13 while maintaining quality[1].

[1] *Ref: Rees. M. et. al., 2014, "Adult Social Care: Understanding Demand in the (Older) Population of Barking and Dagenham", final report.*

2.6 Risk factors across the life course

After smoking, physical inactivity, excessive alcohol consumption and obesity are the most important risk factors for us to focus on. Physical activity has benefits independent of weight loss. It increases life expectancy, decreases blood pressure and blood sugar and improves mental health. Likewise, adoption of a healthy diet including prolonged breast feeding followed by high amounts of fruit and vegetables has the potential to decrease population death rates by around 5%. The Health and Wellbeing Board has prioritised obesity as its most important prevention priority.

2.7 Early detection and improved management of long term conditions

The key focus to improving life expectancy is addressing raised blood pressure and the cardiovascular disease risk factors that can be detected and treated as risk conditions in their own right or can be partially tackled from their composite parts e.g. losing weight, increasing exercise and improving the diet. Early detection and optimal management of high blood pressure remains one of the most important healthcare interventions.

2.8 Safe and effective maternity services

Maintain a safe and effective maternity service is essential. This is achieved Implementation of the revised antenatal and screening programme. In particular, programmes to reduce smoking prevalence and uptake of breast feeding.

Principles of our Strategy

Our joint Health and Wellbeing Strategy has strong links to national policies and strategies. In the local context the Health and Wellbeing Board will not seek to replicate the work of existing boards and strategists such as the Housing Strategy and Sport and Physical Activity Strategy. However, we will work across all partner agencies and through staff at all levels of the organisations, to ensure the achievement of our outcomes is supported across the whole partnership.

This is a key principle as outlined in the 2014 Annual Report of the Director of Public Health that suggests that for the new prevention agenda to delivery we need to grow and strengthen our communities, building on the energy and compassion that exists within them. While individuals could take on more responsibility for improving and maintaining their own health, it is easier to do this in a society, where all the elements of that society combine in a supportive manner to promote health.

To further support this, we have incorporated the work of Sir Michael Marmot and his published review into health inequalities in England as well as the NHS Five Year Forward View and the London Health Commission's Better Health for London. The Board's key task is to deliver an innovate approach tailored to local needs that tackles the diseases and consequences of modern living, as well as strives to raise standards of care and addresses health inequalities. Growth and regeneration provide an opportunity by developing and using our community assets, strengthening partnership between those who deliver and those who benefit from our services, and looking beyond needs and treatments to a healthy and prosperous community where residents and business contribute as well as gain.

People from higher socio-economic backgrounds have more opportunities to lead a fuller life with better health than those from less affluent backgrounds. Inequalities in health can be seen from birth, with children from poorer socio-economic backgrounds showing poorer cognitive development from a very early age, when compared with children from more affluent areas. In line with Marmot's recommendations we cover the resident population across the life courses from pre birth to end of life; and take account of the needs of residents in the most vulnerable circumstances and excluded groups. We have decided that the life course, in the local context, can be divided into the following categories in Figure 2. These are not typical age ranges but work in our context as for example, we find a significant number of our middle aged adults, because of chronic disease, as frail as our over 70's.

Insert figure 2 from original strategy that illustrates our life course approach

Working with our stakeholders

The Board recognises that no individual agency can overcome the challenges facing the borough and its residents, but by working together and building on the resources from individuals' doorsteps to the Town Hall; we can work collectively to make the changes needed to give our residents the best opportunity for a healthy, happy and longer life.

The assets we have to draw on in Barking and Dagenham include:

- Children's Centres
- 41 Primary Schools
- 8 secondary schools plus one outstanding special schools and two further education colleges
- 41 general practices
- 22 dental practices (including community dental service).
- 36 pharmacies employing 70 pharmacists, 50 pharmacy technicians and 120 healthcare assistants.
- 17 Optometrists.
- Housing associations
- Barking Learning Centre, active age centres and 25 parks and open spaces.
- Over 500 voluntary and community groups and 65 sports clubs,

We will in this Strategy improve health and wellbeing through all stages of life to:

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

Within this broad vision, the Health and Wellbeing Board has identified some key principals. These are:

- To set out shared priorities based on evidence of greatest need that puts the emphasis on prevention and early intervention.
- To make health and wellbeing a personal agenda supported by borough based programmes and interventions.
- To set out a clear rationale for the locally agreed priorities and also what that means for the other needs identified in the JSNA and how they will be handled.
- Not to try to solve everything, but take a strategic overview on how to address the key issues identified in the JSNA, including tackling the worst inequalities.
- To concentrate on an achievable amount with an outcomes focus – prioritisation is difficult but important to maximise resources and focus on issues where the greatest gains in health and wellbeing can be achieved.
- To address issues through joint working across the local systems and also describe what individual services will do to tackle priorities and give effective solutions to individual problems.
- To enable improved patient and service user engagement in the development of our Strategy and plans.
- To enable increased choice and control by residents who use services with independence, prevention and integration at the heart of how choices can be made.

National and regional context

The Children and Families Act 2014 & Working Together 2015	The Care Act 2014
The Children and Families Act sets out a swathe of changes to be implemented from September 2014. In particular for local authorities, the Act: • Introduces a single assessment process and an Education, Health and Care (EHC) Plan to support children, young people and their families from birth to 25 years. EHC Plans replace 'statements of educational needs'. • Requires health services and local authorities to jointly commission and plan services for children, young people and families. • States those local authorities must publish a clear, easy-to-read 'local offer' of services available to children and families. Our Local Offer can be found here: http://www.lbbd.gov.uk/ChildrenAndYoungPeople/SEN/Pages/Home.aspx as it does now; the Council is working with young people and their families and carers, to prepare children and young people for adulthood and set out arrangements for transition to adulthood, particularly where young people will be eligible for Adult Social Care support. It is thought that there will be some cross-over with the requirements of the Care Act and this is currently being worked through. It should be noted that this Autism Strategy focuses on adults over the age of 18, but it does have a section on 'transitions'.	Throughout 2014/15 the Council has been preparing for the implementation of the Care Act 2014, which received Royal Assent in May 2014. The Act promotes integration with the NHS in the delivery of care and support services and strengthens procedures for the safeguarding of vulnerable adults. It will be a significant area of the Council's work for the coming years, with major dates for implementation on 1 April 2015 and 1 April 2016. To implement the Care Act 2014 and meet its statutory obligations the Council must develop a clear approach to prevention and how it plans to meet its responsibility in this regard. This model is heavily influenced by the Council's priority to enable social responsibility. It uses the Care Act guidance on the 'wellbeing principle' placing the individual at the centre and starting point for judging their wellbeing and taking responsibility, using their strengths and personal resources, to maintain wellbeing. The person is then encouraged to seek support from the community before intervention from the Council and partners to meet needs and put in place preventative support. A distinct policy document has been developed that outlines our approach to prevention and demonstrates alignment with the wider local wellbeing and prevention agenda and the priorities of this Strategy.

London Health Commission	The Francis Report
Better Health for London, the report of the London Health Commission, an independent inquiry established by the Mayor of London and chaired by Professor the Lord Darzi of Denham, drew on the views of many Londoners to propose the biggest public health drive in the world. The report makes 64 recommendations which are intended to support the Commission's aspirations for London: • Give all London's children a healthy, happy start to life • Get London fitter with better food, more exercise and healthier living • Make work a healthy place to be in London • Help Londoners to kick unhealthy habits • Care for the most mentally ill in London so they live longer, healthier lives • Enable Londoners to do more to look after themselves • Ensure that every Londoner is able to see a GP when they need to and at a time that suits them.	The Public Inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of the Mid Staffordshire NHS Foundation Trust was published on 6 February 2013. It was followed by the Governments response on 26 March 2013, which sets out how the quality of patient care is to be put at the heart of the NHS. Both will have far-reaching implications for the care and support system, not just the NHS. This Inquiry and earlier well documented systems failings in institutional care settings (such as hospitals or care homes) or community settings (including people's own homes) demonstrate that when individual children or adults are not adequately safeguarded or their quality of care is poor the consequences are both significant and far reaching. It is clear the role of local organisations is very much around ensuring that patients and the public are safeguarded and that poor care is prevented in the first place.
Public Health England	**The NHS Five Year Forward View**
October 2014 saw the publication of the document by Public Health England (PHE*) 'From Evidence to Action: opportunities to protect and improve the nation's health'*[2]. In this document Public Health England publishes 7 priorities for the next 5 years, having looked closely at the evidence to determine where it can most effectively focus its efforts. The document acknowledges that our health is shaped by where and how we live: by our jobs, families, homes; but also recognises the power of individuals to change their lifestyles, especially if they get the right support at the right time.	The NHS Five Year Forward View was published in October 2014 by NHS England, promising a radical upgrade in prevention and public health, greater control for patients and new support for carers, breaking down of the barriers in how care is provided and radical new care delivery options.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366852/PHE_Priorities.pdf

The challenges ahead

The borough faces a series of challenges from national and regional policy decisions outside the control of the local partnership, these include:

- Changes to the welfare and benefits system will negatively impact on the majority of households in the borough.
- Demographic challenge and changing communities up to 2020.
- Evidencing quality improvement and rebuilding public confidence in Barking, Havering and Redbridge University Hospitals NHS Trust following the Care Quality Commission interventions.
- Economic recession and the impact of the Government's economic policy on the public sector finances.
- Tackling child sexual exploitation to improve the protection of vulnerable children.
- Transforming care in London through new models of delivery that contain cost and manage demand on the health and social care system, the role of early detection of disease is critical.
- Increasing the social productivity of public services and new forms of community regeneration to help individuals and communities to make positive change.
- Influencing national and London policies and investment decisions to support growing the borough and its distinctive housing market.
- Commissioning an integrated approach to early years from fragmented services that can miss the wider factors influencing a child's development, to a "whole child" and "whole family" approach.
- Supporting the best possible educational outcomes for children and young people is central to the Council's vision and priorities.

Local strategies/plans

Policies and Strategies	Summary
Children and Young People's Plan	Sets out how the Children's Trust will improve outcomes for all children and young people.
Housing Strategy 2012-2017	Sets out our vision for housing in the area from 2012 to 2017 and identifies how we will work with our partners to improve all housing in the borough.
Barking & Dagenham's Core Strategy (2010) and Borough Wide Development Policies Development Plan (2011)	Sets out the need to improve the health and wellbeing of local residents. It aims to reduce health inequalities by ensuring good access to high quality sports and recreation opportunities and health care provision. Requires new schemes to address the health impacts of development.
Pharmaceutical Needs Assessment for Barking and Dagenham 2015-18	Provides an assessment of the local need for pharmaceutical services
Sports and Physical Activity Strategy	Sets out the borough's approach to increasing sport and physical activity.
Carers Strategy 2015-2018	Sets out the outcomes for improving support to carers and the critical role that they play in supporting people to remain healthy and independent for as long as possible.
Information and Advice Plan for Adult Social Care and Support 2015-18	Sets out the strategic approach to meeting the requirements of the Care Act 2014 in relation to providing information and advice locally.
Growth Strategy 2013-2023	Sets out how the Council will deliver growth to improve the local economy and make the borough a more sustainable and resilient place.
Barking and Dagenham Community Safety Partnership Strategic Assessment of Crime and Community Safety Partnership Plan	Sets out actions to reduce crime and disorder, antisocial behaviour and other behaviour affecting the local environment, as well as reducing the misuse of drugs, alcohol and other substances, reduce the fear of crime and increase public confidence.
Education Strategy 2014-2017	The Council's two overarching objectives for education are for all our children and young people to have a place in a good or outstanding school or early years setting and for them to have the best possible life opportunities by the time that they leave school with reaching national and then London averages as the benchmark.
Barking, Havering and Redbridge Integrated Care Coalition 5 Year Strategic Plan 2014/15 – 2018/19	Sets out how we will work collaboratively across the Barking Havering and Redbridge in order to achieve our shared vision, deliver improved outcomes and patient experience, ensure a financially sustainable system, and meet the expectations of patients and the public.

Policies and Strategies	Summary
Safeguarding Adults Board Strategy	Sets out the strategic framework for the borough to ensure that adults at risk in our community live lives free from abuse and neglect.
Inclusive Framework Strategy for Children and Young People with Special Educational Needs and/or Disabilities	Sets out our shared vision, principles and priorities to ensure inclusive practice in providing for children and young people with Special Educational Needs and Disabilities.
Troubled Families Programme	Outlines our approach to working with troubled families and the outcomes we are looking to achieve.
Barking and Dagenham Safeguarding Children's Board Annual Report	This sets out thee priorities for safeguarding children
Primary Care Transformation Programme (Prime Minister's Challenge Fund)	The programme focuses on achieving excellence in general practice through improvements in quality and accessibility of services and the experience of patients using services.
Promoting Wellbeing and Developing Prevention	This document sets out the approach of the London Borough of Barking and Dagenham to the requirements in the Care Act 2014 to be clear about wellbeing and prevention.
The Council's Corporate Plan	This sets out the Council's overall aspirations for the borough under the heading 'One borough; One community; London's growth opportunity'; one of the three key priorities is enabling social responsibility through which the Council aims to protect the most vulnerable while supporting residents to take responsibility for themselves and their families.
Better Care Fund	Health and social care services have agreed ambitious plans to prevent people going into hospital unnecessarily.

Outcomes

The outcomes we want to achieve for our joint Health and Wellbeing Strategy are:

- To increase the life expectancy of people living in Barking and Dagenham.
- To close the gap between the life expectancy in Barking and Dagenham with the London average.
- To improve health and social care outcomes through integrated services.

Our vision and outcomes can only be achieved through a change in the way we do things in Barking and Dagenham. This will involve change for residents by taking on more responsibility for their own health and wellbeing supported by those planning and delivering local services. So what will this mean for local residents if we achieve these outcomes?

Residents are supported to make informed choices about their health and wellbeing to take up opportunities for self help in changing lifestyles such as giving up smoking and maintaining a healthy weight. This also involves fostering a sense of independence rather than dependence.	Service providers have and use person centred skills across their services that makes every contact with a health professional count to improve health.
Every resident experiences a seamless service.	Services support individuals to make choices about their health and care to help them reach their potential
Long term action with our more disadvantaged groups and communities will overcome generational poverty.	Bringing health and social care planning and service provision together will enable less costly interventions with better outcomes in the long term.
Children having the best possible start in life from conception so breaking the link between early disadvantage and poor outcomes throughout life.	More older people feel healthy, active and included.
Being able to take part in the design and delivery of services that are suitable for their needs.	Threats to public health are minimised and dealt with speedily.
Having a decent home that is warm and meets their needs.	Early diagnosis and increased awareness of signs and symptoms of disease will enable residents to live their lives confidently, in better health for longer.

Priority themes

The Health and Wellbeing Board mapped the outcome frameworks for the NHS, Public Health, Adult Social Care and Children and Young People. We agreed, based on this, to establish four priority themes that covered the breadth of the frameworks. We then mapped our priorities, outcomes and outcome measures across these four strategic themes:

Care and Support	Protection and Safeguarding
Ensuring that patients, service users and carers have control and choice over the shape of the care and support that they receive in all care settings.	Protecting local people from threats to their health and wellbeing. These include: ■ Infectious disease ■ Deaths relating to extreme weather Enablers to protect health include: ■ Built environment and housing stock Safeguarding individuals of all ages and identities from abuse, sexual exploitation, crime and ill treatment.
Improvement and Integration of Services	**Prevention**
Improving treatment and care by benchmarking against best practice and where we identify that care has failed. Exploring new and different ways of providing health and social care that is more accessible and person centered with particular emphasis on improving this for older people and disabled children.	Supporting local people to make lifestyle choices at an individual level which will positively improve the quality and length of their life and overall increase the health of the population.

How we decided our priorities

Our criteria:

The Board considered all the relevant recommendations from the JSNA 2014 using the criteria below:

- Evidence of need
- Influencing all partner priorities
- Focus on the most important priorities
- Will be achievable
- Value for money
- Have clear outcomes

We were then able to:

- Identify the key actions for public health and safeguarding across each stage of the life course.
- Identify the key actions for health and social care across each stage of the life course.
- Identify the basket of key actions to be addressed through the 2015/16 commissioning and business planning round.
- Identify those priorities that should be addressed in later years for each stage of the life course.

Theme 1: Pre birth and early years

Children, aged 0-4 years, made up around 10.1 per cent of the population of Barking and Dagenham in the 2013 Census, compared to 7.4 per cent across London. Between 2008 and 2013 the 0-4 years population in Barking and Dagenham increased by over 22 per cent compared to just over 12 per cent increase in London.

These early years lay a foundation and the Health and Wellbeing Board are working in partnership to provide children with the best start in life. The impacts of early years behaviours like breastfeeding and healthy weaning, exposure to cigarette smoke or domestic violence can impact children throughout their lives. The Healthy Child programme (0-5 years) sets out an expectation that every child is offered a health review with a trained professional and additional multi-agency support for children and families with higher need through the common assessment framework.

Priority Area: Care and Support

- All children are offered health reviews in line with national guidance
- More children identified with special needs have their needs met and demonstrate improved health and mental health outcomes
- More children have regular dental checks and as a result have less dental decay aged 4/5 years

Priority Area: Protection and Safeguarding

- Most children are protected through vaccination against measles, mumps, rubella and whooping cough
- Fewer children come into local authority care due to emotional abuse or neglect, including domestic violence
- Fewer children grow up in poverty

Priority Area: Improvement and Integration of Services

- Most children achieve a healthy standard of school readiness by age 5 through coherent and integrated support
- More children and families have access to urgent care community services which meet their needs
- More children with chronic and/or complex health and social care needs are supported in an integrated way at home
- Introduce an integrated early years services from conception to age 5

Priority Area: Prevention

- More infants are breastfed in the first months of life
- More children are taking part in regular physical activity and fewer parents are exposing their children to cigarette smoke

Theme 2: Primary School Children

Children aged 5-11 years, made up just over 10 per cent of the population of Barking and Dagenham in the 2011 Census, compared to just over 8 per cent across London. Between 2008 and 2013 the primary school population in Barking and Dagenham increased by over 25.4 per cent compared to 11.9 per cent increase in London and 4.5 per cent nationally.

Primary School is a period of growth, physically, emotionally and educationally and a period where lifestyle behaviours like healthy eating and physical activity can be the key to future health and wellbeing. Research has demonstrated the serious negative impacts of excess weight in childhood directly on the cardio-vascular system. The Healthy Child Programme (5-19 years) sets out an expectation that every child is offered a health review with a trained professional at entry to Reception year and at Year 6, this includes measures of physical health like height and weight and mental and emotional wellbeing.

Priority Area: Care and Support

- All children are offered a health review at least twice in their primary school experience
- More children with special education needs have their needs met and demonstrate improved educational and health outcomes
- Most children demonstrate improvements between their Reception and Year 6 health review

Priority Area: Protection and Safeguarding

- Most children have their eyesight and hearing tested at Reception entry to identify issues early and provide access to support
- Fewer children experience bullying or hate crime at home or in school
- Fewer children are exposed to domestic violence at home

Priority Area: Improvement and Integration of Services

- More services are accredited as young people friendly with direct access to young people engagement groups
- More children and families have access to urgent care community services which meet their needs
- More children with chronic and/or complex health and social care needs are supported to continue their education
- More children and families have access to effective early help services

Priority Area: Prevention

- Fewer children attend school without the protection of immunisation
- More children are taking regular physical activity through school and leisure service provision
- More children are eating healthy school meals and continuing to improve the food environment around schools
- More children are developing coping and rebound skills to manage life stresses

Theme 3: Adolescence

Adolescents, aged 12-18 years, made up 9.4 per cent of the population of Barking and Dagenham in mid-year 2013 estimation of population, compared to 7.7 per cent across London. Between 2008 and 2013 the secondary school population in Barking and Dagenham increased by 10.4 per cent compared to 1.8 per cent increase for London and drop by 3.8 per cent nationally.

Adolescence is a period of substantial change, individuals are developing health behaviours, beliefs and concepts that forms the basis of their health and wellbeing for the rest of their lives. The impacts of developing physical or mental ill health in adolescence can affect educational attainment and core life skills around relationships and identity.

Priority Area: Care and Support

- More young mothers/fathers access the support provided through the Family Nurse Partnership project and Children Centres targeted support
- More adolescents take up the opportunity for a mid-teen health review with qualified health professionals
- Improving health outcomes for children with Special Educational Needs and Disability (SEND)
- Improving health outcomes for looked after children, Care leavers and youth offenders

Priority Area: Protection and Safeguarding

- More adolescents over 16 years take up the opportunity to protect themselves through Chlamydia screening
- More adolescent girls are protected through vaccination against cervical cancer
- Fewer adolescents experience bullying or hate crime at school
- Putting improved measures to protect children from sexual exploitation

Priority Area: Improvement and Integration of Services

- More services are accredited as young people friendly with direct access to young people engagement groups
- More adolescents are protecting their own health through contraceptive and sexual health services
- Continued improvement in educational attainment

Priority Area: Prevention

- Fewer adolescents smoke and/or problematically use alcohol
- More adolescents are taking regular physical activity and improve the opportunities to use green space
- More adolescents have developed coping and rebound skills to manage life stresses.
- Empower adolescents to make informed choices about their sexual and emotional health

Theme 4: Maternity

There were 3,796 live births to mothers resident in Barking and Dagenham in 2013, which has increased by 46 per cent since 2003. There have also been substantial changes in the profile of mothers in the borough, between 2004 and 2013 the proportion of mothers born within the UK fell from 58.8 per cent to 37.2 per cent. The largest group of non-UK born mothers come from Africa and Asia, where conditions like sickle cell disease and diabetes are more common.

High quality maternity services and structured and multi-disciplinary support for parents during pregnancy is key to ensuring that babies are born health and safe in Barking and Dagenham.

Priority Area: Care and Support

- All women in pregnancy receive high quality health care support during pregnancy and labour and as a result fewer women and babies experience preventable complications
- Fewer children die in their first year of life
- More women who are identified in pregnancy with additional needs have their needs met and demonstrate improved outcomes
- All women in pregnancy have access to antenatal education and postnatal breastfeeding support
- All partners (e.g fathers and life partners) have access to postnatal parenting support

Priority Area: Protection and Safeguarding

- Most women in pregnancy and infants are protected through vaccination against measles, mumps, rubella and seasonal flu
- Fewer mothers live in fear of violence at home
- The majority of women in pregnancy take up the opportunity of antenatal screening including testing for HIV

Priority Area: Improvement and Integration of Services

- All mothers have an integrated maternity care plan which they develop in partnership with the relevant healthcare professionals
- Maternity pathways including those delivered outside of the borough, have clear and integrated pathways of care with local service providers and safeguarding mechanisms
- More women in pregnancy from vulnerable groups have specific and dedicated support and care in pregnancy and improved outcomes.

Theme 5: Early adulthood

Early adults are the group making their first independent steps in the world, moving out of home, leaving school or university, forming relationships and starting their own families. Early adults are aged 19-29 years and made up 15.7 per cent of the population of Barking and Dagenham in mid-year 2013 estimation of population, compared to 18 per cent across London.

The health and wellbeing of this group is crucial to the foundation of their own and their families live in the future. Both physical and mental illness can be a barrier to employment and opportunity at this age and in the future. 5.8% of 16 – 18 year olds in Barking and Dagenham are not in education and training (NEETS) (12/13 data), which is substantially higher than the London average of 3.8% of 16-18 year olds. Although maternity is considered in a separate section it is important to note that 53 per cent of births in the borough were to women in under 30 years old age group, compared to 41 per cent across London (2012).

Priority Area: Care and Support

- More people living with severe mental illness will be physically healthy

Priority Area: Protection and Safeguarding

- Fewer young adults will become infected with a sexually transmitted disease or HIV
- Fewer women will have unplanned and unwanted pregnancies
- Fewer young adults will be living in fear of intimate partner violence or hate crime
- More women will protect themselves through taking up the offer of screening for cervical cancer

Priority Area: Improvement and Integration of Services

- We will focus on improving services for people living with sickle cell disease in the first year of the partnership and then build on this partnership work to improve the quality of care and support for people living with diabetes in the second year
- More young adults with long term conditions are satisfied with the transition to adult care and support services
- More young adults with depression are supported, through improved access, and uptake of, talking therapies.

Priority Area: Prevention

- Fewer young adults smoke and/or problematically use alcohol or illegal drugs
- More young adults have a healthy weight and have access to healthy food produce
- More young adults take regular physical activity and use active forms of transport

Theme 6: Established adults

Established adults are aged 30-64 years and made up 43 per cent of the population of Barking and Dagenham in the 2013 ONS mid-year population estimates, compared to 47 per cent across London. The health and wellbeing of this group is often best addressed through the workplace health initiatives and for the period between October 2013 and September 2014, 71.6 per cent of the population (16-64 years) were economically active. However 7 per cent of the adult population remain unemployed and over 3,000 of these are adults with long term health conditions, demonstrating the importance of initiatives to mitigate the impact of chronic disease on an individual's ability to achieve their personal potential.

Another substantial group are the 16,200 adults with caring responsibilities identified in the 2011 census of which some will be economically active, maternity issues are discussed in a separate section, but this group require specific attention regarding the health and wellbeing impacts of caring responsibilities and how organisations can work together to help support them to achieve their potential.

Priority Area: Care and Support

- More adults with early signs of dementia are recognised in primary care and referred for treatment
- More adults who are eligible use direct payments to control their own care and services
- More adults infected with TB complete treatment
- More adults over 40 take up the offer of review their own health through the NHS Health Check
- Fewer adults with depression require hospital admission because of better community care and support

Priority Area: Protection and Safeguarding

- More adults take up the opportunity to protect themselves through cancer screening (cervical, bowel and breast)
- Fewer adults will be living in fear of violence
- Fewer adults are injured through accidents in the workplace or in our public spaces

Priority Area: Improvement and Integration of Services

- Improve services for people living with long term conditions
- More adults with the early signs of chronic disease are identified in primary care and start treatment and care
- More adults have access to community based urgent care services in ways that suit their work/life balance

Priority Area: Prevention

- Fewer adults smoke and/or problematically use alcohol or illegal drugs
- More adults have a healthy weight and more have access to healthy affordable food produce
- More adults are taking regular physical activity including cycling and walking.

Theme 7: Older adults

Many older adults are active and engaged in their local communities, supported by networks of friend and family, using their retirement to contribute to the community and society, and we aim to support more local people to live in later life with dignity and independence, achieving their potential in old age as much as at any other life stage. In 2015 older adults are aged over 64 years and made up 10 per cent of the population of Barking and Dagenham according to the 2013 ONS mid-year population estimates, compared to just over 11 per cent across London, although the proportion of the population over 90 years has remained constant at 0.5 per cent.

The health and wellbeing of this group is often characterised by an increasing dependency on support as individuals' age and become frailer. According to the Eye care Trust over a quarter of adults aged over 60 years have such a poor quality of vision that it restricts their daily routine, and over 20 per cent of those over 75 years have significant sight impairment[3]. Based on Department of Health estimates, Barking and Dagenham have around 9,400[4] falls made by residents aged over 65 years each year. Of those 9,400 around 4,060 will fall twice or more in a year and according to Public Health England, 526 individuals attended A&E, many of these are preventable. The impact of social isolation, poverty and the lifetime effects of health risk behaviours such as smoking, all contribute to an older person's health and wellbeing. There is no avoiding that old age is followed by death, and providing individuals support and dignity in dying is an important part of the health and social care agenda.

Priority Area: Care and Support

- Fewer frail elderly adults to be supported to live independently
- More older adults with signs of dementia and/or depression are recognised in primary care and referred for treatment
- More older adults who are eligible use direct payments to control their own care and services
- More older adults under 75 years take up the offer to review their own health through the NHS Health Check.

Priority Area: Protection and Safeguarding

- More older adults take up the opportunity to protect themselves through cancer screening (bowel and breast)
- More older adults are protected through vaccination against seasonal flu
- Fewer older adults live in fear of older abuse
- Fewer older adults are injured through accidents in the home
- More older adults live in high quality and more energy efficient homes, protected from weather extremes

[3] https://www.actionforblindpeople.org.uk/about-us/media-centre/facts-and-figures-about-issues-around-sight-loss/

[4] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110099.pdf

Priority Area: Improvement and Integration of Services

- More older adults live active and independent live with support from integrated services
- More older adults who are terminally ill die with dignity in a planned and supported way
- More older adults have access to community based urgent care services
- More older adults regularly access high quality dental services

Priority Area: Prevention

- Fewer older adults smoke and/or problematically use alcohol
- More older adults are taking regular physical activity and use the green spaces in the borough
- More older people are actively engaged in their community.

Theme 8: Vulnerable and minority groups

Consultation and the equalities impact assessment of the draft strategy highlighted the need to coherently consider the needs of some specific minority communities in Barking and Dagenham. Barking and Dagenham is a diverse and vibrant community with many different ethnic groups. Individuals who identify as lesbian, gay, bisexual and transgender, people living with disability all their life and people who become disabled through disease or injury, and communities of faith. Some of these communities have specific needs which the Health and Wellbeing Board have highlighted as areas for specific and targeted consideration. As the Strategy is implemented, in some cases this means targeted work and in others it means monitoring service utilisations to ensure that groups are not disadvantaged or marginalised b the way things are being done.

Priority Area: Care and Support

- All individuals with learning difficulties and/or disabilities have a key worker and a structured health and wellbeing plan which takes into account key life stages and transitions e.g. the move from education into employment
- All young people who are looked after or are in the Youth Justice System should have an annual health check and a health plan in place
- Improve support for carers

Priority Area: Protection and Safeguarding

- More people from minority groups feel confident to report abuse and harassment
- The gap is reduced in uptake of health screening programmes for ethnic minority groups living in Barking and Dagenham
- Protect vulnerable adults and children from abuse and harm

Priority Area: Improvement and Integration of Services

- More integrated support is provided to troubled families to reduce the impact on children and young people
- All service commissioners and providers ensure that staff have explicit equality and diversity training which includes the justification and methodology for monitoring all legally protected strands in line with national guidance
- Mental health services and pathways explicitly consider access for individuals from minorities, including sexual orientation where there is evidence of enhanced need

Priority Area: Prevention

- The gap is reduced between individuals from minorities and the general population for those who carry excess weight
- The gap is reduced between individuals and minorities and the general population for those who smoke and/or use alcohol and/or drugs.

How we will deliver our priorities

On the basis of policy and experience, we have agreed to produce a delivery plan that outlines the actions and resource to deliver our 18 priorities to achieve the outcomes. We will tackle the priorities through the following settings:-

- **Health and Social Care:**
  The Clinical Commissioning Group and Council has agreed locality structures which align local public sector services including health, social care, and education teams to support integrate working across agencies and teams

- **The Work Place:**
  Working with employers in the borough to improve wellness in the workplace

- **Schools:**
  Working with Children's Services to ensure all settings and schools promote healthy lifestyles which support attainment and positive outcomes for children and young people

- **The Community:**
  We will work with our partners, residents and voluntary sector groups in delivering community based programmes

The detailed action plan that supports this Strategy will focus on the following seven impacts

Delivery Impact	Summary
Putting the emphasis on prevention	Energy needs to go towards helping individuals, families, communities and organisations understand what they can do to promote positive health and wellbeing. Working closely with the other partnership boards will strengthen the impact of early prevention across the borough and avoid more intense difficulties later, building on the 'Think Family' programme.
Making health and wellbeing a personal agenda	Our starting belief is that change is most effective when initiated and controlled by individual residents and their family. This means that members of the community need to be actively enabled by information on health and wellbeing and services. Messages and solutions need to be more personal and this can be achieved through more effective use of occasions where members of the public engage with local professionals to assess and plan for improvement; for example personal health assessments, health MOTs, child development visits. The main emphasis needs to be on enabling individuals and families to take action through timely information, advice, education and then reference to supportive services and groups.
Making health and wellbeing a local agenda	Local neighbourhoods working with local professionals can also take control of the agenda and design and implement local solutions, but they need to be empowered with good local public health and wellbeing information on issues, as well as feedback on progress.
Borough based programmes and interventions are an important strategy for achieving general impact on issues	Our Older People's Offer is a good example of the impact that can be made through such large scale programmes. We can see the benefit of coordinated and timely health and wellbeing initiatives drawing resources together to educate, inform on issues and to promote and ensure access to specific services. We need to ensure carefully crafted communication based on real understanding of the needs of different segments of the community.
Joining up services to ensure timely and effective solutions to individual problems	Joining up might mean the effective transfer of information from one service provider to another but it could mean joint location and joint presentation of service. The establishment of the Better Care Fund offers an opportunity for much improved integration of services to ensure smooth and effective linkage of health and social care solutions, reaching broader solutions of education, housing, leisure and employment. Wherever practical services should be accessible locally within the community or at home.
Developing greater local community capacity to achieve change	There is already a track record of working with local voluntary and community groups, but it is clear that there is much more that can be done to develop local resources. This has the twin benefits of developing very local and more accessible support on a number of key issues as well as providing the opportunity for local skill development.

Delivery Impact	Summary
Strengthening partnerships for change and improvement	We need to build on the existing partnership processes to ensure tighter joint performance expectations from investments and championing of change by leaders across the organisations. Joint commissioning of services will play a key role in ensuring the most effective investments of public money. Through pooling our resources, people and funding, we can work together to develop new and creative solutions that more quickly tackle difficult issues within the borough.

Monitoring, evaluation and review

The Health and Wellbeing Strategy is supported by an outcomes framework and delivery plan which sets out how progress will be measured by the Board and what the key priority actions are in the first year of the partnership. These will be reviewed and refreshed annually.

Like all strategies, success depends on regular and robust monitoring and review to ensure that the intended outcomes are being achieved and action is taken to address service failings, or any other problems that may arise. Many of these outcomes link to existing partnership and organisational strategies, such as the Housing Plan and the Education Strategy.

The outcome measures for the priorities can be separated into activity and uptake indicators that ensure we are supporting residents to take up the opportunities offered to improve their health, and outcome indicators which reflect the impact of the changes we are making on the health of local people. We use both types of indicators because some activity and uptake indicators can provide more timely information than the outcome impact which takes time to be reflected at a population level.

For example we monitor the uptake of vaccination to protect against cervical cancer in teenagers which we can measure every year, rather than the outcome of women affected by cervical cancer which would take several years to show the impact of changes we make to improve uptake of vaccination now.

Another example is how we will monitor the support for careers. It would be difficult to measure effectively across the range of carers in the borough what their support and needs are, but we can monitor how many of them have been identified by general practice, how many have their annual health check and how may have a carer support plan in place, all of which provide proxy measurers for making sure we are doing what we can do support carers and meeting their needs as well as those they care for.

We recognise that we will need to reintroduce the TellUs Survey of school aged children, using Access and Connect technology, in order to monitor health outcomes more effectively and that we will need to significantly improve the quality of data from service providers to enable us to drill down and recognise the outcomes for vulnerable groups.

A full set of the outcome measures forms part of the delivery framework for the Strategy, providing some examples of the measures being used by the Board.

Equality and diversity

An equality impact assessment (EIA) was completed to give due regard to the impact of the priorities set in the Joint Health and Wellbeing Strategy 2015-2018 on residents in Barking and Dagenham across the protected characteristics

The EIA found that overall the strategy has in place actions that will contribute to the reduction of existing barriers to equality and address potential inequalities, as its overarching purpose is to address the greatest need by reducing health inequalities through universal and targeted action.

A series of consultations were undertaken to engage residents, voluntary and community groups from the 9 protected characteristics to inform the development of the Strategy.

As a key part of the EIA recommendations outlined by these groups to:-

- Address health inequalities experienced by, specific equalities groups as identified through consultation and by the data
- Provide inclusive and accessible information and support to ensure equity in access to services and health outcomes
- Develop a strategy to engage with all sections of the borough, in particular seldom heard groups will feed into the development of the Strategy and delivery plan.

The full EIA and summary document can be found on the website at _____

Produced in partnership by the Health and Wellbeing Board

Date

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

12 MAY 2015

Title: Draft refreshed Health and Wellbeing Strategy Delivery Plan 2015 - 2018	
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: All	**Key Decision:** Yes
Report Author: Matthew Cole Director of Public Health	**Contact Details:** Tel: 020 8227 3914 Email: matthew.cole@lbbd.gov.uk

Sponsor:

Anne Bristow Deputy Chief Executive & Corporate Director for Adult & Community Services

Summary:

The Health and Wellbeing Strategy is the overarching strategy working to improve health outcomes for local people. The breadth of the Strategy is supported through an outcomes framework which will enable the Health and Wellbeing Board to monitor progress and success in the short, medium and long term. Our refreshed Delivery Plan (Plan) focuses on the key milestones and actions that the Board wish to see implemented to support delivery of the priorities set out in the Strategy.

The original Plan was written at a time of major evolution of new organisations and responsibilities in health and social care and therefore the Plan is now being revised as the new organisations have started to develop commissioning intention documents and strategies of their own. The refreshed Plan sets out key actions that the Board hopes these new organisations will prioritise in 2015-18.

The delivery of the Plan relies on partner organisations aligning and collaborating, both in terms of financial and human resource, to maximise the health gain.

Recommendation(s):

The Health and Wellbeing Board is recommended:

(i) To discuss and approve the refreshed Health and Wellbeing Strategy Delivery Plan

Reason(s):

The Health and Wellbeing Board has a duty to balance needs carefully and to make difficult decisions about strategic priorities given the resources available. The production of the joint Health and Wellbeing Strategy was enshrined in the Local Government and Public Involvement in Health Act 2007 and the Health and Social Care Act 2012 imposes this duty on local authorities and clinical commissioning groups, discharged through the Health and Wellbeing Board.

The Joint Health and Wellbeing Strategy also informs other strategies linked to the Council's priorities for delivering **One borough; one community; London's growth opportunity**.

1. Background

1.1 The Health and Wellbeing Strategy is supported by two key documents:

- Health and Wellbeing Strategy Delivery Plan
- Health and Wellbeing Outcomes Framework

1.2 The refreshed Health and Wellbeing Strategy Delivery Plan 2015-18 focuses on the key actions that the Board will focus on achieving over the next 3 years. In developing the delivery plan we have reflected existing strategic action plans where possible and focused on an approach which limits the focus to key actions under the four strategic themes, while reflecting the life course and partnership approach set out in the Strategy document itself.

1.3 The Delivery Plan has been circulated for consultation prior to submission to the May Health and Wellbeing Board for ratification.

2. Introduction

2.1 The joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment (JSNA) are two of the key statutory documents that are produced by the Health and Wellbeing Board under the Health and Social Care Act 2012. NHS Barking and Dagenham Clinical Commissioning Group has a duty to develop the JSNA and the Joint Health and Wellbeing Strategy together with the Council through the Health and Wellbeing Board.

2.2 The refreshed delivery plan supports delivery of the Health and Wellbeing Strategy to create an infrastructure for monitoring progress, while focusing on actions and milestones over the next three years of the Board.

2.3 The Health and Wellbeing Board sub groups will be responsible for the monitoring progress against the milestones in the delivery plan.

3. Policy Context

3.1 National Frameworks

In constructing the delivery plan we have taken into account national priorities and outcomes frameworks.

3.2 Local Strategies

The plan has also been informed by local partnership and individual agency strategies to minimise replication and reduce additional workload for reporting.

4. Delivery Plan

4.1 The Delivery Plan is set out in Appendix 1.

5. Mandatory Implications

5.1 Joint Strategic Needs Assessment

This report is grounded on the most recent findings and recommendations of the JSNA.

5.2 Health and Wellbeing Strategy

The Strategy aligns well with the recommendations of the JSNA. The refreshed strategy will continue to serve the borough well as a means to tackle the health and wellbeing needs of local people, as identified in the JSNA.

5.3 Integration

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

5.4 Financial Implications

Financial implications completed by Roger Hampson, Group Manager Finance, Adults and Community Services, LBBD.

The Health and Wellbeing Strategy Delivery Plan and Outcomes Framework provide a focus for existing resources to be targeted at those key priorities that will have a significant impact on the health and wellbeing of residents of the borough. There are no new resources to support implementation.

The Council has agreed a two year budget for 2015/16 and 2016/16; it is likely that additional savings will need to be considered across both the Council and health in 2017/18; the level of resources available will need to be reflected in the annual review of the delivery plan.

With regard to the further integration of services with health and partnership working, this is likely to form part of the development of Better Care Fund planning arrangements beyond the current agreement for 2015/16. These arrangements are dependent on the outcome of the General Election, not known at the time of writing these comments.

5.5 Legal Implications

Legal implications completed by Dawn Pelle Adult Care Lawyer, Legal and Democratic Services, LBBD.

There are no legal implications because in the 84 page Delivery Plan the provisions of the Care Act 2014 have been extensively referred to.

5.6 Risk Management

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

6. Appendices

6.1 Appendix 1: Joint Health and Wellbeing Strategy Delivery Plan 2015-18

This page is intentionally left blank

Health and Wellbeing Strategy Delivery Plan 2015-18

About this document

The Health and Wellbeing Strategy is the overarching strategy working to improve health outcomes for local people. The breadth of the Strategy is supported through an outcomes framework which will enable the Health and Wellbeing Board to monitor progress and success in the short, medium and long term.

The Delivery Plan (Plan) focuses on the key milestones and actions that the Board wish to see implemented to support delivery of the priorities set out in the Strategy. The Delivery Plan is set out according the responsibilities and reporting for each of the sub-groups. These are:

- Children and Maternity Sub-group
- Integrated Care Group
- Public Health Programmes Board
- Learning Disability Sub-group
- Mental Health Sub-group

Outcomes are shown for each of the life-course groupings with attached actions for 2015-16 and 2016-18. Not all the cells will be filled as they will not be relevant to the particular sub-group in question e.g. Life-stage Older People will not be populated in the Children and Maternity Subgroup. Some of the sub-groups and boards work across the whole life course, e.g. Mental Health, Learning Disability and Public Health.

Many milestones are already included in the strategies and action plans which support the joint Health and Wellbeing Strategy's delivery, and so the Plan has limited the number of key actions to focus on priorities and ensure that measurable targets are included. This document does not contain all the outcomes but those that are high level and require a partnership approach. The Plan has no 'new' financial resources to support its implementation but provides a focus for existing resources to be targeted at those key priorities that will have a significant impact on the health and wellbeing of the borough. Care City has also arisen as an innovation centre for Healthy Ageing that the borough has jointly funded and is optimistic that the delivery of the vision will support the local area to collaborate across sectors to secure improved health outcomes for the community by tackling cross system issues.

The Plan was written at a time of major evolution of our partner organisations and responsibilities in health and social care and therefore the Plan is now being revised as the partners have started to develop commissioning intention documents and strategies of their own. The updated Plan sets out key actions that the Board hopes these organisations will prioritise in 2015-18.

The delivery of the Plan relies on partner organisations aligning and collaborating, both in terms of financial and human resource, to maximise the health gain. Chairs of the sub-groups are responsible for overseeing delivery and escalating any performance issues to an appropriate member of the senior management team. The delivery plan will be reviewed on an annual basis by the respective subgroups.

Children and Maternity Subgroup								
Priority	**CARE AND SUPPORT**							
Life stage	**Pre-Birth & Early Years**	**Primary School Age**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome	Maintain the proportion of children seen by a health visitor within 14 days of birth at or above 95% year-on-year.	Maintain the percentage of children measured under the National Child Measurement Programme (NCMP), at Reception and Year 6 at 95% year-on-year.	Achieve a year-on-year increase in the percentage of first time mothers enrolled on the Family Nurse Partnership (FNP) Programme before 16 weeks, and 100% of mothers enrolled no later than 28 weeks - with the achievement of at least 75% enrolment per annum by 2018.					

Children and Maternity Subgroup

Priority	CARE AND SUPPORT							
Milestone Action for 2015-16	The Healthy Child Programme for 0-5 years will transfer from NHS England to the Council from October 2015. Service implementation planning and joint working across the Council and the NHS will take place to support increased uptake of local health visitor services to 95% by March 2016.	Increase the percentage of children measured under the NCMP at Reception and Year 6 year-on-year to 95% by March 2016. To achieve this Public Health and Children's Services will jointly review the local delivery of the NCMP and referral pathways to weight management services for obese and overweight children by April 2016. The review will support the commissioning of effective healthy lifestyle programmes promoting healthier eating and physical activities in schools and the community, which will be targeted where appropriate. Improve quality and choice of healthy eating options in schools through curriculum and catering responsibilities.	At least 60% of first time mothers enrolled on the Family Nurse Partnership (FNP) Programme before 16 weeks, and 100% no later than 28 weeks. To support this outcome a FNP engagement plan will be developed by October 2015 and referral pathways refreshed by April 2016. Baby intervention pathways will be refreshed by April 2016 to ensure that young parents who do not meet the criteria for FNP will receive appropriate early intervention and support.					

Children and Maternity Subgroup

Priority	CARE AND SUPPORT							
Action for 2016-18	Increase the proportion of children seen by a health visitor within 14 days of birth to 95% by 2018. Development and delivery of an integrated model for the early life stages by March 2018. This will deliver a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting.	Maintain the percentage of children measured at Reception and Year 6 at 95% year-on-year. Decrease the prevalence of obesity and over weightness in Reception and Year 6 - by 23% in Reception; and 42% in Year 6 by 2018. This will be supported by the commissioning and delivery of the recommended components for the effective delivery of the 5–19 Healthy Child Programme – including prevention and early intervention; safeguarding; health development reviews; screening and immunisation programmes and support for parents in 2016-18. Other child-centred initiatives such as the GET ACTIVE physical activity programme will be commissioned to support increased engagement of children in physical activity interventions in line with identified need by March 2018.	At least 75% of eligible mothers to be enrolled in the FNP in 2018. FNP to be incorporated into the integrated model for early years by March 2018. Baby intervention services to be incorporated into the integrated model for early years by March 2018. Expected to increase caseload capacity by 95% by March 2018.					

Children and Maternity Subgroup								
Priority	**CARE AND SUPPORT**							
Lead organisation	NHS England	LBBD	NELFT					
Named lead	Kenny Gibson – Head of Early Years, NHS England	Matthew Cole - Director of Public Health Meena Kishinani - Divisional Director of Strategic Commissioning and Safeguarding	Gillian Mills – Borough Director , NELFT Toby Kinder – Group Manager, Early Intervention					

Children and Maternity Subgroup

Priority	CARE AND SUPPORT							
Life stage	**Pre-Birth & Early Years**	**Primary School Age**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome		Increase the number of referrals to specialist services where child sexual exploitation risks have been identified – *to be confirmed following development of the local CSE problem profile by September 2015.*	Ensure that children and young people are consulted with and engaged in service planning and commissioning across Children's Services on an annual basis.	Increase the percentage of pregnant women treated for HIV in acute settings to 80% by 2018.				Increase the percentage of children with social care assessments undertaken within 45 days to 80% by 2018.
Milestone Action for 2015-16		Development of a local CSE problem profile by September 2015.	Barking and Dagenham CCG have established children and young people engagement forums – engagement to be monitored including demographics of attendees. Engagement t be monitored year-on-year.	HIV awareness and testing training will be implemented for all midwives at Barking Hospital by April 2016.				

Children and Maternity Subgroup

Priority	CARE AND SUPPORT							
Action for 2016-18	Problem profile is established and updated regularly.	Clear safeguarding pathways and training in place across all services and providers – monitor training uptake and completion levels annually.	Development of overarching engagement plan for CMG priorities by April 2016.	Over 80% of pregnant women to be tested for HIV and referred into appropriate post-test services for treatment and counselling for those with a positive diagnosis.				Increase the percentage of children with social care assessments undertaken within 45 days (80%) To achieve this outcome and ensure appropriate and early identification of SEND children and young people, progress and improvements in health outcomes for children with special educational needs and disabilities will be monitored via the Children and Maternity Subgroup on a quarterly basis. Closer links will be established with adult social care and monitored to ensure that young people with educational and care needs have effective Transition Care Assessments.
Lead organisation	CCG	LBBD	CCG/ NHS England	NHS England				LBBD/CCG
Named lead	Sharon Morrow- Chief Operating Officer	Matthew Cole – Director of Public Health	Dr J John CCG - Patient Involvement Lead	Joanne Murfitt - Head of Public Health, Health in the Justice System and Military Health				Joint Children's Commissioner

Children and Maternity Subgroup								
Priority	**IMPROVEMENT AND INTEGRATION OF SERVICES**							
Life stage	**Pre-Birth & Early Years**	**Primary School**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome	To co-locate health visitors within GP practices and Children's Centres by 2018.	Improved oral health for under 5s by 2018.	Decrease under-18 year's conception rate (per 1000) and percentage change against 1998 baseline by 50% by 2018.	Increase percentage of mothers booked with maternity services by 13th week of pregnancy (in light of new blood tests) by 2018.				Improve health outcomes for looked after children, care leavers and youth offenders by 2018.
Milestone Action for 2015-16		Oral health strategy to be developed and implemented by April 2016, supported by local oral health promotion campaign.	Conduct review of sexual health and contraceptive services currently in place for young people by July 2016, including a review of the quality of sexual and reproductive education (SRE) in schools and mapping of access to emergency hormonal contraception (EHC) via primary care services.	Move 1st booking to 11 weeks. Implement the following actions by October 2016: - Primary care and children's centres education programme to support signposting. - Preparation for parenthood classes – delivered by children's centre staff/health visitors/midwives.				

Children and Maternity Subgroup								
Priority	**IMPROVEMENT AND INTEGRATION OF SERVICES**							
Action for 2016-18	100% of health visitors to be co-located in GP practices and Children's Centres by April 2018.	Reduction to 1.2 DMF in children aged 5 years by April 2018.	Reduce rate of teenage conception by 50% over next by end of 2018.	80% mothers booked in by 9 weeks year-on-year. Focus on borough-based data and performance to monitor activity and performance				At least 95% of all vulnerable groups to have an annual health check encompassing physical, mental health, emotional health and health risk behaviours by 2018.
Lead organisation	LBBD	NHS England	LBBD	CCG				LBBD
Named lead	Toby Kinder - Group Manager Early Intervention	Joanne Murfitt Head of Public Health, Health in the Justice System and Military Health	Eric Stein Group Manager – Integrated Youth Services	Sharon Morrow – Chief Operating Officer				Meena Kishinani Divisional Director Strategic Commissioning and Safeguarding

Children and Maternity Subgroup

Priority	PREVENTION							
Life stage	**Pre-Birth & Early Years**	**Primary School**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome	Increase breastfeeding initiation prevalence to 75% by 2018. Improve breastfeeding prevalence at 6-8 weeks to 60% by 2018.	Increase the percentage of children taking regular exercise to 95% by 2018 as measured at health review.	*National level placeholder* Local Authority to link with Public Health England to set a local target for smoking rates at 15 years *(review and move to prevalence).*	Increase the percentage of teenage mothers supported by Family Nurse Partnership to >85% by 2018.				Improve access to CAMHs for vulnerable children by 2018 -
Milestone Action for 2015-16	Work towards stage 1 of Baby Friendly Initiative Implementation by April 2016.	GET ACTIVE programme to be enhanced to increase the range of leisure and community-based activities offered by April 2016.	The multi-agency smoking strategy will be refreshed and action plan developed by June 2016 to reduce smoking rates in 15 year-olds.	>80% of expected visits made to teenage mothers by health visitors				Develop and implement joint children's mental health and wellbeing strategy by October 2016.

Children and Maternity Subgroup

Priority	PREVENTION							
Action for 2016-18	Develop a multi-borough breastfeeding strategy owned by the Children and Maternity Subgroup by April 2018. Increase the percentage of teenage mothers supported by Baby Intervention to breastfeed and stop smoking by 2018 – to be confirmed	95% of primary school children to be taking regular exercise by 2018.	Implement the action plan to reduce teenage smoking rates in line with agreed local smoking target – to be confirmed.	>85% of expected visits made to teenage mothers.				Number achieving 26-week referral to treatment target (460 looked after children accessed). New target of 500 by 2018.
Lead organisation	BHRUT	LBBD	LBBD	NELFT				LBBD/CCG
Named lead	Wendy Matthews Director of Midwifery BHRUT	Jo Caswell Personal Development Advisor	Consultant in Public Health	Gillian Mills – NELFT Toby Kinder – Group Manager Early Intervention				Meena Kishinani Divisional Director Strategic Commissioning and Safeguarding

Children and Maternity Subgroup

Priority	PREVENTION							
Life stage	**Pre-Birth & Early Years**	**Primary School**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome	Introduce the new 4 routine blood tests for metabolic conditions by 2018	Ensure that 100% of children have complete immunisation records by 2018.		Decrease the number of pregnant women who are smoking in pregnancy through the implementation of BabyClear by 2018.	Reduce the prevalence of STIs by 2018 – target to be confirmed.			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 – to be confirmed
Milestone Action for 2015-16	Introduction of tests at 9 weeks booking by April 2016.	Reach London levels for immunisation and then England levels by 2016. Target is 95%.		Identify funding for Phase 2 to improve assessments (quality and output) and support midwives to deliver improved outcomes by	Ensure equitable access to contraception and STI testing in primary care and GUM clinics. Reduce PID to England and then London levels – to be confirmed.			100% of young offenders to receive annual health check year-on-year. Training programmes for both health and social care staff on youth justice for all front line professionals. Specific additional training support on health risk assessment and understanding of the NHS for YOS professionals

Children and Maternity Subgroup

Priority	PREVENTION							
Action for 2016-18	Meet Government 95% target for introduction of blood tests by April 2018.	Ensure that 100% of children have complete immunisation records by October 2018.		Reduce Smoking Status at Time of Delivery (SATOD) rate to 15% by October 2018.	Introduce training programme for schools to support effective PHSE by September 2016. Increase the numbers testing for STIs and reduce prevalence – target to be confirmed.			Preventative work with vulnerable children including looked after children is essential to ensure that they have opportunities and do not get led into offending through the lack of possibilities available to them
Lead organisation	BHRUT NHS England	CCG		BHRUT	LBBD			LBBD
Named lead	Wendy Matthews - Director of Midwifery Joanne Murfitt Head of Public Health, Health in the Justice System and Military Health	Jo Murfitt - Head of Public Health, Health in the Justice System and Military Health		Wendy Matthews - Director of Midwifery	Erik Stein Group Manager – Integrated Youth Services			Erik Stein Group Manager – Integrated Youth Services

Integrated Care Group

Priority	CARE AND SUPPORT							
Life stage	**Pre-Birth & Early Years**	**Primary School Age**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome		Reduce unintentional injuries attendance by 0-14 year olds at A&E by 2018 – target to be confirmed	Increase uptake of HPV vaccination to 95% by 2018.	Increase the uptake of seasonal flu amongst pregnant women by 60% by 2018.	Repeat MARAC caseload (target to be confirmed by September 2015)	Increase percentage of adults using direct payments to 75% by 2018.	Reduce re-admission to hospital within 50 days of discharge to 12.5% by 2018.	
Milestone Action for 2015-16		Develop a project to improve support to parents in primary care through integration with HV and children's centres by October 2016.	Commissioning of new HPV vaccines with training and governance support for staff by April 2016.	GP practices to ensure that pregnant registrants are aware of the need to receive seasonal flu vaccination year-on-year. Uptake to be monitored on an annual basis.	Ensure 20% of frontline staff have attended multi-agency domestic violence and violence against women and girls training by April 2016.		Implement integrated discharge planning process by October 2016.	
Action for 2016-18			Increase uptake to 95% by October 2018.	Increase flu vaccination coverage to 60%	Ensure caseloads are at optimum levels, do not exceed national guidelines and have a minimum level of repeat referrals year-on-year.	Increase percentage of adults using direct payments to 75% by October 2018.	Re-admission to hospital within 30 days of discharge to 12.5%	

Integrated Care Group								
Priority	**CARE AND SUPPORT**							
Lead organisation		CCG	NHS England	NHS England	LBBD , CCG NHS England	LBBD	Integrated Care Sub Group	
Named lead		Wendy Matthews – Director of Midwifery Joanne Murfitt Head of Public Health, Health in the Justice System and Military Health	Joanne Murfitt Head of Public Health, Health in the Justice System and Military Health	Joanne Murfitt Head of Public Health, Health in the Justice System and Military Health	Karen Proudfoot – Group Manager Community Safety & Offender Management	Mark Tyson - Group Manager Adult Commissioning	Chair Integrated Care Sub Group	

Integrated Care Group

Priority	PREVENTION							
Life stage	**Pre-Birth & Early Years**	**Primary School Age**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome					Increase the number of smoking quitters under 30 years of age by 2018 *(to be confirmed - review target and move to prevalence)*	Increase the percentage of adults cycling or walking to work by 5% year-on-year.	Increase the percentage of over 65 year olds protected through seasonal flu immunisation by to 75% by 2018.	Reduce excess mortality rate of older people in extreme temperatures by 2018 – target to be confirmed by September 2015.
Milestone Action for 2015-16					Action plan for targeted promotion work with high-risk smoking populations and routine and manual groups to be developed by April 2016.	Active transport survey conducted and cycling - strategy to be developed across the partnership by June 2016. Develop and implement promotional campaign by October 2016.	Develop local pathway to improve uptake through partnership by June 2016.	Ensure that all local older people receive correct, clear, consistent, useful and actionable advice and information from the local organisations they come into contact with year-on-year.
Action for 2016-18					Reduce the numbers of R&M workers who smoke by 5%	Determine how many LBBD workers cycle and walk and increase by 5% year-on-year	75% of over 65 year olds protected	Evaluate the effectiveness of the winter warmth payments scheme locally by June 2018.
Lead organisation					LBBD	LBBD	NHS England	NHS England

Integrated Care Group								
Priority	**PREVENTION**							
Named lead					Andy Knight - Group Manager Community, Sport and Arts	Gloria Mills – Active Transport Lead	Kenny Gibson – Head of Early Years and Immunisation	

Public Health Programmes Board								
Priority	**CARE AND SUPPORT**							
Life stage	**Pre-Birth & Early Years**	**Primary School Age**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome	Maintain the proportion of children seen by a health visitor within 14 days of birth at or above 95% year-on-year.		Increase the proportion of young people testing for Chlamydia to London level by 2018.	Reduce rate of teenage conceptions by 50% from ’98 baseline for > 16 year olds.			Increase early diagnosis and identification of at-risk older people in primary care and reduce unnecessary admission to hospital – target to be confirmed	Reduce the number of people claiming health-related benefits by 25% by 2018.

Public Health Programmes Board

Priority	CARE AND SUPPORT							
Milestone Action for 2015-16	The Healthy Child Programme for 0-5 years will transfer from NHS England to the Council from October 2015. Service implementation planning and joint working across the Council and the NHS will take place to support increased uptake of local health visitor services to 95% by March 2016.		Increase Chlamydia screening coverage to 35% by October 2016.	Review teenage pregnancy strategy and develop an action plan by April 2016.			Introduce pilot self-care programme for patients and carers by October 2016.	Implement mental health and back to work initiative. Reassessments of 100% on health related benefits by October 2016.

Public Health Programmes Board

Priority	CARE AND SUPPORT							
Action for 2016-18	Increase the proportion of children seen by a health visitor within 14 days of birth to 95% by 2018. Development and delivery of an integrated model for the early life stages by March 2018. This will deliver a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting.		Increase diagnosis rate to London rate	Decrease rate from 6.9% to 5.5% over 5 yrs			Secure funding for continuation of Frailty Academy model to support pathway redesign by April 2018.	Reduce the number of people claiming health-related benefits by 25% by 2018.
Lead organisation	LBBD		LBBD	LBBD			Care City	LBBD
Named lead	Matthew Cole Director of Public Health		Head of PH commissioning	Head of PH commissioning			Helen Oliver Care City Programme Lead	Terry Regan Group Manager Employment

Public Health Programmes Board

Priority	CARE AND SUPPORT							
Life stage	**Pre-Birth & Early Years**	**Primary School Age**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome	Improve the development of children in early years and introduce integrated reviews by 2018	Maintain the percentage of children measured under the National Child Measurement Programme (NCMP), at Reception and Year 6 at 95% year-on-year.			Reduction in prevalence of adult obesity from baseline by 2018.	Increase the number of adults participating in regular physical activity year-on-year	Increase number of adults participating in regular physical activity year-on-year	Increase the number of adults participating in regular physical activity by 2018

Public Health Programmes Board

Priority	CARE AND SUPPORT							
Milestone Action for 2015-16	To indentify speech, language and communication needs (SLCN) in children before they reach the age of 2 years using robust research methods by 0ctober 2016.	To achieve this Public Health and Children's Services will jointly review the local delivery of the NCMP and referral pathways to weight management services for obese and overweight children by April 2016. The review will support the commissioning of effective healthy lifestyle programmes promoting healthier eating and physical activities in schools and the community, which will be targeted where appropriate.			Develop and implement adult obesity strategy by April 2016. Develop outcomes-based service specification to monitor the effectives and impact of public-health funded adult weight management programmes by October 2015. Increase engagement in commissioned adult weight management (Momenta) and exercise on referral programmes. Reduce obesity levels to 20% and overweight and obesity to 55% by October 2016.	Develop Adult obesity strategy Increase the number of adults taking part in regular physical activity interventions to 50% by October 2016.	100% of older people have access to the Leisure Pass Scheme by October 2016.	80% people with disabilities and those on low incomes are participating in regular physical activities by October 2016.

Public Health Programmes Board

Priority	CARE AND SUPPORT							
Action for 2016-18	To increase percentage of children identified with SLCN achieving expected levels of communication for their age – to be confirmed To increase the of children who have attended children's centre play and communication services who achieve a good level of development in the Early Years Foundation Stage Profile – to be confirmed	Maintain the percentage of children measured at Reception and Year 6 at 95% year-on-year. Decrease the prevalence of obesity and over weightness in Reception and Year 6 - by 23% in Reception; and 42% in Year 6 by 2018. This will be supported by the commissioning and delivery of the recommended components for the effective delivery of the 5–19 Healthy Child Programme – including prevention and early intervention; safeguarding; health development reviews; screening and immunisation programmes and support			Reduce excess weight in LBBD to London levels (57.3%)	Target to be confirmed by September 2015	Target to be confirmed by September 2015	Target to be confirmed by September 2015

Public Health Programmes Board								
Priority	**CARE AND SUPPORT**							
Lead organisation	LBBD	LBBD			LBBD	LBBD	LBBD	LBBD
Named lead	Meena Kishinani Divisional Director Strategic Commissioning and Safeguarding	Nigel Sagar – Senior Advisor Maureen Lowes – Catering Services Manager Children and Young People			Consultant in Public Health Andy Knight – Group Manager Community Sport and Arts	Consultant in Public Health Andy Knight – Group Manager Community Sport and Arts	Andy Knight Group Manager Community, Sport and Arts	Andy Knight Group Manager Community, Sport and Arts

Public Health Programmes Board								
Priority	**IMPROVEMENT AND INTEGRATION OF SERVICES**							
Life stage	**Pre-Birth & Early Years**	**Primary School Age**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome	Increase breastfeeding prevalence at 6-8 week check to 65% by 2018.	Increase percentage of 5-11 year olds participating in 2 hours or more of physical education by 2018.		Reduce number of domestic violence cases among pregnant women – target to be confirmed.	Reduce rate of hospital admissions per 100,000 to annual rate in Year 1 and Peer group in Year 2 by 2018	Increase uptake of NHS Health Checks to 75% by 2018.	Enable those at end of life to die with dignity where they want	Increase the percentage of successful completion of drug treatment (opiate and non-opiate users)

Public Health Programmes Board

Priority	IMPROVEMENT AND INTEGRATION OF SERVICES							
Milestone Action for 2015-16	Introduce individually tailored breastfeeding plans through peer support and buddies by April 2016.	Increase the number of referrals to GET ACTIVE and outcomes measured follow development of outcomes-based service specification by October 2015. Continued support for schools working through Healthy Schools London Award Programme in 2015/16.		Campaign for reducing domestic violence among pregnant women	Hospital audit to be implemented	Implementation of point of care testing by GPs and pharmacies by June 2015. Increase uptake to 50% of 40 – 74 year olds	Expansion of specialist and palliative care services	
Action for 2016-18	Increase breastfeeding prevalence at 6-8 week check to 65% by October 2018.	Target to be confirmed by September 2015		Reduction in the number of cases – target to be confirmed by September 2015		Increase uptake to 75% of 40 – 74 year olds by October 2018. Ensure 100% of carers in cohort receive check	Increase the number of deaths outside hospital to 50% by October 2018.	To be confirmed once national targets for Health Premium published
Lead organisation	NHS England	LBBD		LBBD	LBBD	LBBD	CCG	LBBD
Named lead	Joanne Murfitt Head of Public Health, Health in the Justice System and Military Health	Nigel Sagar		Karen Proudfoot – Group Manager Community Safety & Offender Management	Karen Proudfoot – Group Manager Community Safety & Offender Management	Consultant in Public Health	Sharon Morrow – Chief Operating Officer	Sonia Drpzod Drugs Strategy Manager

Public Health Programmes Board

Priority	PREVENTION							
Life stage	**Pre-Birth & Early Years**	**Primary School Age**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome	Increase the number of adults and children participating in cooking skills courses year-on-year	Reduction in numbers of school children taking up smoking by 2018	Reduction in numbers of school children taking up smoking by 2018	Reduction in the number of pregnant women smoking at time of delivery by 2018	Percentage reduction in smoking prevalence over the 3 year period from 2009/10 baseline by 2018	Percentage reduction in prevalence of adult obesity from baseline by 2018	Increase percentage of bereaved people signposted to appropriate bereavement support services - to be confirmed.	Increase in the number of adults participating in regular physical activity by 2018 – to be confirmed by September 2015.
Milestone Action for 2015-16	Programme of cooking skills classes developed and implemented by April 2016.	Social marketing campaign developed and implemented by April 2016.	Social marketing campaign developed and implemented by April 2016.	Implementation of the BabyClear programme in 2015.	Social marketing campaign to be developed and implemented	Common/core nutritional standards for all commissioned services from 2015.	Establishment of bereavement support services – to be confirmed	Widening access through new and upgraded facilities by October 2018.
Action for 2016-18	Deliver a minimum of 10 courses per annum by 2018.	Target to be confirmed Roll out new smoke free policy guidance for schools Embed effective drug, alcohol and tobacco education in PHSE in schools	Target to be confirmed Roll out new smoke free policy guidance for schools Embed effective drug, alcohol and tobacco education in PHSE in schools	Undertake audit and reduce SATOD to > 10%	Reduce smoking levels to 25% by October 2018.	Reduce levels of obesity to London levels by October 2018.	95% of bereaved people signposted to appropriate services by April 2018.	Target to be confirmed by September 2015. Increase specialist leisure provision for those with SEND – to be agreed.
Lead organisation	LBBD	LBBD	LBBD	BHRUT	LBBD	LBBD	CCG	LBBD

Public Health Programmes Board								
Priority	**PREVENTION**							
Named lead	Paul Starkey – Health Improvement Advanced Practitioner	Jo Caswell Head of Personal Development Advisor	Jo Caswell Head of Personal Development Advisor	Wendy Matthews Director of Midwifery	Andy Knight Group Manager Community, Sport and Arts	Consultant in Public Health	Sharon Morrow – Chief Operating Officer	Andy Knight Group Manager Community, Sport and Arts

Learning Disability Subgroup

Priority	CARE AND SUPPORT							
Life stage	**Pre-Birth & Early Years**	**Primary School Age**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome	100% of children with a learning disability under 5 years have an annual check and health plan by 2018	Improve Health outcomes for children with special educational needs and disabilities						
Milestone Action for 2015-16	Children with complex care needs assessed and given appropriate care	To be confirmed by September 2015						
Action for 2016-18	100% of children with a learning disability under 5 years have an annual check and health plan by October 2018	To be confirmed by September 2015						
Lead organisation	LBBD	LBBD						

Learning Disability Subgroup								
Priority	**CARE AND SUPPORT**							
Named lead	Meena Kishinani Divisional Director Strategic Commissioning and Safeguarding	Meena Kishinani Divisional Director Strategic Commissioning and Safeguarding						

Learning Disability Subgroup								
Priority	**IMPROVEMENT AND INTEGRATION OF SERVICES**							
Life stage	**Pre-Birth & Early Years**	**Primary School Age**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome						Greater acceptance of adults with autism and ability to get a diagnosis and appropriate support by 2018		

Learning Disability Subgroup								
Priority	**IMPROVEMENT AND INTEGRATION OF SERVICES**							
Milestone Action for 2015-16						Ensure 100% people with autistic spectrum disorders with assessed eligible needs for care and support have personal budgets by April 2016.		
Action for 2016-18						Implementation of the Think Autism 15 priority challenges for action by October 2018.		
Lead organisation						LBBD		
Named lead						Bhatti Anjum Group Manager Intensive Support		

Learning Disability Subgroup

Priority	PREVENTION							
Life stage	**Pre-Birth & Early Years**	**Primary School Age**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome			Increase percentage of looked after children with a learning disability with annual health check and personal health plan to 95% by 2018.		Increase percentage of adults with learning disability with annual health check and personal plan to 95% by 2018.			
Milestone Action for 2015-16			Clear communication with staff about the role of health checks and health plans, supported by training and provider performance indicators – reviewed by April 2016.		Clear communication with staff about the role of health checks and health plans, supported by training and provider performance indicators - – reviewed by April 2016.			
Action for 2016-18			95% looked after children with a learning disability with annual health check and personal health plan by October 2018.		95% adults with learning disability with annual health check and personal plan by October 2018			
Lead organisation			CCG		CCG			

Learning Disability Subgroup								
Priority	**PREVENTION**							
Named lead			Sharon Morrow – Chief Operating Officer		Sharon Morrow – Chief Operating Officer			

Mental Health Subgroup								
Priority	**CARE AND SUPPORT**							
Life stage	**Pre-Birth & Early Years**	**Primary School Age**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome						Reduction in number of people claiming incapacity benefit from depression by 2018 – to be confirmed		
Milestone Action for 2015-16						Review and audit of case register and development of action plan by June 2016.		
Action for 2016-18						Implementation of action plan and evaluation of success to feed into Welfare Reform Group by 2018.		
Lead organisation						Mental Health Sub Group		
Named lead						Gill Mills Chair		

Mental Health Subgroup								
Priority	**IMPROVEMENT AND INTEGRATION OF SERVICES**							
Life stage	**Pre-Birth & Early Years**	**Primary School Age**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome			Commission high quality mental health services across the life-course that emphasise recovery by 2018		Assessment for new diagnoses at outset of treatment particularly focussed on diabetes	Increase numbers accessing Psychological Therapies (IAPT) services year on year	Increase percentage of adults with severe mental illness with physical health check by 2018	90% of GP practices to establish depression registers by 2018
Milestone Action for 2015-16			Develop the road map to mental health improvement for the next 5 years by October 2015.		Pathways and services for adults with depression into talking therapies in place by June 2016.	Ensuring commissioned services are IAPT compliant 95% should have access within 28 days by October 2016.	Care pathways and data collection process set up for physical health assessment in mental health patient settings by October 2016.	Development of new pathways for primary and community care by October 2016.
Action for 2016-18			BHR SPG to work with the Children's Strategic Clinical Network to develop joint commissioning and personal budgets		Transforming services to shift care closer to home	Embedding of IAPT in all commissioned mental health services and development of children and young people IAPT	Undertake annual patient reviews for all adults with severe mental illness	Patients with a new diagnosis of depression need regular review and a care plan (thresholds 45-80%) by April 2018.
Lead organisation			CCG		CCG	CCG	CCG	CCG
Named lead			Sharon Morrow - Chief Operating Officer		Sharon Morrow – Chief Operating Officer	Sharon Morrow – Chief Operating Officer	Sharon Morrow – Chief Operating Officer	Sharon Morrow – Chief Operating Officer

Mental Health Subgroup

Priority	PREVENTION							
Life stage	**Pre-Birth & Early Years**	**Primary School Age**	**Adolescence**	**Maternity**	**Early Adulthood**	**Established Adulthood**	**Older People**	**Vulnerable and Minority Groups**
Measurable outcome			Development of a suicide prevention action plan by 2016	Implement strategy to support prevention of post-natal depression by 2018	Improved early diagnosis of mental illness in diabetic patients by 2018	Raise awareness of the response of health and social care staff to mental illness across the system year-on-year	Raise awareness of pathway to support older people get Cognitive Stimulation Therapy (CST)	Develop new approaches to help people with mental health problems who are unemployed move into work and support them whilst they are out of work by 2018
Milestone Action for 2015-16			Undertake a local suicide audit by April 2016.	Training for health workers in order for them to spot early signs of PND % with PND scores > 12 % implemented by October 2016.	Establish Clinical Audit by October 2016.	All mental health first aiders expected to be trained by October 2015	Increase numbers of older people able to access CST – target to be confirmed	Establishment and implementation of a peer support programme by June 2016.
Action for 2016-18			Implement findings from local suicide audit via action plan from May 2016.	95% of women who have a miscarriage, stillbirth or death of a baby to have extra support by October 2018.	Development and implementation of action plan from audit results by June 2017.	Establish a learning network that is able to self organise that is linked to staff CPD by October 2017.		Evaluation of the peer support programme in 2018.
Lead organisation			Mental Health Sub Group	CMG Sub Group	CCG	Mental Health Sub Group	LBBD	LBBD
Named lead			Gill Mills Chair	Wendy Matthews Director of Midwifery	Sharon Morrow – Chief Operating Officer	Gill Mills Chair	Mark Tyson Group Manager Adult Commissioning	Mark Tyson Group Manager Adult Commissioning

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

12 MAY 2015

Title: Draft Health and Wellbeing Strategy Outcomes Framework	
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: All	**Key Decision:** Yes
Report Author: Matthew Cole Director of Public Health	**Contact Details:** Tel: 020 8227 3914 Email: matthew.cole@lbbd.gov.uk

Sponsor:

Anne Bristow Deputy Chief Executive & Corporate Director for Adult & Community Services

Summary:

The Health and Wellbeing Strategy is the overarching strategy working to improve health outcomes for local people. The breadth of the Strategy is supported through an outcomes framework which will enable the Health and Wellbeing Board to monitor progress and success in the short, medium and long term.

The Health and Wellbeing Outcomes Framework sets out the outcome indicators that will be used to monitor progress toward achieving the priorities set out in the Strategy.

Recommendation(s):

The Health and Wellbeing Board is recommended:

(i) To discuss and approve the refreshed Health and Wellbeing Strategy Delivery Plan

Reason(s):

The Health and Wellbeing Board has a duty to balance needs carefully and to make difficult decisions about strategic priorities given the resources available. The production of the joint Health and Wellbeing Strategy was enshrined in the Local Government and Public Involvement in Health Act 2007 and the Health and Social Care Act 2012 imposes this duty on local authorities and clinical commissioning groups, discharged through the Health and Wellbeing Board.

The Joint Health and Wellbeing Strategy also informs other strategies linked to the Council's priorities for delivering **One borough; one community; London's growth opportunity**.

1. Background

1.1 The Health and Wellbeing Strategy is supported by two key documents.

- Health and Wellbeing Strategy Delivery Plan
- Health and Wellbeing Outcomes Framework

1.2 The Health and Wellbeing Outcomes Framework sets out the outcome indicators that will be used to monitor progress toward achieving the priorities set out in the Strategy.

2. Introduction

2.1 The joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment (JSNA) are two of the key statutory documents that are produced by the Health and Wellbeing Board under the Health and Social Care Act 2012. NHS Barking and Dagenham Clinical Commissioning Group has a duty to develop the JSNA and the Joint Health and Wellbeing Strategy together with the Council through the Health and Wellbeing Board.

2.2 The refreshed Outcomes Framework supports delivery of the Health and Wellbeing Strategy to create an infrastructure for monitoring progress, while focusing on actions and milestones over the next three years of the Board.

2.3 The Health and Wellbeing Board sub groups will be responsible for the monitoring progress against the milestones in the delivery plan.

3. Policy Context

3.1 National Frameworks

In constructing the delivery plan we have taken into account national priorities and outcomes frameworks.

3.2 Local Strategies

The plan has also been informed by local partnership and individual agency strategies to minimise replication and reduce additional workload for reporting.

4. Delivery Plan

4.1 The Outcomes Framework is set out in Appendix 1.

5. Mandatory Implications

5.1 Joint Strategic Needs Assessment

This report is grounded on the most recent findings and recommendations of the JSNA.

5.2 Health and Wellbeing Strategy

The Framework aligns well with the recommendations of the JSNA. The refreshed strategy will continue to serve the borough well as a means to tackle the health and wellbeing needs of local people, as identified in the JSNA.

5.3 Integration

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

5.4 Financial Implications

Financial implications completed by Roger Hampson, Group Manager Finance, Adults and Community Services, LBBD.

The Health and Wellbeing Strategy Delivery Plan and Outcomes Framework provide a focus for existing resources to be targeted at those key priorities that will have a significant impact on the health and wellbeing of residents of the borough. There are no new resources to support implementation.

The Council has agreed a two year budget for 2015/16 and 2016/16; it is likely that additional savings will need to be considered across both the Council and health in 2017/18; the level of resources available will need to be reflected in the annual review of the delivery plan.

With regard to the further integration of services with health and partnership working, this is likely to form part of the development of Better Care Fund planning arrangements beyond the current agreement for 2015/16. These arrangements are dependent on the outcome of the General Election, not known at the time of writing these comments.

5.5 Legal Implications

Legal implications completed by Dawn Pelle Adult Care Lawyer, Legal and Democratic Services, LBBD.

There are no legal implications as the Health and Wellbeing Framework has been aligned with the variety of National Frameworks outlined in the Strategy Frameworks document and the provisions of the Care Act 2014 has been extensively referred to.

5.6 Risk Management

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

6. Appendices

6.1 Appendix 1: Joint Health and Wellbeing Strategy Outcomes Framework 2015-18

This page is intentionally left blank

Barking and Dagenham Health and Wellbeing Strategy Outcomes Framework

Introduction

Barking and Dagenham's Health and Wellbeing Board brings together representatives across the NHS, local authority public health, adult social care and children's services with elected councillors and Healthwatch to jointly consider local needs and plan the right services for our population. Working together to improve the health and wellbeing of local people and reduce health inequalities requires us to share an understanding of what we are trying to achieve, and how we will measure progress towards that aim. For this purpose, the Board has developed a Health and Wellbeing Strategy as its mechanism for addressing the needs identified in the Joint Strategic Needs Assessment, setting out agreed priorities for partnership working and collective action. The Delivery Plan for the Health and Wellbeing Strategy focuses on the key milestones and actions for the respective subgroups of the Health and Wellbeing Board.

The Health and Wellbeing Strategy Outcomes Framework provides a supporting structure with which to monitor and measure achievement of the priorities and actions stated in the Health and Wellbeing Strategy Delivery Plan. It sets out the expected and desired outcomes for people who access health and social care services within the London Borough of Barking and Dagenham and their families and carers, in order to help us understand how the needs of the population is being met and how well the health and wellbeing of local communities is being improved and protected.

The Outcomes Framework Indicators

The Outcomes Framework describes in detail the measurements we will use to monitor progress against the Delivery Plan. To achieve this, actions stated in the Delivery Plan have been aligned to indicators and outcomes from national outcome frameworks.

The framework concentrates on high-level outcomes to be achieved across the local health and social care system in 2015/16. The outcomes reflect a focus on the four key themes for public health, health and social care in Barking and Dagenham across the whole life course - prevention, protection, improvement and personalisation. Indicators are grouped according to the life stage which they are most relevant to. Where an indicator is relevant to more than one life stage or the same data source is used for age-bracketed information a single framework template is included rather than replicate information. The indicator definitions are in the appendices.

Within the framework, the local health and wellbeing outcome indicators have been aligned with the following national health and social care frameworks:

- **Public Health Outcomes Framework (PHOF) 2015/16** – contains indicators for which a breakdown of data is currently collected and published at both national level and upper tier Local Authority level (unless otherwise stated).
- **NHS Outcomes Framework (NHSOF) 2015/16** - contains indicators for which data is available on the Health and Social Care Information Centre (HSCIC) Indicator Portal (NHS OF or CCG Indicators sections) unless otherwise stated.
- **Adult Social Care Outcomes Framework (ASCOF) 2015/16**

Local targets are also included where applicable. This includes any related indicators in local corporate / strategic plans including Children and Young People's plans.

Glossary:

ASCOF – Adult Social Care Outcomes Framework

BHRUT – Barking, Havering and Redbridge University Hospitals NHS Trust

CCG – Clinical Commissioning Group

NELFT – North East London Foundation Trust

NHSOF – National Health Service Outcomes Framework

NSHE – NHS England

LBBD – London Borough of Barking and Dagenham (Council)

PHOF – Public Health Outcomes Framework

The framework sets out the responsibilities and reporting for each indicator for the respective subgroups:

- Children and Maternity
- Integrated Care Group
- Learning Disability Subgroup
- Mental Health Subgroup
- Public Health Programmes Board

Pre-Birth and Early Years

Indicator no.	Outcome Indicator	Activity Indicator	Delivery Plan Indicator	Delivery Plan Action	Lead Organisation	Delivery Plan Responsibility	Corporate Indicator
PHOF 2.2	Breastfeeding (all sub-indicators)	2.2i Breastfeeding initiation within 48 hours of delivery	Increased breastfeeding prevalence and rates, prevalence of breastfeeding and attachment Improved initiation Breastfeeding prevalence at 6-8 week check	Work towards stage 1 of Baby Friendly Initiative Implementation	BHRUT / NHS England	Children and Maternity Subgroup / Public Health Programmes Board	
PHOF 2.5	Child development at 2-2½ years	2.5i Proportion of children aged 2-2½yrs who received an assessment as part of the Healthy Child Programme or an integrated review (using any tool)	% of children seen by health visitor by day 14 Health Visitor transition	Healthy Child Programme for 0-5 years commissioned Transfer in October 2015 of the commissioning of the Early Years Programme services to the Council	LBBD	Public Health Programmes Board	

PHOF 3.3	Population vaccination coverage	3.3i Hepatitis B vaccination coverage (1 and 2 year olds)					13 - Percentage uptake of MMR (measles, mumps and rubella) vaccination (2 doses) at 5 years old 14 - Percentage uptake of DTaP/IPV (diphtheria, tetanus, whooping cough and polio) vaccination at age 5
			Number of unborn care assessment frameworks initiated	Clear safeguarding pathways and training in place across all maternity providers	CCG	Children and Maternity Subgroup	
			Introduce the new 4 routine blood tests for metabolic conditions	Successful introduction of tests at 9 weeks booking	BHRUT / NHS England	Children and Maternity Subgroup	

			Ensure that children with a LD under 5 years have an annual check and health plan	Children with complex care needs assessed and given appropriate care		Learning Disability Subgroup	

Primary School Years

Indicator no.	Outcome Indicator	Activity Indicator	Delivery Plan Indicator	Delivery Plan Action	Lead Organisation	Delivery Plan Responsibility	Corporate Indicator
PHOF 1.2	School readiness	1.2i Percentage of children achieving a good level of development at the end of reception	Improve the development of children in early years and introduce integrated reviews	To indentify speech, language and communication needs (SLCN) in children before they reach the age of 2 years using robust research methods	LBBD	Public Health Programmes Board	
PHOF 2.6	Excess weight in 4-5 and 10-11 year olds (all sub-indicators)	2.6i Percentage of children aged 4-5 classified as overweight or obese	% children with health review, including BMI at reception and Year 6 % children taking regular exercise as measured at health review Reduction in unhealthy weight	Physical Activity programme GET ACTIVE	LBBD	Children and Maternity Subgroup / Public Health Programmes Board	67 - The percentage of children in Reception recorded as obese 68 - The percentage of children in Year 6 recorded as obese

			in Reception and Year 6 Reduction in obesity % of 5-11 yr olds participating in 2 hours PE or more Improve cooking skills of adults and children % of children from ethnic and gender groups with a healthy weight				
PHOF 4.2	Tooth decay in children aged 5	4.2 Rate of tooth decay in children aged 5 years based on the mean number of teeth per child sampled which were either actively decayed or had been filled or extracted – decayed/missing/filled teeth	Improved oral health	Improved oral health across all age groups	NHS England	Children and Maternity Subgroup	
			Ensure that all children have complete immunisation records	Reach London levels for immunisation and then England levels	CCG	Children and Maternity Subgroup	

			Improving health outcomes for children with special educational needs and disabilities		LBBD	Learning Disability Subgroup	

Adolescence

Indicator no.	Outcome Indicator	Activity Sub-Indicator	Delivery Plan Indicator	Delivery Plan Action 2015/16	Lead Organisation	Delivery Plan Responsibility	Corporate Indicator
PHOF 1.5	16-18 year olds not in education, employment or training	1.5 Percentage of 16-18 year olds not in education, employment or training (NEET)					27 - 16 to 18 year olds who are not in education, employment or training (NEET)
PHOF 2.4	Under 18 conceptions	2.4 Under 18 conception rate per 1,000 population	Under 18 yrs conception rate (per 1000) and % change against 1998 baseline Reduce rate of teenage conceptions by 50% from '98 baseline for > 16 yr olds	Coherent sexual health and contraceptive services in place for young people Review strategy and develop an action plan	LBBD	Children and Maternity Subgroup / Public Health Programmes Board	* *Use of local data collection and record keeping systems to assess prevalence and impact on health and mental health outcomes of children at risk of CSE within a multi-agency framework*
PHOF 2.9	*Smoking prevalence - 15 year olds*	2.9i Prevalence of smoking among 15	Smoking rates at 15 yrs (review and	Multi-agency smoking strategy	LBBD / NELFT	Children and Maternity	

	(Placeholder)	years olds	move to prevalence) % teen mothers supported by Family Nurse Partnership %teen mothers supported by Baby Intervention to breastfeed and stop smoking Reduction in numbers of school children taking up smoking	refreshed and action plan developed to reduce smoking in 15 yrs >80% of expected visits made to teenage mothers Social marketing campaign		Subgroup / Public Health Programmes Board	
PHOF 3.2	Chlamydia diagnoses (15-24 year olds)	3.2i Crude rate of chlamydia diagnoses screening detection per 100,000 young adults aged 15-24 using old National Chlamydia Screening Programme (NCSP) data	Increase the proportion of young people testing for Chlamydia	Increase coverage to 35%	LBBD	Public Health Programmes Board	

			% teen mothers supported by Family nurse partnership	FNP engagement plan and pathways refreshed. At least 60% of first time mums enrolled before 16 weeks and 100% no later than 28 weeks Baby Intervention pathways refreshed to ensure young parents who do not meet the criteria for FNP still get early intervention and support	NELFT	Children and Maternity Subgroup	
			Increase overall wellness score	Ensure health and wellbeing addressed within council and CCG OD plans	LBBD	Public Health Programmes Board	
			Perceptions of drunk or rowdy behaviour as a problem	Campaign for young men	LBBD	Public Health Programmes Board	

			% Looked after children with a learning disability with annual health check and personal health plan	Clear communication with staff about the role of health checks and health plans, supported by training and provider performance indicators	CCG	Learning Disability Subgroup	
			Change the way frontline health services respond to self-harm and how walk-in centres can be supported		CCG	Learning Disability Subgroup	
			Commissioning high quality mental health services across the life-course that emphasise recovery	Develop the road map to mental health improvement for the next 5 yrs	CCG	Mental Health Subgroup	

Maternity

Indicator no.	Outcome Indicator	Activity Sub-Indicator	Delivery Plan Indicator	Delivery Plan Action 2015/16	Lead Organisation	Delivery Plan Responsibility	Corporate Indicator
PHOF 2.3	Smoking status at time of delivery	2.3 Rate of smoking at time of delivery per 100 maternities	% teen mothers supported by Family Nurse Partnership Reduction in the number of pregnant women smoking at time of delivery %teen mothers supported by Baby Intervention to breastfeed and stop smoking Decrease the number of pregnant women who are smoking in pregnancy through the implementation of BabyClear	>80% of expected visits made to teenage mothers Identify funding for phase 2, improve assessments and support midwives Implementation of the BabyClear programme	NELFT / BHRUT	Children and Maternity Subgroup	

			Number of births at Barking hospital	Training for midwives and children's centres staff to support pathways of care	CCG	Children and Maternity Subgroup	
PHOF 2.21	Access to non-cancer screening programmes	2.21i: HIV coverage: The percentage of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result (national only)	% of women treated for HIV in pregnancy % of mothers booked with maternity services by 13th week of pregnancy in light of new blood tests Uptake of HPV vaccination Increase the uptake of seasonal flu amongst pregnant women %of over 65 yr olds protected through seasonal flu immunisation	Training for midwives supported by public awareness campaign Primary care and children's centres education programme to support signposting Move 1st booking to 11 weeks Preparation for parenthood classes – delivered by children's centre staff/Health visitors/midwives Commissioning of new HPV vaccines with training and governance support for staff Increase the uptake of seasonal	NHS England / CCG	Children and Maternity Subgroup / Public Health Programmes Board	

				flu amongst pregnant women Local pathway work to improve uptake through partnership			

Early Adulthood

Indicator no.	Outcome Indicator	Activity sub-Indicator	Delivery Plan Indicator	Delivery Plan Action 2015/16	Lead Organisation	Delivery Plan Responsibility	Corporate Indicator
PHOF 1.9	Sickness absence rate	1.9i: Percentage of employees who had at least one day off sick in the previous week	Decrease average rates of sickness of those in work	Pilot with local employers	LBBD	Public Health Programmes Board	
PHOF 1.11	Domestic abuse	1.11 Rate of domestic abuse incidents reported to the police, per 1,000 population	Repeat MARAC caseload Reduce number of domestic violence cases among pregnant women	Ensure 20% of frontline staff have attended multi-agency domestic violence and violence against women and girls training	LBBD / CCG / NHSE	Integrated Care Group / Public Health Programmes Board	Repeat incidents of domestic violence (MARAC) – no more than 28% (2014/15 target)
PHOF 2.12	Excess weight in adults	2.12 Proportion of adults classified as overweight or obese	% reduction in prevalence of adult obesity from baseline	Develop adult obesity strategy Common/core nutritional standards for all commissioned services	LBBD	Public Health Programmes Board	

			Reduce the prevalence of STIs	Increase equitable access to contraception and STI testing Reduce PID to England and then London levels	LBBD	Children and Maternity Subgroup	
			% of Adults with Learning Disability with annual health check and personal plan	Clear communication with staff about the role of health checks and health plans, supported by training and provider performance indicators	CCG	Learning Disability Subgroup	
			% of people of different backgrounds getting on well	Development of peer intervention programme for the borough	Mental Health Subgroup	Mental Health Subgroup	
			Assessment for new diagnoses at outset of treatment particularly focussed on diabetes	Pathways and services for adults with depression into talking therapies taking place	CCG	Mental Health Subgroup	

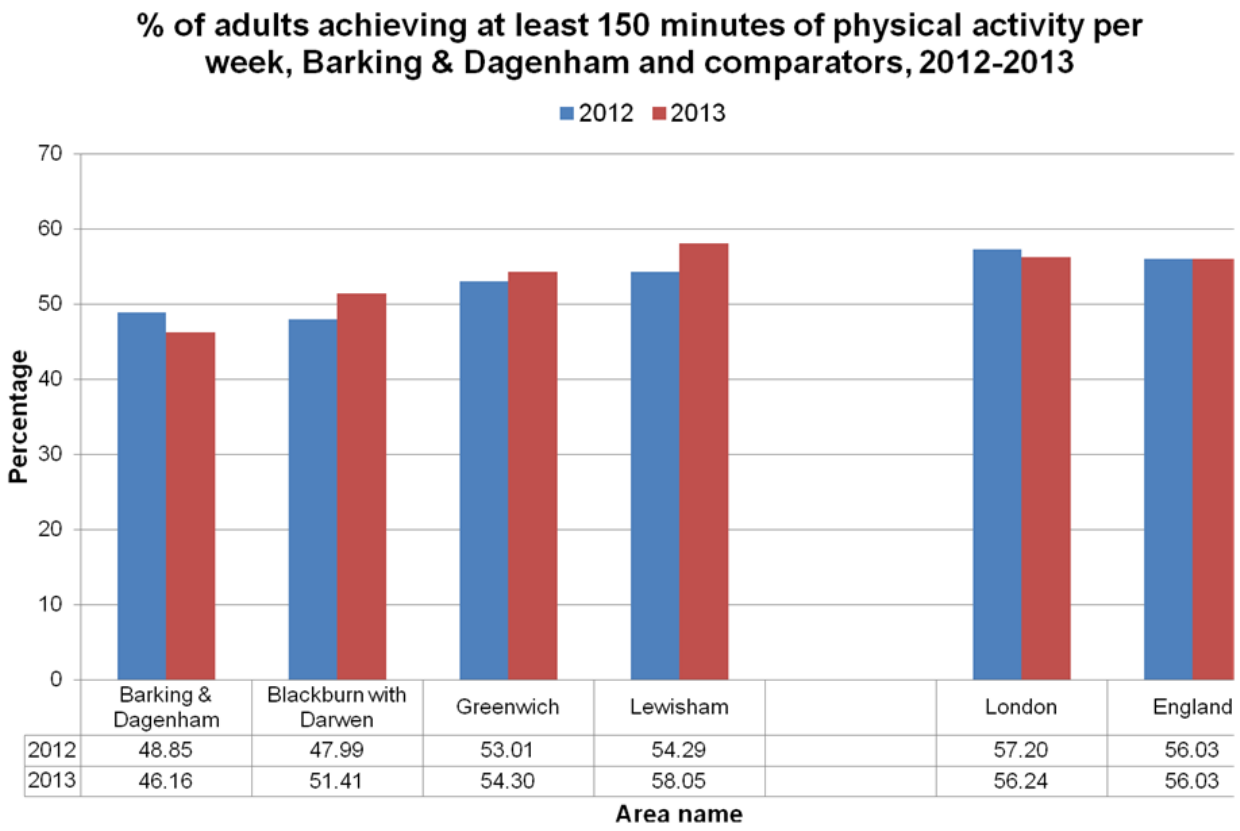
Established Adulthood

Indicator no.	Outcome Indicator	Activity Sub-Indicator	Delivery Plan Indicator	Delivery Plan Action 2015/16	Lead Organisation	Delivery Plan Responsibility	Corporate Indicator
PHOF 2.13	Proportion of physically active and inactive adults	2.13i Proportion of adults achieving at least 150 minutes of physical activity per week in accordance with UK CMO recommended guidelines on physical activity	% of adults cycling or walking to work % increase in the number of adults participating in regular physical activity	Active transport survey conducted and cycling strategy developed across the partnerships Develop adult obesity strategy Leisure pass scheme for older people Leisure pass scheme for people with disabilities and those on low incomes Widening access through new and upgraded facilities	LBBD	Integrated Care Group	

PHOF 2.14	Smoking prevalence – adults (over 18s)	2.14 Prevalence of smoking among persons aged 18 years and over	Number of smoking quitters under 30 (review and move to prevalence) % reduction in smoking prevalence over the 3 year period from 2009/10 baseline	Targeted promotion work with high-risk smoking populations and routine and manual groups Social marketing campaign	LBBD	Integrated Care Group / Public Health Programmes Board	
PHOF 2.15	Successful completion of drug treatment	2.15 Number of drug users that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number in treatment 2.15i - Successful completion of drug treatment - opiate users 2.15ii - Successful completion of drug treatment - non-opiate users	Increase the % successful completion of drug treatment (opiate and non-opiate users)		LBBD	Public Health Programmes Board	

PHOF 2.22	Take up of the NHS Health Check programme – by those eligible	2.22iii Cumulative percentage of eligible population aged 40-74 offered an NHS Health Check in the five year period 2013/14 - 2017/18 (Replaces indicator 2.22i)	Increase uptake of NHS Health Checks	Health checks process and pathways secured during transition Increase uptake to 50% of 40 – 74 yr olds	LBBD	Public Health Programmes Board	
PHOF 4.11	Emergency readmissions within 30 days of discharge from hospital		Re-admission to hospital within 30 days of discharge	Implement integrated discharge planning process	Integrated Care Subgroup	Integrated Care Group	
NHSOF 3b	Emergency readmissions within 30 days within 30 days of discharge from hospital		Re-admission to hospital within 30 days of discharge	Implement integrated discharge planning process	Integrated Care Subgroup	Integrated Care Group	
ASCOF 1C	Proportion of people using social care who receive self-directed support and those receiving direct payments		Number of adults using direct payments	Increased choices for older people – more personal assistance available	LBBD	Integrated Care Group	10 - The proportion of social care clients accessing care and support in the home via direct payments

			Greater acceptance of adults with autism and ability to get a diagnosis and appropriate support	Ensure people with autistic spectrum disorders with assessed eligible needs for care and support have personal budgets	LBBD	Learning Disability Subgroup	
			Reduction in number of people claiming incapacity benefit from depression	Review and audit of case register and development of action plan	Mental Health Subgroup	Mental Health Subgroup	
			Access to Psychological Therapies (IAPT) services	Ensuring commissioned services are IAPT compliant 95% should have access within 28 days	CCG	Mental Health Subgroup	


% of adults achieving at least 150 minutes of physical activity per week, Barking & Dagenham and comparators, 2012-2013
2012
2013
70
60
50
40
30
20
10
0
Percentage
Barking & Dagenham
Blackburn with Darwen
Greenwich
Lewisham
London
England
2012 48.85 47.99 53.01 54.29 57.20 56.03
2013 46.16 51.41 54.30 58.05 56.24 56.03
Area name

Older Adults

Indicator no.	Outcome Indicator	Activity Sub-Indicator	Delivery Plan Indicator	Delivery Action plan 2015/16	Lead Organisation	Delivery Plan Responsibility	Corporate Indicator
PHOF 4.14	Health-related quality of life for older people		Increase early diagnosis and identification of at risk older people in primary care and reduce unnecessary admission to hospital	Pilot Self-care programme for patients and carers	LBBD	Public Health Programmes Board	
PHOF 4.15	Excess winter deaths		Reduce excess mortality of older people in extreme temperatures	At risk older people receive correct, clear, consistent, useful and actionable advice and information from the local organisations they come into contact with	NHSE	Integrated Care Group	
			Enable those at end of life to die with dignity where they	Expansion of specialist and palliative care	LBBD	Public Health Programmes Board	

			want	services			
			All bereaved people signposted to appropriate bereavement support services	Establishment of bereavement support services	CCG	Public Health Programmes Board	
			Measurement of the effects of austerity and welfare reform	Council to set up a system to measure the effects of austerity and levels of need so that partners can understand the impact on residents	LBBD	Mental Health Subgroup	
			% adults with severe mental illness with physical health check	Care pathways and data collection process set up for physical health assessment in mental health patient settings	CCG	Mental Health Subgroup	

Vulnerable and Minority Groups

Indicator no.	Outcome Indicator	Activity Sub-Indicator	Delivery Plan Indicator	Delivery Plan Action 2015/16	Lead Organisation	Delivery Plan Responsibility	Corporate Indicator
PHOF 1.8	Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services	1.8i: Percentage of respondents in the Labour Force Survey (LFS) who have a long-term condition who are classed as employed using the International Labour Organisation (ILO) definition of employment, compared to the percentage of all respondents classed as employed					66 - The proportion of adults with a learning disability in paid employment
			Reduce numbers of people on incapacity benefit		LBBD	Public Health Programmes Board	

			% people who feel that they belong to their local neighbourhood IAPT take up amongst men	Increasing community resilience through development of programmes to support community	LBBD	Mental health Subgroup	
			Practices to establish depression registers	Development of new pathways for primary and community care	CCG	Mental health Subgroup	

The Activity Indicator Templates

Where the Local Authority and the NHS share national indicators these are highlighted as follows:

*Indicator shared with the NHS Outcomes Framework 2015/16

** Complementary to indicators in the NHS Outcomes Framework

† Indicator shared with the Adult Social Care Outcomes Framework

†† Complementary to indicators in the Adult Social Care Outcomes Framework

Indicator No	Outcome Indicator	Lead authority
PHOF 1.1	Children in poverty	LBBD
PHOF 1.2	School readiness	LBBD
PHOF 1.3	Pupil absence	LBBD
PHOF 1.4	First time entrants to the youth justice system	LBBD
PHOF 1.5	16-18 year olds not in education, employment or training	LBBD
PHOF 1.6	Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation	LBBD
	† *ASCOF 1G and 1H*	
PHOF 1.8	Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services	LBBD
	*(i-NHSOF 2.2) ††(ii-ASCOF 1E) **(iii-NHSOF 2.5) †† (iii-ASCOF 1F)	
PHOF 1.9	Sickness absence rate	LBBD
PHOF 1.10	Killed and seriously injured casualties on England's roads	LBBD
PHOF 1.11	Domestic abuse	LBBD
PHOF 1.12	Violent crime (including sexual violence)	LBBD
PHOF 1.13	Re-offending levels	LBBD
PHOF 1.15	Statutory homelessness	LBBD
PHOF 1.16	Utilisation of outdoor space for exercise / health reasons	LBBD
PHOF 1.17	Fuel poverty	LBBD
PHOF 1.18	Social isolation	LBBD
	† *ASCOF 1I*	
PHOF 2.1	Low birth weight of term babies	LBBD
PHOF 2.2	Breastfeeding (all sub-indicators)	LBBD
PHOF 2.3	Smoking status at time of delivery	LBBD

PHOF 2.4	Under 18 conceptions	LBBD
PHOF 2.5	Child development at 2-2½ years	LBBD
PHOF 2.6	Excess weight in 4-5 and 10-11 year olds (all sub-indicators)	LBBD
PHOF 2.7	Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years	LBBD
PHOF 2.8	Emotional well-being of looked after children	LBBD
PHOF 2.9	*Smoking prevalence - 15 year olds (Placeholder)*	LBBD
PHOF 2.12	Excess weight in adults	LBBD
PHOF 2.13	Proportion of physically active and inactive adults	LBBD
PHOF 2.14	Smoking prevalence – adults (over 18s)	LBBD
PHOF 2.15	Successful completion of drug treatment	LBBD
PHOF 2.17	Recorded diabetes	LBBD
PHOF 2.18	Alcohol-related admissions to hospital	LBBD
PHOF 2.19	Cancer diagnosed at stage 1 and 2	LBBD
PHOF 2.20	Cancer screening coverage	LBBD
PHOF 2.21	Access to non-cancer screening programmes	LBBD
PHOF 2.22	Take up of the NHS Health Check programme – by those eligible	LBBD
PHOF 2.24	Injuries due to falls in people aged 65 and over	LBBD
PHOF 3.2	Chlamydia diagnoses (15-24 year olds)	LBBD
PHOF 3.3	Population vaccination coverage	LBBD
PHOF 3.4	People presenting with HIV at a late stage of infection	LBBD
PHOF 3.5	Treatment completion for TB	LBBD
PHOF 4.1	Infant mortality	LBBD
	**NHSOF 1.6i*	
PHOF 4.2	Tooth decay in children aged 5	LBBD
PHOF 4.3	Mortality rate from causes considered preventable	LBBD

	***NHSOF 1a*	
PHOF 4.4	Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)	LBBD
	**NHSOF 1.1*	
PHOF 4.5	Under 75 mortality rate from cancer	LBBD
	**NHSOF 1.4*	
PHOF 4.6	Under 75 mortality rate from liver disease	LBBD
	**NHSOF 1.3*	
PHOF 4.7	Under 75 mortality rate from respiratory diseases	LBBD
	**NHSOF 1.2*	
PHOF 4.8	Mortality rate from communicable diseases	LBBD
PHOF 4.9	Excess under 75 mortality rate in adults with serious mental illness	
	**(NHSOF 1.5)*	
PHOF 4.1	Suicide rate	LBBD
PHOF 4.11	Emergency readmissions within 30 days of discharge from hospital	LBBD
	**NHSOF 3b*	
PHOF 4.12	Preventable sight loss	LBBD
PHOF 4.14	Health-related quality of life for older people	LBBD
PHOF 4.15	Excess winter deaths	LBBD
PHOF 4.16	Estimated diagnosis rate for people with dementia	LBBD
	**NHSOF 2.6i*	
NHSOF 1ai	Potential Years of Life Lost (PYLL) from causes considered amenable to health care - adults	NHS
NHSOF 1aii	Potential Years of Life Lost (PYLL) from causes considered amenable to health care - children and young people	NHS
NHSOF 1.1	Under 75 mortality rate from respiratory disease	NHS
	**PHOF 4.4*	

NHSOF 1.2	Under 75 mortality rate from respiratory disease	NHS
	**PHOF 4.7*	
NHSOF 1.3	Under 75 mortality rate from liver disease	NHS
	**PHOF 4.6*	
NHSOF 1.4	Under 75 mortality from cancer	NHS
	**PHOF 4.5*	
NHSOF 1.4i	One-year survival for all cancers	NHS
NHSOF 1.4iii	One-year survival for breast, lung and colorectal cancer	NHS
NHSOF 2	Healthy-related quality of life for people with long-term conditions	NHS
NHSOF 2.1	Proportion of people feeling supported to manage their condition	NHS
NHSOF 2.3i	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)	NHS
NHSOF 2.3ii	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	NHS
NHSOF 3a	Emergency admissions for acute conditions that should not usually require hospital admission	NHS
NHSOF 3b	Emergency readmissions within 30 days within 30 days of discharge from hospital	NHS
	**PHOF 4.11*	
NHSOF 3.2	Emergency admissions for children with lower respiratory tract infections (LRTI)	NHS
NHSOF 3.5i	Proportion of patients with hip fractures recovering to their previous levels of mobility/walking ability at 30 days	NHS
NHSOF 3.3ii	Proportion of patients with hip fractures recovering to their previous levels of mobility/walking ability at 120 days	NHS
NHSOF 4a.i	Patient experience of GP services	NHS
NHSOF 4aii	Patient experience of out of hours GP services	NHS
NHSOF 4aiii	Patient experience of NHS dental services	NHS
NHSOF 4b	Patient experience of hospital care	NHS
NHSOF 4.2	Responsiveness to in-patients' personal needs	NHS
NHSOF 4.4i	Access to GP services	NHS

NHSOF 4.4ii	Access to NHS dental services	NHS
ASCOF 1A	Social care-related quality of life	LBBD
ASCOF 1B	Proportion of people who use services who have control over their daily life	LBBD
ASCOF 1C	Proportion of people using social care who receive self-directed support and those receiving direct payments	LBBD
ASCOF 1D	Carer-reported quality of life	LBBD
ASCOF 1E	Proportion of adults with a learning disability in paid employment	LBBD
ASCOF 1F	Proportion of adults in contact with secondary mental health services in paid employment	LBBD
ASCOF 1G	Proportion of adults with a learning disability who live in their own home or with their family	LBBD
ASCOF 1H	Proportion of adults in contact with secondary mental health services who live independently, with or without support	LBBD
ASCOF 1I	Proportion of people who use services and their carers who reported that they had as much social contact as they would like	LBBD
ASCOF 2A	Permanent admissions to residential and nursing care homes, per 100,000 population	LBBD
ASCOF 2B	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services	LBBD
ASCOF 2C	Delayed transfers of care from hospital and those which are attributable to adult social care	LBBD
ASCOF 2D	The outcomes of short-term support: sequel to service	LBBD
ASCOF 2E	*Effectiveness of re-ablement services (Placeholder)*	LBBD
ASCOF 2F	*Dementia - a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life (Placeholder)*	LBBD
ASCOF 3A	Overall satisfaction of people who use services with their care and support	LBBD
ASCOF 3B	Overall satisfaction of carers with social services	LBBD
ASCOF 3E	Improving people's experience of integrated care	LBBD
ASCOF 3C	The proportion of carers who report that they have been included or consulted in discussions about the person they care for	LBBD

ASCOF 3D	The proportion of people who use services and carers who find it easy to find information about services	LBBD
ASCOF 4A	The proportion of people who use services who feel safe	LBBD
ASCOF 4B	The proportion of people who use services who say that those services have made them feel safe and secure	LBBD
ASCOF 4C	*Proportion of completed safeguarding referrals where people report they feel safe (Placeholder)*	LBBD

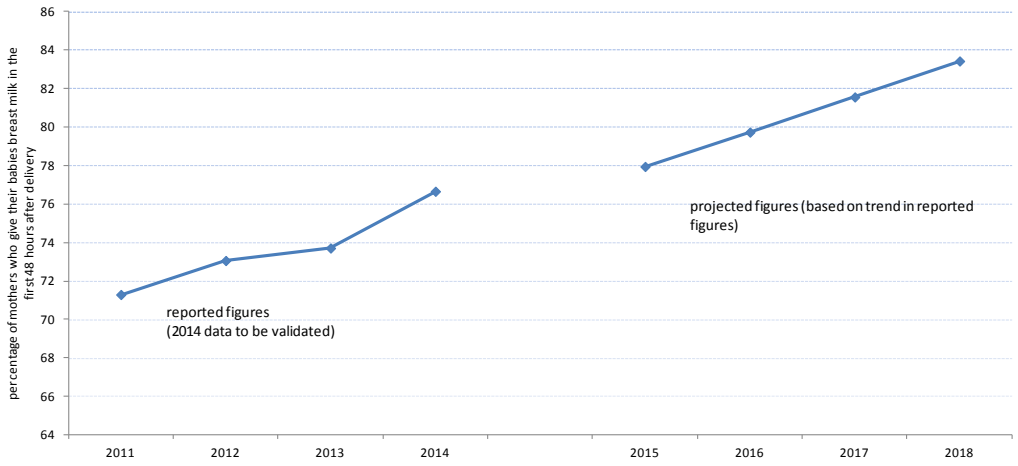
Appendix A

The Outcome Indicator Templates

For each outcome indicator there is an indicator template setting out:

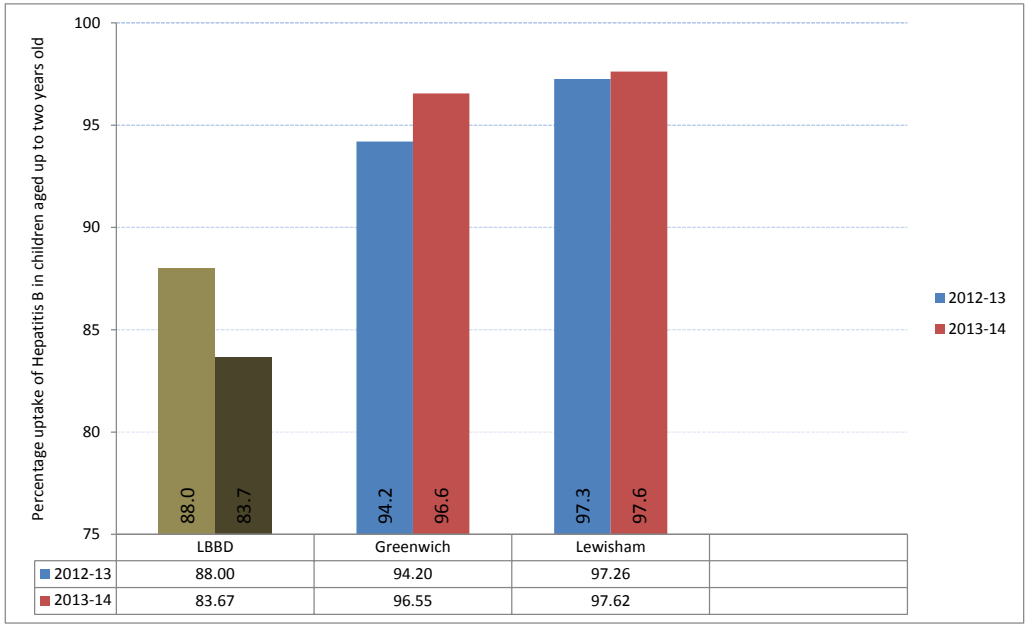
- Definition for the indicator, including definition of the denominator
- Source of the data
- Frequency of the data
- Responsible lead organisation for providing the data to the performance sub-group
- Historical activity to date where available

Pre-Birth and Early Years

Indicator Number	2.2i	Indicator Name	Breastfeeding prevalence at 6-8 weeks checks	Indicator Type	Outcome
Definition	Measures the percentage of mothers who give their babies breast milk in the first 48 hours after delivery. The numerator is the number of mothers initiating breast feeding and the denominator is the total number of maternities.				
Source	Department of Health				
Frequency	Quarterly				
National target	??				
Responsible Lead	BHRUT/NHS England				
Historical performance	**Breastfeeding initiation (PHOF 2.1) - Projected changes based on current trends** 				

	2011	2012	2013	2014
Actual rates (%)	71.29	73.06	73.71	76.66
Reporting Period	**2015**	**2016**	**2017**	**2018**
Predicted rates, % (based on trend)	77.95	79.73	81.56	83.43
Actual rates., % (to be submitted)				

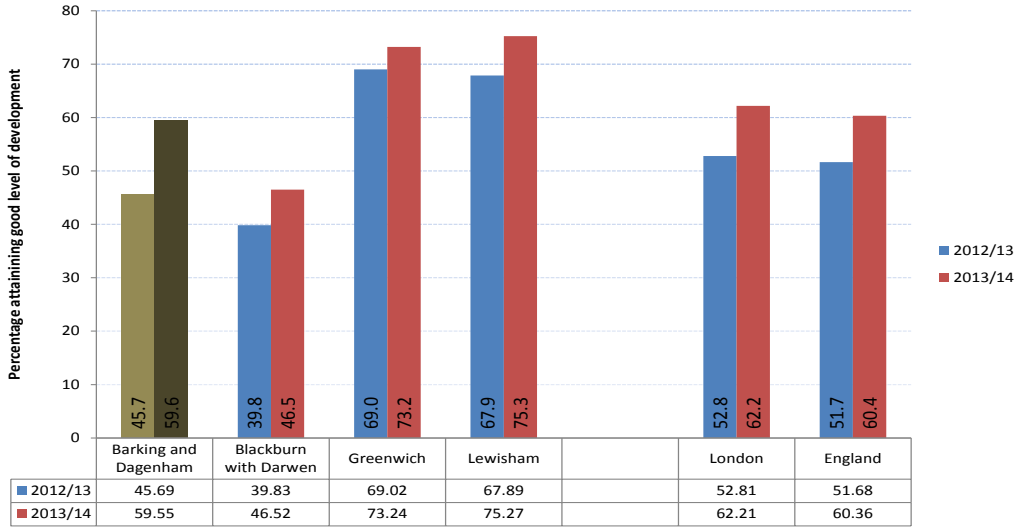
Indicator Number	2.5	Indicator Name	Child development at 2-2½ years	Indicator Type	Outcome
Definition	*Proportion of children aged 2-2½yrs who received an assessment as part of the Healthy Child Programme or an integrated review (using any tool)*				
Source	LBBD??				
Frequency	??				
Target	Data not available on PHE/PHOF website to set target/trajectory. May require discussion with Programme Leads. Two additional sets of indicators also included for activity				
Responsible Lead	To be confirmed				
Historical performance					

Indicator Number	PHOF 3.3	Indicator Name	Population vaccination coverage	Indicator Type	Outcome
Definition	Hepatitis B vaccination coverage (1 and 2 year olds)				
Source	Department of Health				
Frequency	Quarterly				
National target	Coverage to be confirmed with PH consultants, but likely to be 95%. Coverage for other vaccinations (COVER stats) to be included in list. Target should be set at minimum national uptake rates, but could also be considered for stretching to match SNs uptake rates				
Responsible Lead					
Historical performance	Hepatitis B Vaccine uptake in LBBD compared with some London statistical neighbours 				

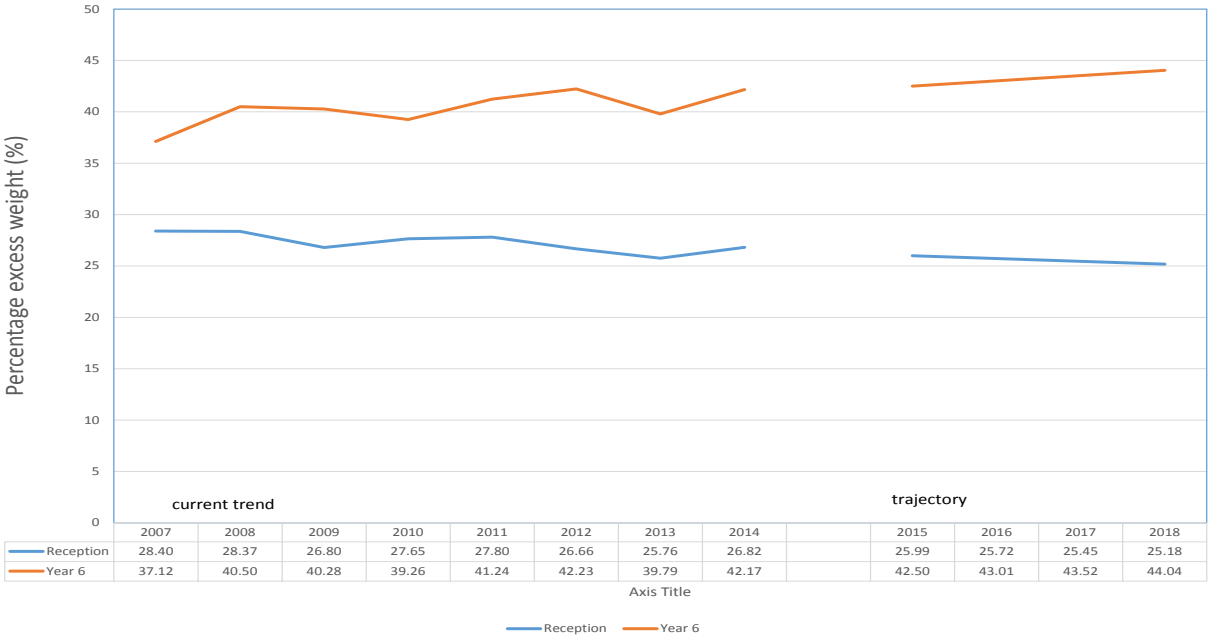
	LBBD	Greenwich	Lewisham	
2012-13	88.00	94.20	97.26	
2013-14	83.67	96.55	97.62	

Primary School Years

Indicator Number	1.2i	Indicator Name	School Readiness	Indicator Type	Outcome
Definition	**1.2i Percentage of children achieving a good level of development at the end of reception**				
Source	Department for Education (DfE), EYFS Profile (Produced by PHE); http://www.gov.uk/government/statistics/eyfsp-attainment-by-pupil-characteristics-2013-to-2014				
Frequency	Annual publication				
National target	To be clarified – but in absence of target, comparisons with come statistical neighbours, London and England is appropriate. To match either London SNs, OR at least London/national levels at 61-62%, reaching 75% by 2018. May want to average for all SNs for more precision				
Responsible Lead					
Historical performance	**Percentage of LBBD children eligible for EYFS profile achieving a good level of development at the end of reception (compared to some statistical neighbours, London and England)**				



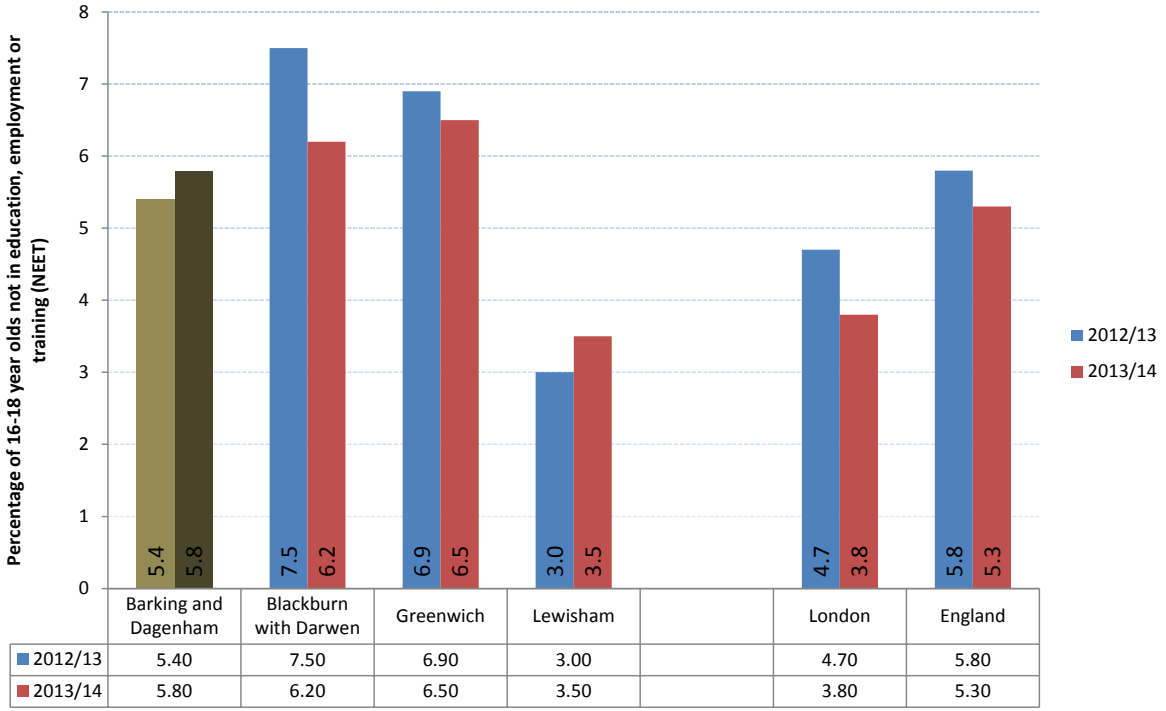
	Barking and Dagenham	Blackburn with Darwen	Greenwich	Lewisham		London	England
2012/13	45.69	39.83	69.02	67.89		52.81	51.68
2013/14	59.55	46.52	73.24	75.27		62.21	60.36

Indicator Number	1.5	Indicator Name	16-18 year olds not in education, employment or training	Indicator Type	Outcome
Definition	Annual rate of Children who are of excess weight (obese and overweight) in in the Reception/Year Six Children cohort.				
Source	National Child Measurement Programme				
Frequency	Annually - published in December of the year following the academic measurement year				
National target	Based on current trends, trajectory suggests increase in rates of excess weight in both cohorts. Comparatively rates are set to decrease in London and England, so suggest benchmark against these standards (for Reception, 22-23%, and Year 6, 34-38% between 2015-18.				
Responsible Lead					
Historical performance	% of Children who are of excess weight (Reception and Year 6), And trajectory based on current trends 				

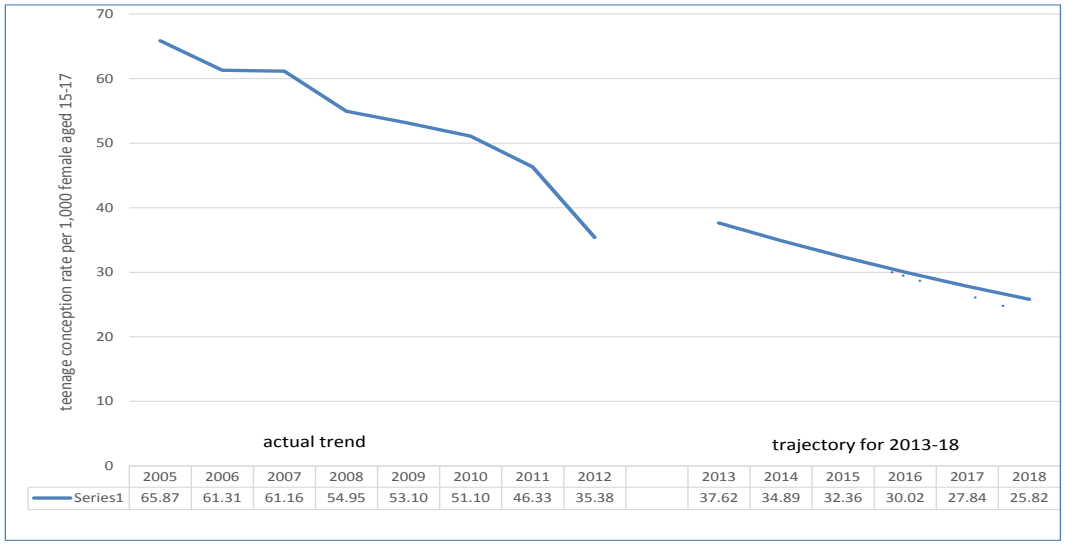
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Reception	28.40	28.37	26.80	27.65	27.80	26.66	25.76	26.82	25.99	25.72	25.45	25.18
Year 6	37.12	40.50	40.28	39.26	41.24	42.23	39.79	42.17	42.50	43.01	43.52	44.04

Adolescence

Indicator Number	1.5	Indicator Name	16-18 year olds not in education, employment or training (NEET)	Indicator Type	Outcome
Definition	1.5 Percentage of 16-18 year olds not in education, employment or training (NEET)				
Source	Department for Education				
Frequency	Annually				
National target	Targets can be set consistent with the rates for London – 3.8-4.7% between 2015 and 2018.				
Responsible Lead	To be confirmed				
Historical performance	Percentage of 16-18 year olds not in education, employment or training (NEET)				



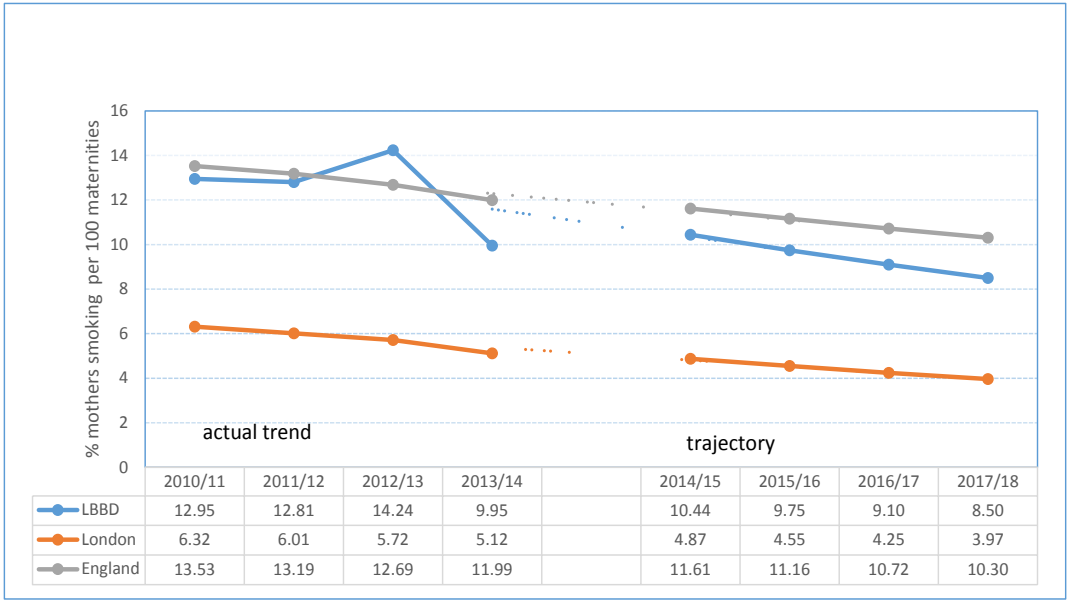
Indicator Number	2.4	Indicator Name	Conception rates	Indicator Type	Outcome
Definition	Under 18 conception rate per 1,000 population				
Source	Office for National Statistics (ONS)				
Frequency	Annual				
National target	Trajectory benchmarked against 2005 rather than 1998 for which targets will not be as challenging considering rates of 35/1000 already reached at 2012. Target set are in tables below chart (2013-18)				
Responsible Lead	To be confirmed				

Historical performance	Trajectory for teenage conception based on 2005-2012 trend 

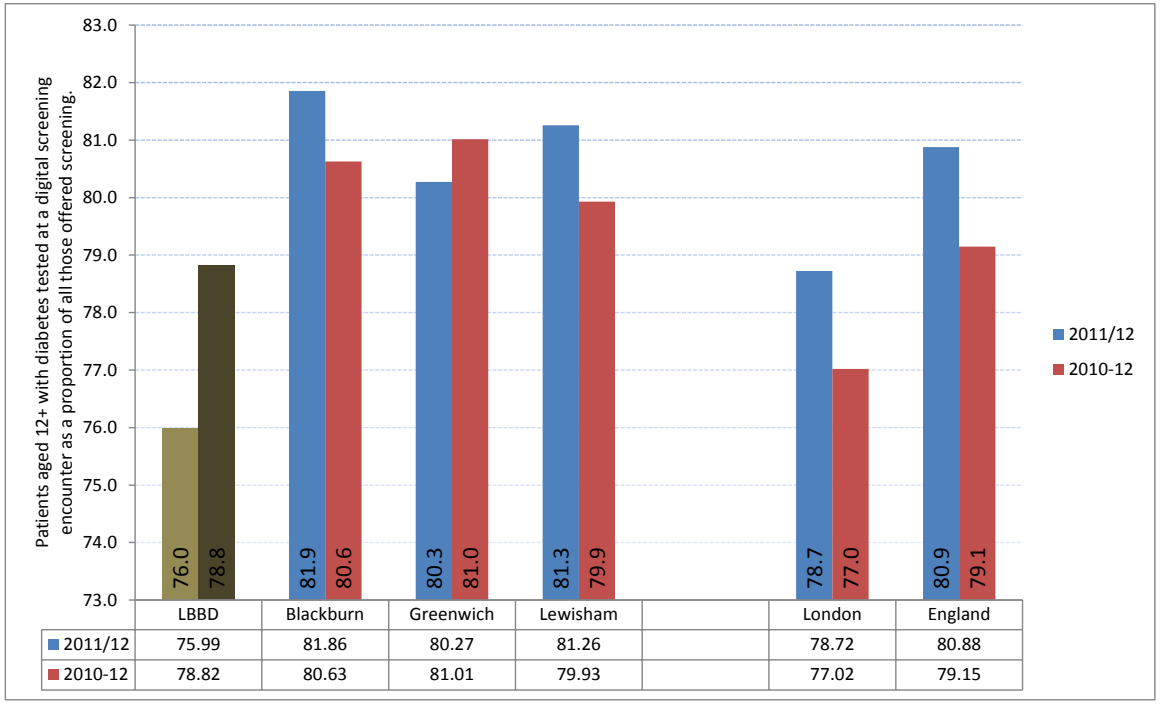
	2005	2006	2007	2008	2009	2010	2011	2012		2013	2014	2015	2016	2017	2018
Series1	65.87	61.31	61.16	54.95	53.10	51.10	46.33	35.38		37.62	34.89	32.36	30.02	27.84	25.82

Maternity

Indicator Number	2.3	Indicator Name	Smoking status at time of delivery	Indicator Type	Outcome
Definition	**2.3 Number of women who currently smoke at time of delivery per 100 maternities.**				
Source	Health and Social Care Information Centre				
Frequency	Annual				
Target	Reduce the gap between LBBD and London average; and marked reductions in LBBD rates matching that of London				
Responsible Lead	To be confirmed				
Historical performance	LBBD smoking status at time of delivery (with trajectory benchmarked against current trends), London and England				



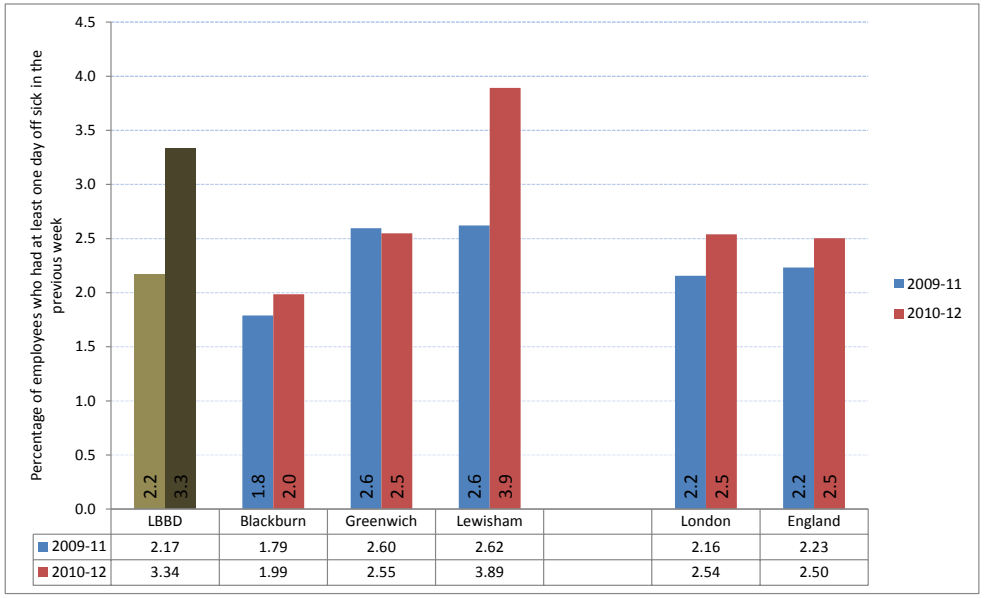
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
LBBD	12.95	12.81	14.24	9.95	10.44	9.75	9.10	8.50
London	6.32	6.01	5.72	5.12	4.87	4.55	4.25	3.97
England	13.53	13.19	12.69	11.99	11.61	11.16	10.72	10.30

Indicator Number	2.21	Indicator Name	Access to non-cancer screening programmes - diabetic retinopathy	Indicator Type	Outcome
Definition	Patients aged 12+ with diabetes tested at a digital screening encounter as a proportion of all those offered screening.				
Source	Department of Health				
Frequency	Annual				
Target	Aspire to match coverage consistent with SNs and England. Programme Leads can review comparative rates to set targets, but suggest not less than 8-% coverage by 2018 (on the assumption that there is no national target set)				
Responsible Lead	BHRUT Divisional Director for Maternity Services				
Historical performance					

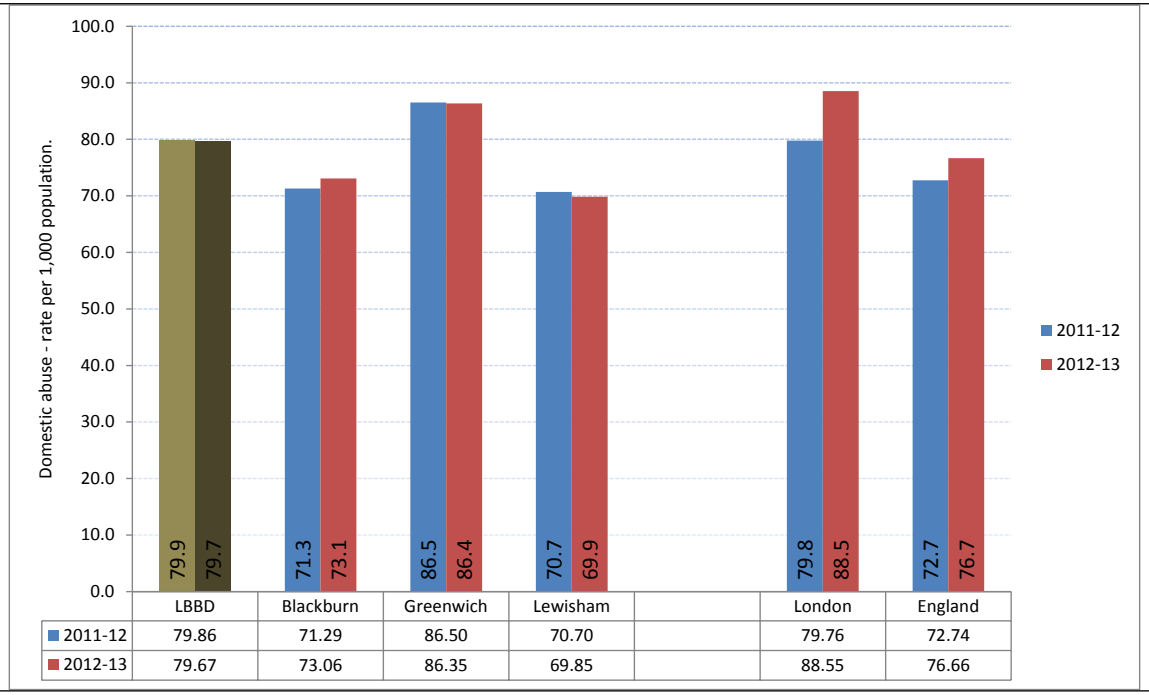
	LBBD	Blackburn	Greenwich	Lewisham		London	England
2011/12	75.99	81.86	80.27	81.26		78.72	80.88
2010-12	78.82	80.63	81.01	79.93		77.02	79.15

Early Adulthood

Indicator Number	1.9i	Indicator Name	Sickness absence rate	Indicator Type	Outcome
Definition	Percentage of employees who had at least one day off sick in the previous week				
Source	Labour Force Survey - Data provided by ONS				
Frequency	Annual				
Target	Unclear if target set, but to see a declining trend in rates consistent with regional and/or national average could be a realistic objective				
Responsible Lead	LBBD				
Historical performance	Percent of employees who had at least one day off due to sickness absence in the previous working week.				

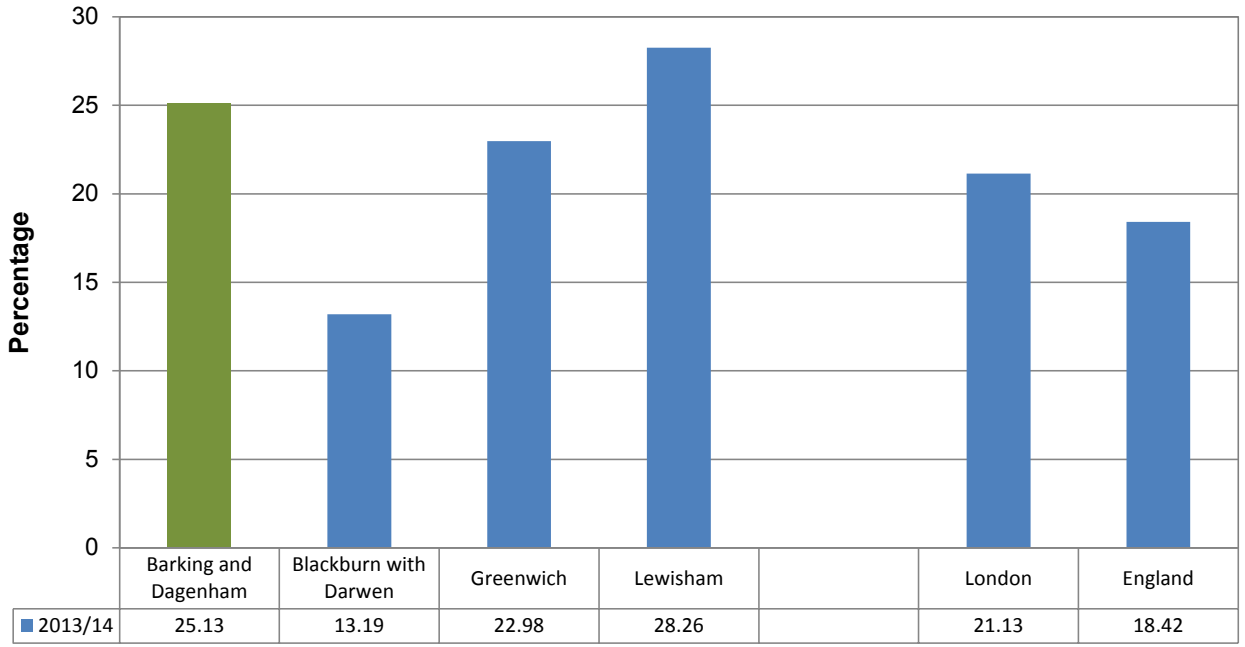


Indicator Number	1.11	Indicator Name	Domestic abuse	Indicator Type	Outcome
Definition	Rate of domestic abuse incidents reported to the police, per 1,000 population				
Source	Office for National Statistics (ONS)				
Frequency	Annual				
Target	No set target, but reduction in rates will be a key objective. Based on SN trends, aspire to aim at rates close to Lewisham's (or SN average), and definitely below London and national rates				
Responsible Lead					
Historical performance	Rate of domestic abuse incidents reported to the police, per 1,000 population				

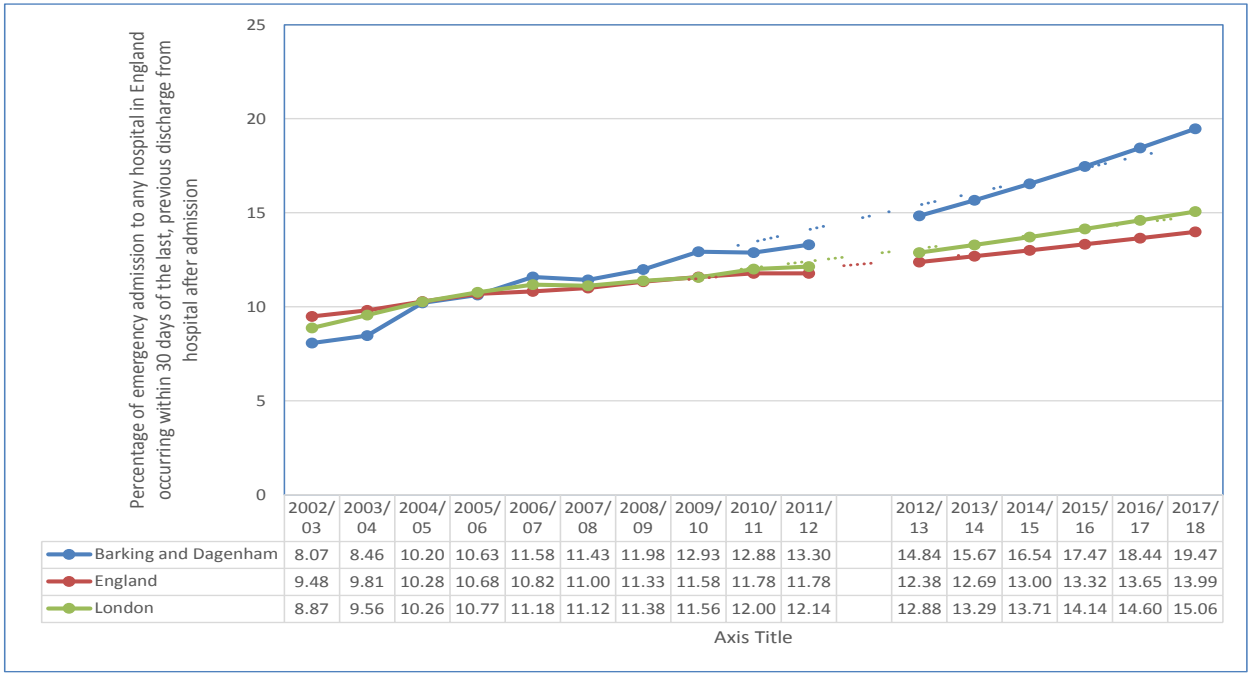


	LBBD	Blackburn	Greenwich	Lewisham		London	England
2011-12	79.86	71.29	86.50	70.70		79.76	72.74
2012-13	79.67	73.06	86.35	69.85		88.55	76.66

Established Adulthood

Indicator Number	2.2iii	Indicator Name	Take up of the NHS Health Check programme – by those eligible	Indicator Type	Outcome
Definition	The 5 year cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check				
Source	http://www.healthcheck.nhs.uk; PHE				
Frequency	Quarterly				
Target	Frequency of coverage improves at faster pace compared to London and England. Targets could be benchmarked against SN (Lewisham), or set against local borough targets for individual Practices to aspire for attainment.				
Responsible Lead	LBBD				
Historical performance	**Cumulative % of the eligible population aged 40-74 offered an NHS Health Check** 				

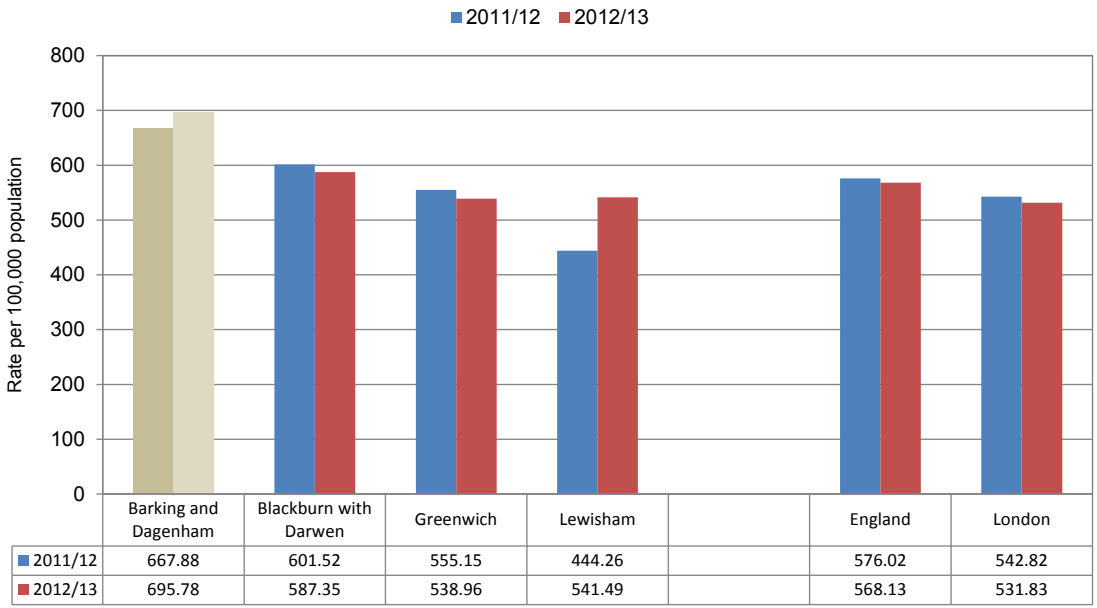
Indicator Number	4.11	Indicator Name	Emergency readmissions within 30 days of discharge from hospital	Indicator Type	Outcome
Definition	Percentage of emergency admission to any hospital in England occurring within 30 days of the last, previous discharge from hospital after admission.				
Source	Hospital Episode Statistics (HES); https://indicators.ic.nhs.uk/webview/				
Frequency	Annual but could possibly be retrieved locally on a quarterly bases for active monitoring				
National target	Close gap between LBBD, London and England Average. Trajectory is an indication of likely admission rates. Targets might have to be set to, initially be on a declining trend, although rates are rising across all areas, but slower pace of increase compared to LBBD. SNs trends also slower pace. Discussions between groups to set targets based on benchmark/trajectory, and consider quarterly active monitoring				
Responsible Lead	Integrated Care Subgroup				
Historical performance	Emergency readmissions within 30 days of discharge from hospital				



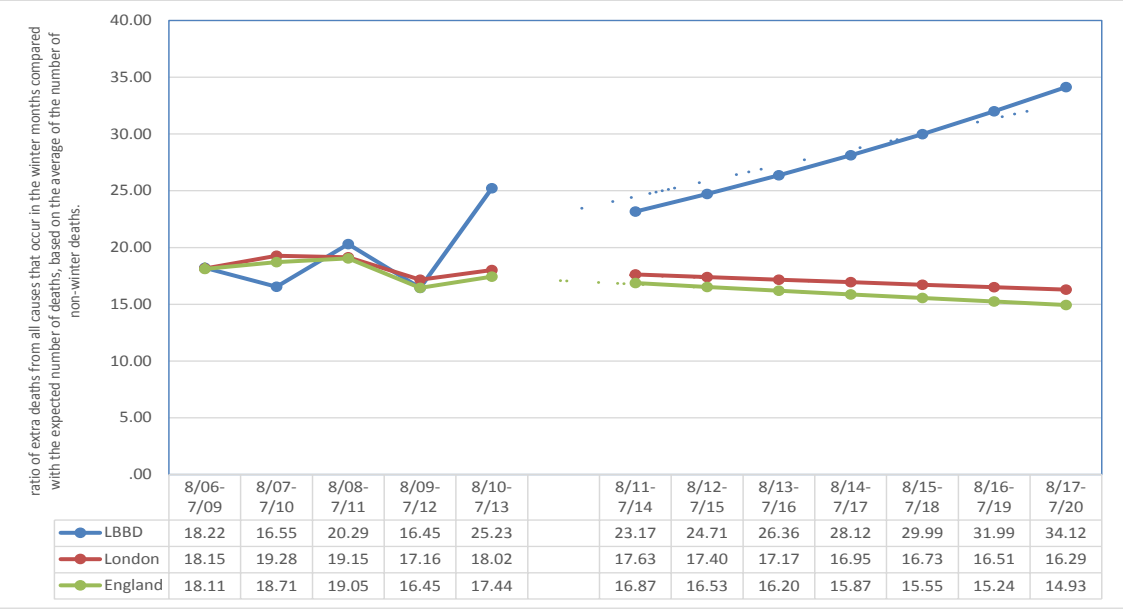
	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Barking and Dagenham	8.07	8.46	10.20	10.63	11.58	11.43	11.98	12.93	12.88	13.30		14.84	15.67	16.54	17.47	18.44	19.47
England	9.48	9.81	10.28	10.68	10.82	11.00	11.33	11.58	11.78	11.78		12.38	12.69	13.00	13.32	13.65	13.99
London	8.87	9.56	10.26	10.77	11.18	11.12	11.38	11.56	12.00	12.14		12.88	13.29	13.71	14.14	14.60	15.06

Older Adults

Indicator Number	4.14	Indicator Name	Hip fractures in people aged 65 and over	Indicator Type	Outcome
Definition	Emergency Hospital Admission for fractured neck of femur in persons aged 65 and over, directly age-sex standardised rate per 100,000.				
Source	Hospital Episode Statistics (PHE calculation, but can also be done locally with correct ICD10 codes)				
Frequency	Annual				
Target	Quarterly monitoring of these figures is recommended. Rates in LBBD have gone up from previous year; much higher than SNs. Suggest target set close to London and England rates (more realistic reductions from these figures, but with review on quarterly basis by CCG/PHI and, with such trends, set realistic targets based on trajectory and other system factors. Discussions between key groups recommended.				
Responsible Lead	CCG (or jointly with LBBD)?				
Historical performance	**Hip fractures in people aged 65 and over, rate per 100,000 population**				



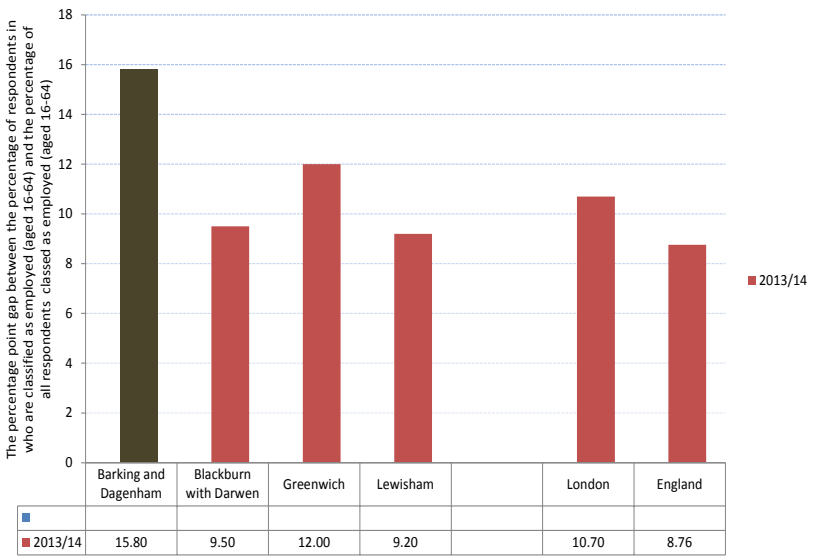
	Barking and Dagenham	Blackburn with Darwen	Greenwich	Lewisham		England	London
2011/12	667.88	601.52	555.15	444.26		576.02	542.82
2012/13	695.78	587.35	538.96	541.49		568.13	531.83

Indicator Number	4.15	Indicator Name	Excess Winter Deaths Index (3 years, all ages)	Indicator Type	Outcome
Definition	Excess winter deaths measured as the ratio of extra deaths from all causes that occur in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths.				
Source	Annual Public Health Mortality File provided by ONS				
Frequency	Annual				
Target	Current trends suggest a significant increase in rates of EWD in LBBD. Consider review of current figures with key players and set reasonable/realistic target that perhaps could match, aspirationally, rates consistent with relatively low rates at London and England levels (or perhaps comparisons with that of statistical neighbours)				
Responsible Lead	LBBD??				
Historical performance	Excess winter deaths - All ages (and trajectory based on current trends 				

	8/06-7/09	8/07-7/10	8/08-7/11	8/09-7/12	8/10-7/13	8/11-7/14	8/12-7/15	8/13-7/16	8/14-7/17	8/15-7/18	8/16-7/19	8/17-7/20
LBBD	18.22	16.55	20.29	16.45	25.23	23.17	24.71	26.36	28.12	29.99	31.99	34.12
London	18.15	19.28	19.15	17.16	18.02	17.63	17.40	17.17	16.95	16.73	16.51	16.29
England	18.11	18.71	19.05	16.45	17.44	16.87	16.53	16.20	15.87	15.55	15.24	14.93

Vulnerable and Minority Groups

Indicator Number	1.8	Indicator Name	1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	Indicator Type	Outcome
Definition	The percentage point gap between the percentage of respondents in the Labour Force Survey who have a long-term condition who are classified as employed (aged 16-64) and the percentage of all respondents in the Labour Force Survey classed as employed (aged 16-64)				
Source	Annual Population Survey - Labour Force Survey				
Frequency	Annual				
National target	Rates can be set at London or England rates – to be achieved by 2018 (with equal reductions on an annual basis)				
Responsible Lead					
Historical performance					



	Barking and Dagenham	Blackburn with Darwen	Greenwich	Lewisham		London	England
2013/14	15.80	9.50	12.00	9.20		10.70	8.76

Appendix B

The Activity Indicator Templates

For each outcome indicator there is an indicator template setting out:

- Indicator number (where applicable)
- Outcome indicator
- Activity indicator
- Delivery plan indicator and related action
- Lead organisation
- Historical activity to date where available
- Frequency of reporting

Activity Indicator Templates

Pre-Birth and Early Years

Indicator no.	Outcome Indicator	Activity Indicator	Delivery Plan Indicator	Delivery Plan Action	Lead Organisation	Historical baseline	Reporting Frequency
PHOF 2.2	Breastfeeding (all sub-indicators)	2.2i Breastfeeding initiation within 48 hours of delivery	Increased breastfeeding prevalence and rates, prevalence of breastfeeding and attachment Improved initiation Breastfeeding prevalence at 6-8 week check	Work towards stage 1 of Baby Friendly Initiative Implementation	BHRUT / NHS England		
PHOF 2.5	Child development at 2-2½ years	2.5i Proportion of children aged 2-2½yrs who received an assessment as part of the Healthy Child Programme or an integrated review (using any tool)	% of children seen by health visitor by day 14 Health Visitor transition	Healthy Child Programme for 0-5 years commissioned Transfer in October 2015 of the commissioning of the Early Years Programme services to the Council	LBBD		
PHOF 3.3	Population vaccination coverage	3.3i Hepatitis B vaccination coverage (1 and 2 year olds)					

			Number of unborn care assessment frameworks initiated	Clear safeguarding pathways and training in place across all maternity providers	CCG		
			Introduce the new 4 routine blood tests for metabolic conditions	Successful introduction of tests at 9 weeks booking	BHRUT / NHS England		
			Ensure that children with a LD under 5 years have an annual check and health plan	Children with complex care needs assessed and given appropriate care			

Primary School Years

Indicator no.	Outcome Indicator	Activity Indicator	Delivery Plan Indicator	Delivery Plan Action	Lead Organisation	Historical baseline	Reporting Frequency
PHOF 1.2	School readiness	1.2i Percentage of children achieving a good level of development at the end of reception	Improve the development of children in early years and introduce integrated reviews	To indentify speech, language and communication needs (SLCN) in children before they reach the age of 2 years using robust research methods	LBBD		
PHOF 2.6	Excess weight in 4-5 and 10-11 year olds (all sub-indicators)	2.6i Percentage of children aged 4-5 classified as overweight or obese	% children with health review, including BMI at reception and Year 6 % children taking regular exercise as measured at health review Reduction in unhealthy weight in Reception and Year 6 Reduction in obesity % of 5-11 yr olds participating in 2 hours PE or more Improve cooking skills of adults and	Physical Activity programme GET ACTIVE	LBBD		

			children % of children from ethnic and gender groups with a healthy weight				
PHOF 4.2	Tooth decay in children aged 5	4.2 Rate of tooth decay in children aged 5 years based on the mean number of teeth per child sampled which were either actively decayed or had been filled or extracted – decayed/missing/filled teeth	Improved oral health	Improved oral health across all age groups	NHS England		
			Ensure that all children have complete immunisation records	Reach London levels for immunisation and then England levels	CCG		
			Improving health outcomes for children with special educational needs and disabilities		LBBD		

Adolescence

Indicator no.	Outcome Indicator	Activity Sub-Indicator	Delivery Plan Indicator	Delivery Plan Action 2015/16	Lead Organisation	Historical baseline	Reporting Frequency
PHOF 2.4	Under 18 conceptions	2.4 Under 18 conception rate per 1,000 population	Under 18 yrs conception rate (per 1000) and % change against 1998 baseline Reduce rate of teenage conceptions by 50% from '98 baseline for > 16 yr olds	Coherent sexual health and contraceptive services in place for young people Review strategy and develop an action plan	LBBD		
PHOF 2.9	*Smoking prevalence - 15 year olds (Placeholder)*	2.9i Prevalence of smoking among 15 years olds	Smoking rates at 15 yrs (review and move to prevalence) % teen mothers supported by Family Nurse Partnership %teen mothers supported by Baby Intervention to breastfeed and stop smoking Reduction in numbers of school children taking up smoking	Multi-agency smoking strategy refreshed and action plan developed to reduce smoking in 15 yrs >80% of expected visits made to teenage mothers Social marketing campaign	LBBD / NELFT		

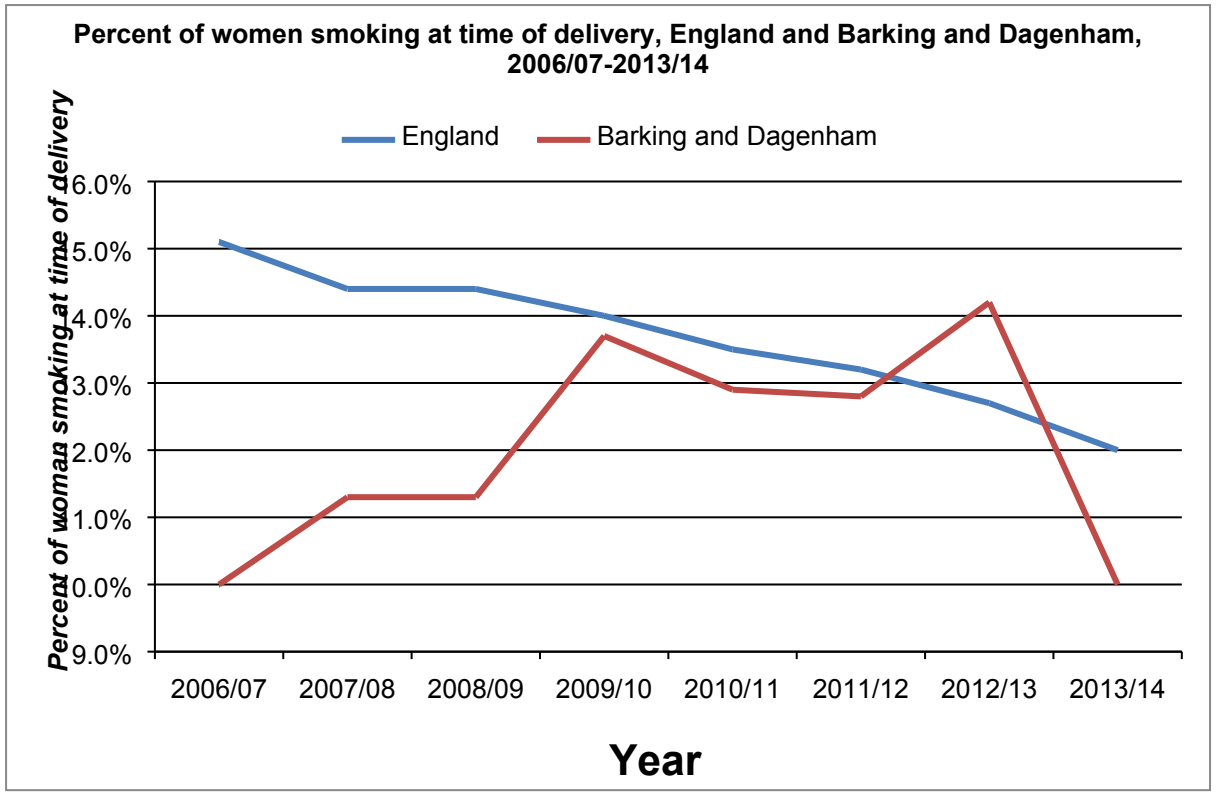
PHOF 3.2	Chlamydia diagnoses (15-24 year olds)	3.2i Crude rate of chlamydia diagnoses screening detection per 100,000 young adults aged 15-24 using old National Chlamydia Screening Programme (NCSP) data	Increase the proportion of young people testing for Chlamydia	Increase coverage to 35%	LBBD		
			% teen mothers supported by Family nurse partnership	FNP engagement plan and pathways refreshed. At least 60% of first time mums enrolled before 16 weeks and 100% no later than 28 weeks Baby Intervention pathways refreshed to ensure young parents who do not meet the criteria for FNP still get early intervention and support	NELFT		
			Increase overall wellness score	Ensure health and wellbeing addressed within council and CCG OD plans	LBBD		
			Perceptions of drunk or rowdy behaviour as a problem	Campaign for young men	LBBD		

			% Looked after children with a learning disability with annual health check and personal health plan	Clear communication with staff about the role of health checks and health plans, supported by training and provider performance indicators	CCG	Learning Disability Subgroup	
			Change the way frontline health services respond to self-harm and how walk-in centres can be supported		CCG	Learning Disability Subgroup	
			Commissioning high quality mental health services across the life-course that emphasise recovery	Develop the road map to mental health improvement for the next 5 yrs	CCG	Mental Health Subgroup	

Maternity

Indicator no.	Outcome Indicator	Activity Sub-Indicator	Delivery Plan Indicator	Delivery Plan Action 2015/16	Lead Organisation	Historical baseline	Reporting Frequency
PHOF 2.3	Smoking status at time of delivery	2.3 Rate of smoking at time of delivery per 100 maternities	% teen mothers supported by Family Nurse Partnership Reduction in the number of pregnant women smoking at time of delivery %teen mothers supported by Baby Intervention to breastfeed and stop smoking Decrease the number of pregnant women who are smoking in pregnancy through the implementation of BabyClear	>80% of expected visits made to teenage mothers Identify funding for phase 2, improve assessments and support midwives Implementation of the BabyClear programme	NELFT / BHRUT		
			Number of births at Barking hospital	Training for midwives and children's centres staff to support pathways of care	CCG		

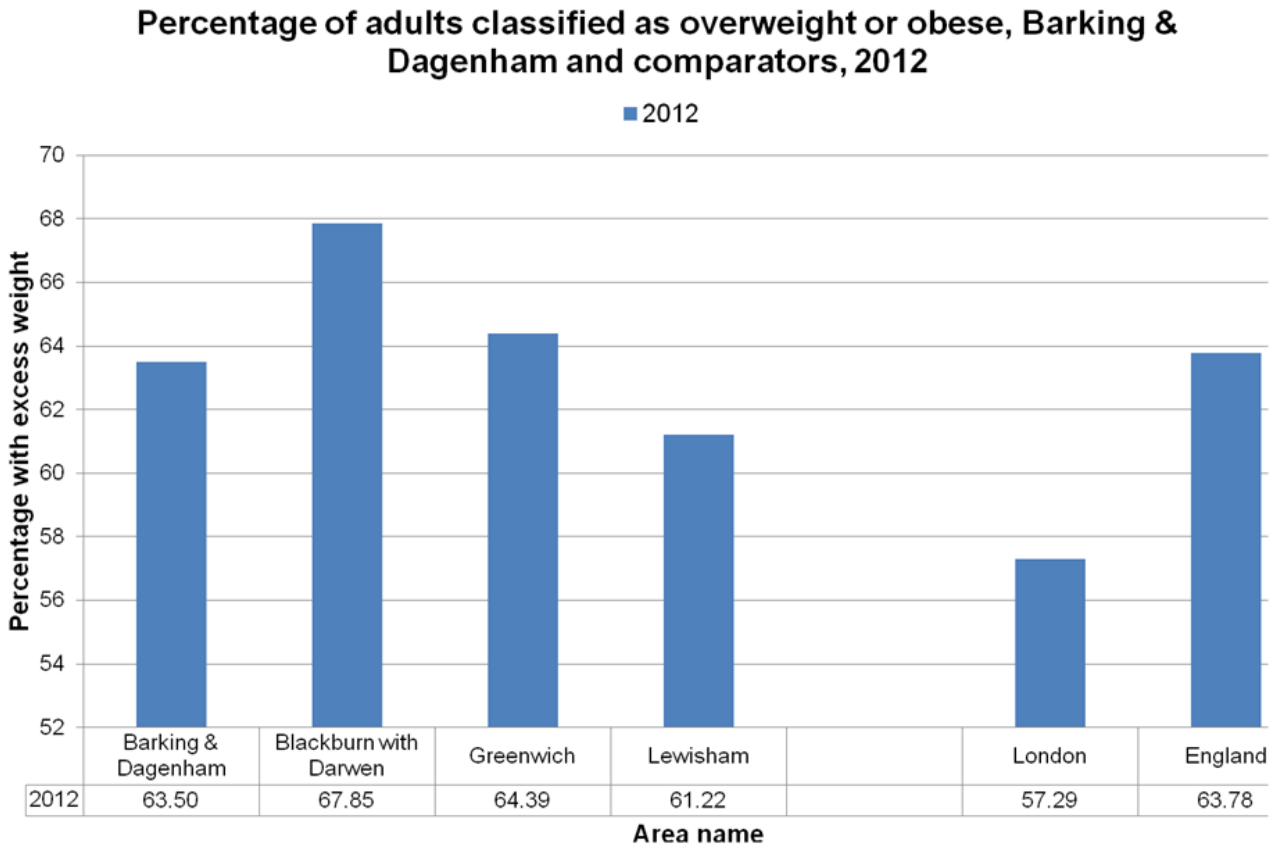
PHOF 2.21	Access to non-cancer screening programmes	2.21i: HIV coverage: The percentage of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result (national only)	% of women treated for HIV in pregnancy % of mothers booked with maternity services by 13th week of pregnancy in light of new blood tests Uptake of HPV vaccination Increase the uptake of seasonal flu amongst pregnant women %of over 65 yr olds protected through seasonal flu immunisation	Training for midwives supported by public awareness campaign Primary care and children's centres education programme to support signposting Move 1st booking to 11 weeks Preparation for parenthood classes – delivered by children's centre staff/Health visitors/midwives Commissioning of new HPV vaccines with training and governance support for staff Increase the uptake of seasonal flu amongst pregnant women Local pathway work to improve uptake through partnership	NHS England / CCG		


Percent of women smoking at time of delivery, England and Barking and Dagenham, 2006/07-2013/14
England
Barking and Dagenham
Percent of woman smoking at time of delivery
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
9.0%
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
Year

Early Adulthood

Indicator no.	Outcome Indicator	Activity sub-Indicator	Delivery Plan Indicator	Delivery Plan Action 2015/16	Lead Organisation	Historical Baseline	Reporting Frequency
PHOF 1.9	Sickness absence rate	1.9i: Percentage of employees who had at least one day off sick in the previous week	Decrease average rates of sickness of those in work	Pilot with local employers	LBBD		
PHOF 1.11	Domestic abuse	1.11 Rate of domestic abuse incidents reported to the police, per 1,000 population	Repeat MARAC caseload Reduce number of domestic violence cases among pregnant women	Ensure 20% of frontline staff have attended multi-agency domestic violence and violence against women and girls training	LBBD / CCG / NHSE		
PHOF 2.12	Excess weight in adults	2.12 Proportion of adults classified as overweight or obese	% reduction in prevalence of adult obesity from baseline	Develop adult obesity strategy Common/core nutritional standards for all commissioned services	LBBD		
			Reduce the prevalence of STIs	Increase equitable access to contraception and STI testing Reduce PID to England and then London levels	LBBD		

			% of Adults with Learning Disability with annual health check and personal plan	Clear communication with staff about the role of health checks and health plans, supported by training and provider performance indicators	CCG		
			% of people of different backgrounds getting on well	Development of peer intervention programme for the borough	Mental Health Subgroup		
			Assessment for new diagnoses at outset of treatment particularly focussed on diabetes	Pathways and services for adults with depression into talking therapies taking place	CCG		

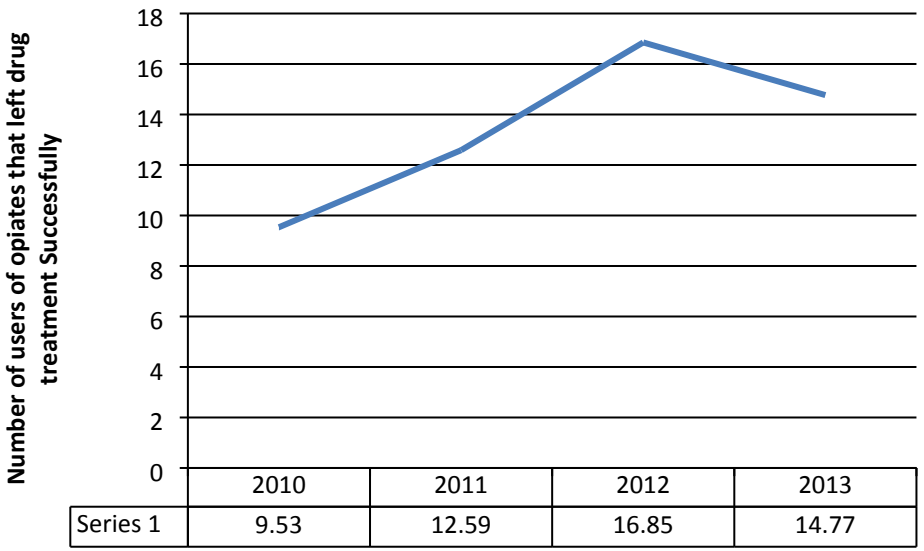

Percentage of adults classified as overweight or obese, Barking & Dagenham and comparators, 2012
2012
Percentage with excess weight
70
68
66
64
62
60
58
56
54
52
Barking & Dagenham
Blackburn with Darwen
Greenwich
Lewisham
London
England
2012
63.50
67.85
64.39
61.22
57.29
63.78
Area name

Established Adulthood

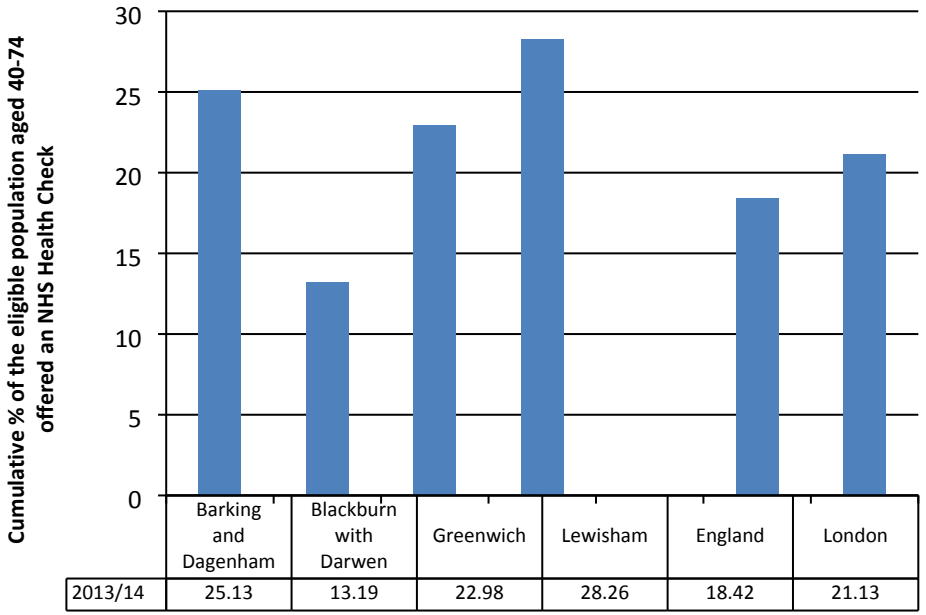
Indicator no.	Outcome Indicator	Activity Sub-Indicator	Delivery Plan Indicator	Delivery Plan Action 2015/16	Lead Organisation	Historical Baseline	Reporting Frequency
PHOF 2.13	Proportion of physically active and inactive adults	2.13i Proportion of adults achieving at least 150 minutes of physical activity per week in accordance with UK CMO recommended guidelines on physical activity	% of adults cycling or walking to work % increase in the number of adults participating in regular physical activity	Active transport survey conducted and cycling strategy developed across the partnerships Develop adult obesity strategy Leisure pass scheme for older people Leisure pass scheme for people with disabilities and those on low incomes Widening access through new and upgraded facilities	LBBD		
PHOF 2.14	Smoking prevalence – adults (over 18s)	2.14 Prevalence of smoking among persons aged 18 years and over	Number of smoking quitters under 30 (review and move to prevalence) % reduction in smoking prevalence over the 3 year period from 2009/10 baseline	Targeted promotion work with high-risk smoking populations and routine and manual groups Social marketing campaign	LBBD		

PHOF 2.15	Successful completion of drug treatment	2.15 Number of drug users that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number in treatment 2.15i - Successful completion of drug treatment - opiate users 2.15ii - Successful completion of drug treatment - non-opiate users	Increase the % successful completion of drug treatment (opiate and non-opiate users)		LBBD		
PHOF 2.22	Take up of the NHS Health Check programme – by those eligible	2.22iii Cumulative percentage of eligible population aged 40-74 offered an NHS Health Check in the five year period 2013/14 - 2017/18 (Replaces indicator 2.22i)	Increase uptake of NHS Health Checks	Health checks process and pathways secured during transition Increase uptake to 50% of 40 – 74 yr olds	LBBD		
PHOF 4.11	Emergency readmissions within 30 days of discharge from hospital		Re-admission to hospital within 30 days of discharge	Implement integrated discharge planning process	Integrated Care Subgroup		

NHSOF 3b	Emergency readmissions within 30 days within 30 days of discharge from hospital		Re-admission to hospital within 30 days of discharge	Implement integrated discharge planning process	Integrated Care Subgroup		
ASCOF 1C	Proportion of people using social care who receive self-directed support and those receiving direct payments		Number of adults using direct payments	Increased choices for older people – more personal assistance available	LBBD		
			Greater acceptance of adults with autism and ability to get a diagnosis and appropriate support	Ensure people with autistic spectrum disorders with assessed eligible needs for care and support have personal budgets	LBBD		
			Reduction in number of people claiming incapacity benefit from depression	Review and audit of case register and development of action plan	Mental Health Subgroup		
			Access to Psychological Therapies (IAPT) services	Ensuring commissioned services are IAPT compliant 95% should have access within 28 days	CCG		

Indicator Number	2.15i	Indicator Name	Successful completion of drug treatment - opiate users	Indicator Type	Outcome
Definition	Number of users of opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of opiate users in treatment.				
Source	National Drug Treatment Monitoring System				
Frequency	Annual				
Target					
Responsible Lead	LBBD?				
Historical performance	Trajectory for successful completion of drug treatment – opiate users 				

Indicator Number	2.22	Indicator Name	Cumulative % of the eligible population aged 40-74 offered an NHS Health Check	Indicator Type	Outcome
Definition	The 5 year cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check				
Source	Public Health England				
Frequency	Annual				
Target					
Responsible Lead	LBBD				
Historical performance	**Cumulative % of the eligible population aged 40-74 offered an NHS Health Check**				

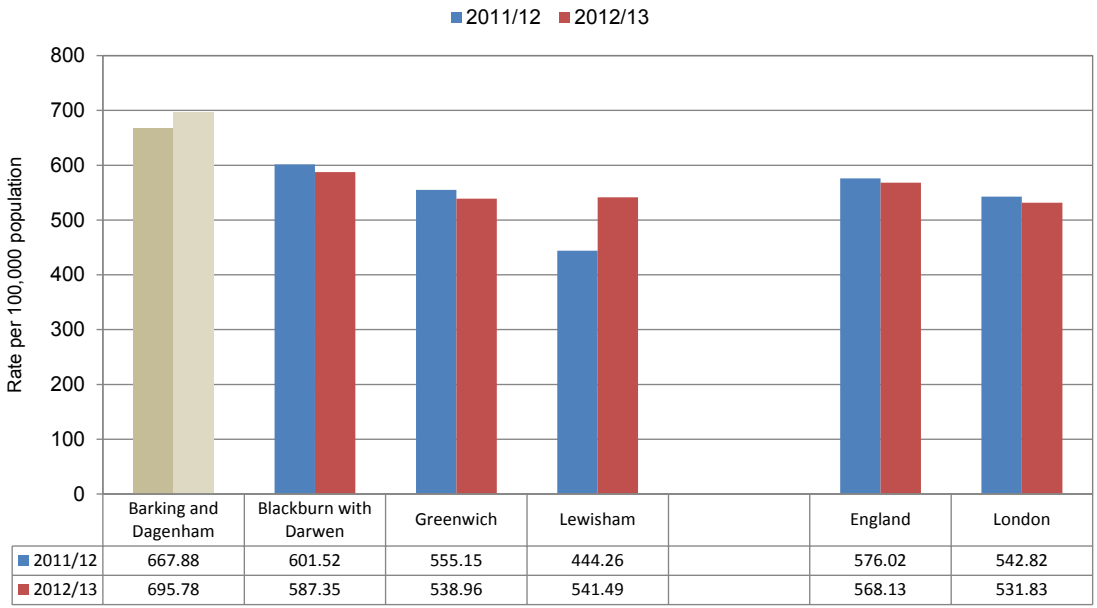


Older Adults

Indicator no.	Outcome Indicator	Activity Sub-Indicator	Delivery Plan Indicator	Delivery Action plan 2015/16	Lead Organisation	Historical Baseline	Reporting Frequency
PHOF 4.14	Health-related quality of life for older people		Increase early diagnosis and identification of at risk older people in primary care and reduce unnecessary admission to hospital	Pilot Self-care programme for patients and carers	LBBD		
PHOF 4.15	Excess winter deaths		Reduce excess mortality of older people in extreme temperatures	At risk older people receive correct, clear, consistent, useful and actionable advice and information from the local organisations they come into contact with	NHSE		
			Enable those at end of life to die with dignity where they want	Expansion of specialist and palliative care services	LBBD		
			All bereaved people signposted to appropriate bereavement support services	Establishment of bereavement support services	CCG		

			Measurement of the effects of austerity and welfare reform	Council to set up a system to measure the effects of austerity and levels of need so that partners can understand the impact on residents	LBBD		
			% adults with severe mental illness with physical health check	Care pathways and data collection process set up for physical health assessment in mental health patient settings	CCG		

Indicator Number	4.14	Indicator Name	Hip fractures in people aged 65 and over	Indicator Type	Outcome
Definition	Emergency Hospital Admission for fractured neck of femur in persons aged 65 and over, directly age-sex standardised rate per 100,000.				
Source	Hospital Episode Statistics (PHE calculation, but can also be done locally with correct ICD10 codes)				
Frequency	Annual				
Target	Quarterly monitoring of these figures is recommended. Rates in LBBD have gone up from previous year; much higher than SNs. Suggest target set close to London and England rates (more realistic reductions from these figures, but with review on quarterly basis by CCG/PHI and, with such trends, set realistic targets based on trajectory and other system factors. Discussions between key groups recommended.				
Responsible Lead	CCG (or jointly with LBBD)?				
Historical performance	**Hip fractures in people aged 65 and over, rate per 100,000 population**				



	Barking and Dagenham	Blackburn with Darwen	Greenwich	Lewisham		England	London
2011/12	667.88	601.52	555.15	444.26		576.02	542.82
2012/13	695.78	587.35	538.96	541.49		568.13	531.83

Vulnerable and Minority Groups

Indicator no.	Outcome Indicator	Activity Sub-Indicator	Delivery Plan Indicator	Delivery Plan Action 2015/16	Lead Organisation	Historical Baseline	Reporting Frequency
PHOF 1.8	Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services	1.8i: Percentage of respondents in the Labour Force Survey (LFS) who have a long-term condition who are classed as employed using the International Labour Organisation (ILO) definition of employment, compared to the percentage of all respondents classed as employed					
			Reduce numbers of people on incapacity benefit		LBBD	Public Health Programmes Board	
			% people who feel that they belong to their local neighbourhood IAPT take up amongst men	Increasing community resilience through development of programmes to support community	LBBD	Mental health Subgroup	
			Practices to establish depression registers	Development of new pathways for primary and community care	CCG	Mental health Subgroup	

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

12 MAY 2015

Title:	Prevention: A Local Framework for Preventing, Reducing and Delaying Care and Support Needs In Adults
Report of the Cabinet Member for Adult Social Care and Health	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: YES**
Report Author: Ian Winter CBE, Care Act Programme Lead	**Contact Details:** Tel: 020 8227 5796 E-mail: ian.winter@lbbd.gov.uk

Sponsors:

Cllr M Worby, Cabinet Member for Adult Social Care and Health

Anne Bristow, Corporate Director, Adult and Community Services

Summary:

To implement the Care Act 2014 and meet its statutory obligations, the Council and its partners must develop a clear approach to prevention and how it plans to meet its responsibility in this regard. This report:

- sets out the statutory requirements in the Care Act 2014 relating to prevention
- proposes a way in which the Council and its partners should respond to the requirements through the Framework at Appendix A
- proposes next steps to further define and develop the approach.

This report should be considered alongside the refresh of the Health and Wellbeing Strategy. This proposed prevention approach will be part of the borough wide delivery of Health and Wellbeing.

Recommendation(s)

The Health and Wellbeing Board is asked to:

(i) Note the duties and responsibilities of the local authority and its partners to help prevent, delay or reduce the likelihood of individuals developing increased needs for care and support as a whole borough responsibility.

(ii) Comment on and agree the Prevention Framework set out in Appendix A and, in particular, agree the proposed next steps.

Reason

Section 2 of the Care Act 2014 requires that a local authority must provide or arrange for services, facilities or resources which would prevent, delay or reduce individuals' needs for care and support, or the needs for support to carers. Local authorities should develop a clear, local approach to prevention which sets out how they plan to fulfil this responsibility, taking into account the different types and focus of preventative support.

1. Background and context

1.1. **Enabling social responsibility** is a key priority for the Council across Barking and Dagenham, encouraging residents to do as much as they can for themselves. The emphasis in NHS services and Public Health is similar.

1.2. Part one[1] of the Care Act 2014 became operational on 1 April 2015. The Health and Wellbeing Board has been well sighted on the local implementation programme and is familiar with the provisions of the Care Act and the implications for the Council and its partner organisations. The full scope of duties and requirements can be found in Chapters 1, 2, 3 and 15 of the Care and Support Statutory Guidance.

1.3. In summary, the Care Act requires that local authorities must:

- promote wellbeing when carrying out any of their care and support functions in respect of a person.
- provide or arrange for services, facilities or resources which would prevent, delay or reduce individuals' needs for care and support, or the needs for support of carers. Local authorities should develop a clear, local approach to prevention which sets out how they plan to fulfil this responsibility, taking into account the different types and focus of preventative support.
- establish and maintain a service for providing people with information and advice relating to care and support. In addition to any more targeted approaches to communicating with individuals who may benefit from preventative support, this service should include information and advice about preventative services, facilities or resources so that anyone can find out about the types of support available locally that may meet their individual needs and circumstances, and how to access them.
- ensure the integration of care and support provision, including prevention with health and health-related services which include housing. This responsibility includes in particular a focus on integrating with partners to prevent, reduce or delay needs for care and support.

1.4. Underpinning the Care Act is the concept and principle of promoting wellbeing (which includes prevention) which states that local authorities must promote wellbeing when carrying out any of their care and support functions in respect of a person. This means that wellbeing should be embedded through the local authority care and support system and be a feature of all stages of care and support. Importantly the principle applies to the whole population, regardless of having eligible needs or a pre-existing relationship with the local authority.

1.5. In response to the requirement of the Care Act 2014, the proposed Prevention Framework has been developed and is attached as Appendix A.

[1] Excluding the cap on care costs and appeals system which come into effect from 1 April 2016

2. Aim of the Framework

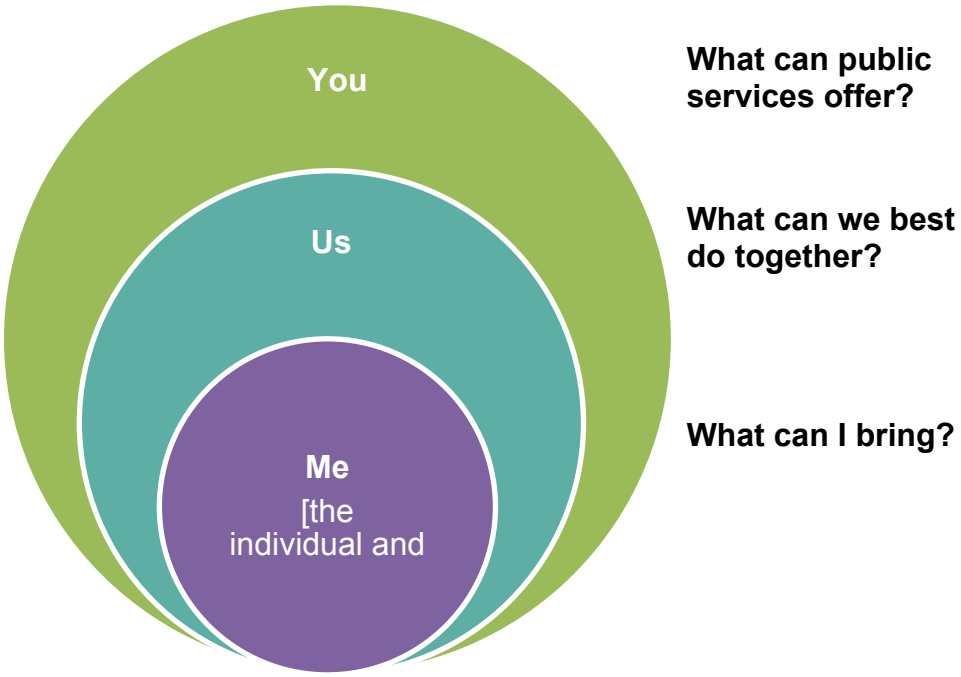
2.1. The aim of the Framework is to:

- engage the whole Council in the Prevention Approach and be a positive development to support priorities in Housing, Leisure, Children's Services, Planning and all aspects of the Council's activities
- set out a borough-wide approach to prevention that can be used consistently by all partners working together
- set out how the ways in which this approach is integral to the Health and Wellbeing Strategy and public health priorities
- make practical the approach to enabling social responsibility across the borough while maintaining support to the most vulnerable individuals and their carers, ensuring that the most help is given to those with the greatest need at the most appropriate time
- ensure that prevention is taken into account in:
  - Council wide activities
  - commissioning of specific social care activities
  - day-to-day interactions for social workers and related health and care professionals
  - priority setting for community based partners and the developing care sector
  - throughout the lifetime of people who may be at risk and particularly to underpin direct services

3. Prevention approach

3.1. The proposed Prevention Framework has three guiding principles.

3.2. Prevention is only effective when individuals (**Me**), communities (**Us**) and public services (**You**) work together. This promotes the strengths-based approach to assessing needs and supporting people. The diagram below illustrates the approach.



Starting with the individual further emphasises the whole person – a person centered approach. In doing this it is often useful to think of a person you know whose situation can represent the key principles. This helps to make this real for individuals and for agencies. For example, the experience in Torbay and Sweden where they characterise their approach using a named individual to make this seem more personal.

Principle 1: Prevention starts with every individual (Me)

3.3. The approach starts with the individual – the person who may have needs. This may include the contribution of friends and relatives who are providing care for someone with needs. The starting point is considering what the individual already has to help meet their needs, and what is potentially available.

Principle 2: Prevention is a job for the community (Us)

3.4. The next step is for the individual to consider what the wider community might be able to offer. Putting **Me** and **Us** together helps to create a community that underpins effective social responsibility. By bringing together civic pride, individual responsibility and local growth, neighbourhoods across the borough can recreate a sense of community wellbeing.

Principle 3: Prevention and the role of statutory agencies (You)

3.5. The statutory agencies, for example, the NHS, Council, police, employment agencies, colleges and schools continue to have duties of care. However, their role may be focused on specific population groups, or on people with high levels of need. Nonetheless, the principle of prevention that can delay or reduce the impact of needs must be ever-present.

4. Making it happen

4.1. The borough already has collective organisational, political, public and partner sign-up to prioritise promotion of wellbeing and development of a preventative approach. This is reflected through public health priorities, the Better Care Fund, integrated work with the NHS, partnership working with the third sector and commissioning. All this is set within the context of the Health and Wellbeing Strategy, and it is why there is no requirement for a separate prevention strategy.

4.2. Taking a preventative approach is not a new initiative or an additional burden imposed on or by the Council and its partners. Instead, the Framework:

- re-emphasises prevention as part of day-to-day business as usual
- embeds the preventative approach in existing services and current initiatives
- sets prevention as a guiding principle in commissioning and service development

5. Next steps

5.1. Consult on the proposed preventative approach following comments and endorsement by the Health and Wellbeing Board.

5.2. Build the approach into our public health priorities for action and the Health and Wellbeing Strategy.

5.3. Emphasise and refine the Better Care Fund priorities and resources across NHS and Social Care on an individual basis.

5.4. Use the consultation as the basis for prioritising development of “commissioning for prevention” priorities.

5.5. Develop a “commissioning for prevention” methodology and scoring analysis/system along with a straightforward process for partners to use to apply to commissioning and contracting. Revise current contracts and develop new contracts to emphasise the preventative approach throughout all individual care or service pathways.

5.6. Set up a series of information seminars and briefing sessions to refine and develop the prevention approach and simultaneously revise existing activity.

5.7. Develop an action plan to review progress based on the above. This will be presented at the Health and Wellbeing Board in November 2015 with a final version of the Framework.

6. Consultation

6.1. While the prevention approach has been developed within the Commissioning workstream of the Care Act Implementation Programme, it has far wider cross Council and partner considerations. In drawing up the Framework, key departments (Public Health, Leisure and Housing) have been engaged and consulted, and this engagement will continue and increase.

6.2. In agreeing the Framework at Appendix A, the Health and Wellbeing Board will initiate a process of consultation with wider stakeholders, including the Health and Wellbeing Board member organisations. The purpose of further consultation is to align priorities around prevention and achieve collective buy-in from partners to

ensure that the thread of prevention (reduce and delay) in all situations and develop the 'commissioning for prevention' approach in Appendix A.

7. Mandatory implications

7.1. Joint Strategic Needs Assessment

The Framework is grounded on the most recent findings and recommendations of the JSNA.

7.2. Health and Wellbeing Strategy

The refreshed Health and Wellbeing Strategy priority areas are reflected in the Framework (see Appendix A of this report). Prevention priorities are set out in the in the Strategy with deliverables aligned to the Health and Wellbeing Strategy Delivery Plan. The report also takes on board the observations made by the Director of Public Health in his 2014 Annual report.

7.3. Integration

The Care Act is very specific that the responsibility for prevention is shared between stakeholders. The Care and Support Statutory Guidance states that 'Local authorities must ensure the integration of care and support provision, including prevention with health and health-related services, which include housing. This responsibility includes in particular a focus on integrating with partners to prevent, reduce or delay needs for care and support.' (para 2.34)

More generally the Care Act places new duties on the Council and its partners to further integrate. Sections 3, 6 and 7 of the Care Act require that:

- 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 co-operate 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.

The Framework at Appendix A has been developed in the spirit of the duties above and seeks to strengthen local integration. A key outcome in drawing up this Framework is to bring coherence, alignment and direction to a range of activities that exist across the partnership.

7.4. Financial implications

There are no additional financial implications directly arising from this report. Resources for preventative services of approximately £1.5m funded from the Public Health grant are included in the Better Care Fund plan for 2015/16 agreed by the Health and Wellbeing Board.

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

7.5. Legal implications

There are no legal issues as all the statutory provisions have been dealt with and noted in the report to include the Care and Statutory Support Guidance to include policies such as the Joint Health and Wellbeing Strategy and the JSNA.

Comments prepared by: Dawn Pelle, Adult Social Care Lawyer

8. Non-mandatory Implications

8.1. Safeguarding

Protection from abuse and neglect is one of the nine domains of wellbeing as defined by the Care Act 2014. All initiatives under the umbrella of the Prevention Framework must have regard for safeguarding vulnerable adults in line with local safeguarding policies and procedures.

8.2. Contracts

Commissioners will need to ensure that existing providers are aware of the need to comply with the Framework which may require further engagement and development.

Where appropriate, when re-tendering or commissioning new services, it is essential that specifications for services have regard to the Framework, ensuring that it provides the guiding principles and foundation of key actions and activities in commissioning and service development. All such arrangements should incorporate 'commissioning for prevention'.

The Council's Market Position Statement, which will be refreshed later in 2015, should also have regard to this approach so that our vision is clearly articulated to the market so that local care and support providers (and providers from other sectors) can respond accordingly.

9. Background papers used in preparation of the report:

- DH Care and Support Statutory Guidance
- Joint Strategic Needs Assessment
- Better Care Fund Plan
- Joint Health and Wellbeing Strategy
- LBBD Market Position Statement (July 2014)
- Adult Social Care – the service and its role in an integrated system, NHS England Board (March 2015)

10. List of appendices

- Appendix A: Prevention: a local framework (DRAFT)

This page is intentionally left blank

Prevention: a local framework

Care and support for adults
London Borough of Barking and Dagenham

April 2015

Contents

1. Introduction

Enabling social responsibility is a key priority for Barking and Dagenham, encouraging residents to do as much as they can for themselves.

This means that individuals, with support where necessary from communities and local networks, will be primarily responsible for making their own decisions about their personal life choices and for seeking the advice and information they need to achieve the outcomes they desire. Individuals with the highest levels of need will continue to receive support from statutory agencies such as the NHS and, for those who meet the national eligibility criteria, from the local authority.

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

The Care Act 2014 provides a new emphasis and role for local authorities and statutory agencies (principally the NHS) to actively promote wellbeing and independence rather than respond only in a crisis. The Act introduces the wellbeing approach and places duties on the Council to ensure that it:

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

This Prevention Framework acknowledges that wellbeing is essentially personal and by no means the same for everyone. The impact of life events may impact very differently on each individual and may influence their wellbeing. Some communities and individuals may have greater or lesser resilience for sustaining wellbeing. Our approach to prevention is therefore flexible, diverse, and responsive to individual need.

To make the approach real, we are developing local care and support so that the delivery of adult social care functions and related services fits with these strategic objectives and legal duties.

2. Legal and policy context

Care Act 2014: the most important piece of adult social care legislation and guidance for a generation. It starts with the principle of wellbeing for the individual and provides a primary focus on prevention (including reducing and delaying the impact of needs).

Children and Families Act 2014: applies to children and young people from birth to 18 years (and to 25 years in the case of young people with special educational needs and disabilities). In combination with the Care Act, this includes preparation for transition to adulthood and adult services from the earliest possible stage.

Health and Social Care Act 2012: the largest piece of health legislation since the creation of the NHS. Part 5 of the Act made provision for the establishment of health and wellbeing boards (HWBs) in each upper tier local authority area and set out their role. It also transferred responsibility for certain public health activities to local authorities, including medical inspection, treatment, weighing and measuring of school children, and the transfer of the school nursing service.

Joint Health and Wellbeing Strategy: the Joint Health and Wellbeing Strategy explains the priorities the local Health and Wellbeing Board has set in order to tackle the needs identified in the local Joint Strategic Needs Assessment (JSNA – see below). The Joint Health and Wellbeing Strategy translates JSNA findings into clear outcomes the Board wants to achieve which will inform local commissioning, resulting in locally led initiatives that meet those outcomes and address needs. Barking and Dagenham's Joint Health and Wellbeing Strategy is being refreshed concurrently with the development of this framework. The strategic objectives have therefore been aligned to maximise impact and avoid duplicating activity.

Joint Strategic Needs Assessment (JSNA): an assessment of the health and wellbeing needs of the local area, a statutory duty for local authorities and clinical commissioning groups since 2007, and a requirement to use the information for commissioning services. The JSNA process is led by the Director of Public Health and undertaken on behalf of the Health and Wellbeing Board for the Barking and Dagenham area.

3. Scope and definition

This is an overarching framework setting out the London Borough of Barking and Dagenham's joint approach to prevention, making practical the Council's and partners' priority of enabling social responsibility, and ensuring that the borough is compliant with the requirements of the Care Act 2014.

Good prevention starts at the point of initial contact and continues at all stages throughout someone's life and circumstances. Effective and early prevention at any point may **prevent**, **reduce** and **delay** more complex health or social care needs and enhances quality of life, as well as saving resources and costs in the longer term. A preventative approach is at the heart of assessment and service provision, ensuring that the focus is on the needs of the individual person, and is closely allied to positive wellbeing.

There is no single definition of what constitutes prevention. It can range from wide scale whole population measures aimed at promoting health to more targeted

individual interventions for one person or a particular group, or to lessening the impact of caring on a carer's health and wellbeing. The Council, through its public health and adult services care and support, carries the primary responsibility for developing and maintaining prevention services.

Who should have regard to the principles of the Framework

- All key care and support strategies including partnership strategies, for example, the Health and Wellbeing Strategy
- Commissioning and contracts, with adult and community commissioning having a specific priority for commissioning for prevention
- In terms of the Council, prevention is not just the responsibility of children's and adults' social care, but is equally the responsibility of others, especially public health, housing, leisure and planning.

Prevention responsibilities in adult social care

The Council's responsibility for prevention applies to all adults including:

- Carers, including those who may be about to take on a caring role or who do not currently have any needs for support, and those with needs for support which may not be being met by the local authority or other organisation
- People who do not have any current needs for care and support, but may have in the near future
- People who pay the entirety of the costs of their care (self-funders) who require information and advice and preventative support to meet their needs
- Adults with needs for care and support, whether their needs are eligible or met by the local authority or not.

4. Aim

The aim of the framework is to:

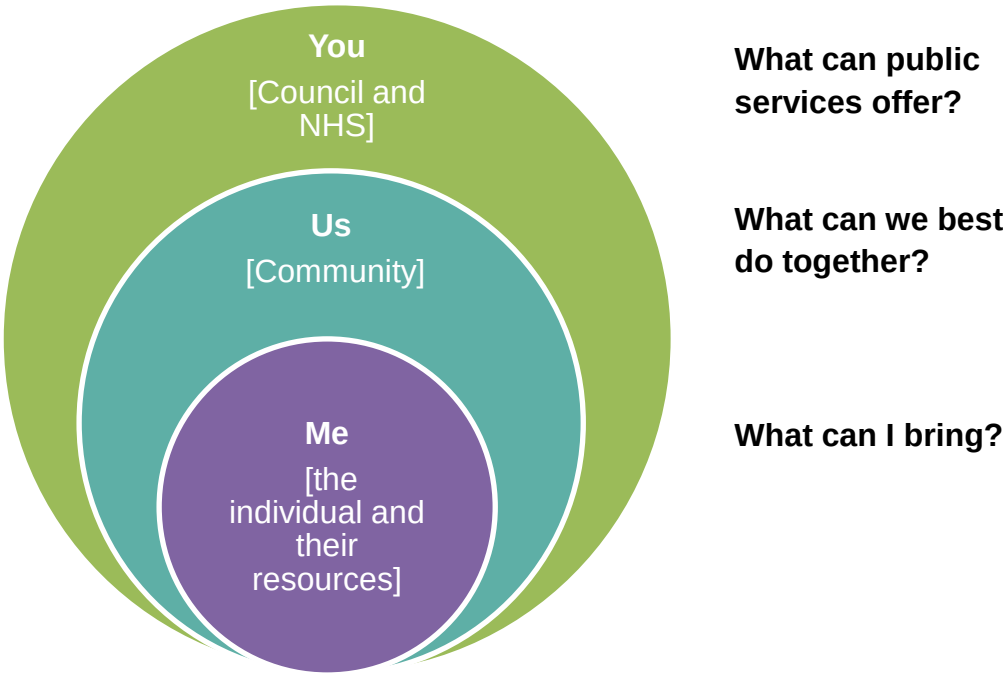
- set out a borough-wide approach to prevention that can be used consistently by all partners working together
- set out how to align the approach with the Health and Wellbeing Strategy and public health priorities
- make practical the approach to enabling social responsibility across the borough while maintaining support to the most vulnerable individuals and their carers, ensuring that the most help is given to those with the highest need at the most appropriate time

- ensure that prevention is taken into account in:
    - commissioning
    - day-to-day interactions for social workers and other health and care professionals
    - priority setting for community based partners and the developing care sector

5. Prevention - the guiding principles

The proposed prevention framework has three guiding principles.

Prevention is only effective when individuals (**Me**), communities (**Us**) and public services (**You**) work together. This promotes the strengths-based approach to assessing needs and supporting people.



Principle 1: Prevention starts with every individual (Me)

The approach starts with the individual – the person who may have needs. This may include the contribution of friends and relatives who are providing care for someone with needs. It means considering what the individual already has to help meet their needs, and what is potentially available.

It is, in some cases, less about money and more about friendships, relationships and other social networks that the person may have built up or those that could be strengthened. It may include social clubs, churches or faith groups.

The starting point for finding out what works best for the individual is best explained by the individual themselves.

Principle 2: Prevention is a job for the community (Us)

The next step is for the individual to ask what the community might be able to offer.

This can achieve real change. Putting **Me** and **Us** together creates the community that underpins effective social responsibility. By bringing together civic pride, individual responsibility and local growth, neighbourhoods across the borough can recreate a sense of community wellbeing.

Principle 3: Prevention: the role of statutory agencies (You)

The statutory agencies, for example, the NHS, Council, police, employment agencies, colleges and schools continue to have duties of care. However, their role is focused on specific population groups, or on people with high levels of need. It is not the role of statutory agencies to find a solution for every need, they cannot do everything, and they are not the first port of call for every situation.

This third step in the prevention pathway is therefore when the individual (**Me**) and the community (**Us**) looks to the statutory agencies (**You**) to find out what additional help can be offered.

As a part of this approach, the Council will begin to set out what it can offer to support individuals and communities as the two central pillars of prevention.

6. Making this happen

The borough already has collective organisational, political, public and partner sign-up to prioritise promotion of wellbeing and development of a preventative approach. This is reflected through our public health priorities, the Better Care Fund, integrated work with the NHS, partnership working with the third sector and commissioning. All this is set within the context of the Health and Wellbeing Strategy, and it is why there is no requirement for a separate prevention strategy.

Taking a preventative approach is not a new initiative or an additional burden imposed on or by the Council and its partners. Instead, the Framework:

- re-emphasises prevention as part of day-to-day business as usual
- embeds the preventative approach in existing services and current initiatives
- sets prevention as a guiding principle in commissioning and service development

Case study

Mr and Mrs M are council tenants. Mrs M has significant mobility issues and receives disability benefit to help manage her condition which has worsened in the past two years.

Ten years ago, they successfully applied to the council to create a parking bay on the front of their property. However, they recently learned that they need to add a dropped kerb if they are to continue using the parking space on their property.

As they are pensioners and will have difficulty in funding the cost, adult social care is working with street and enforcement services to help find a solution which allows Mrs M to continue getting out and about, reduces her isolation and continues to enhance her wellbeing. While a resolution is being sought, enforcement services will allow the couple to continue parking on their property.

Case study

Community Catalysts have been contracted for three years to work with individuals and small organisations wishing to develop services for the adult social care market.

To date, 40 individuals and organisations have been supported to develop an “offer”. Two examples of the wide range of services include:

- *Scrapbooking Memories* in a supported environment which builds confidence and breaks down isolation, through to a community based service for people with complex needs.
- *Whole Body Therapy*, a strength and balance service for people at risk of falls. Its first service option is a community based group session over 14 weeks to build strength and confidence for older people. The second service option is an intensive home service to rebuild skills after a fall/stroke or other similar incident purchased through the individual’s personal budget.

Better Care Fund

The Fund will be delivered in line with the preventative approach, including:

- measures to strengthen our commissioning focus and reduce the emphasis on purely provider led initiatives

- introduction of improved information and advice about the range of services contribution to prevention, and new service initiatives to address risks that are both environmental and those relating to people at risk as a result of their individual needs.

Better Care Fund initiatives in 2015/16 include:

- Prevention mapping: completed with live access via the Clinical Commissioning Group (CCG) to improve links between services, passporting, navigation, understanding and awareness of the role of universal services such as community pharmacy.
- Handyperson scheme: offering a practical solution to people's domestic environment, reducing risks and improving wellbeing.
- Falls prevention: extended reach to people over the age of 75 who may be at particular risk of falling and who are currently not participating in other programmes.
- Reviewing with public health the potential for further targeted activity and resources to support commissioning of further preventative services.

The Better Care Fund provides a preventative focus across partners and agencies.

1. Market Position Statement

Following the development of Barking and Dagenham's Market Position Statement, The Business of Care, in 2014, the Council is refreshing the Statement in 2015 to reflect the preventative approach. Work is already under way and will continue, through Community Catalysts, to support the practical development of micro-providers' contribution to prevention.

Refreshing the Market Position Statement

As services and commissions are reviewed, the preventative approach will be reflected in the work currently being undertaken to help residents find information and advice more easily.

In the past, local people may have looked to professionals to provide information and advice about services to suit their individual circumstances. While this is still available, the model is moving to an approach which empowers the individual. Online sites such as the Citizens Advice Bureaux, the local Care and Support Hub, and the Community Connect knowledge platform are being developed to help residents access information directly. Community Checkpoints are being launched across the borough where community volunteers will be trained to help enquirers find relevant web based information.

7. Responsibilitiesof the local authority and partners

Responsibility	Examples of local initiatives
• **Promote wellbeing** when carrying out any care and support functions in respect of a person	New approaches to assessment and care and support planning have been put in place to ensure practitioners consider wellbeing and prevention.
• Maintain a service for providing people with **information and advice** relating to care and support. This should include information and advice about preventative services, facilities or resources	An information and advice plan has been agreed by the Health and Wellbeing Board to be delivered during 2015/16 as part of the Care Act Implementation Programme. The online Care and Support Hub offers information and advice about care and support services for over-18s in the borough who thinks they need some help to live independently. It is also for people who are caring for someone. It can be used by people outside the borough who want to find information for a relative or friend living locally. The website helps people find information about care and support, and search for local groups, activities and services.
• Provide or arrange for services, facilities or resources to **prevent, delay or reduce** individuals' needs for care and support, or the needs for support of carers.	The Joint Assessment and Discharge multi-agency team is based in local hospitals. The local 'commissioning for prevention' approach is in development. The wider Council is involved for example, leisure services and housing, proactively promoting and supporting prevention and wellbeing

Responsibility	Examples of local initiatives
• Develop a clear, local approach to prevention which sets out how this responsibility will be fulfilled, taking into account different types of preventative support	
• Ensure the **integration** of care and support provision, including prevention with health and health-related services which include housing. • Includes a focus on **integrating with partners** to prevent, reduce or delay needs for care and support	The Better Care Fund, to be implemented in 2015/16, includes a specific focus on prevention. The fund – at least £3.8 billion across England – aims to ensure that people receive better and more integrated care and support through pooled budget arrangements between local authorities and clinical commissioning groups. In Barking and Dagenham, this has aligned services for 2015/16 with a value in excess of £21 million, including new governance arrangements. The Health and Wellbeing Board plays a central role in overseeing performance, outcomes and in considering additional steps required.

Related documents and activities

- Health and Wellbeing Strategy
- Leisure Strategy
- Housing Strategy
- Social care assessment and eligibility pathway
- Care and Support Hub
- Children's Centres/Community Hub Strategy
- Troubled Families Programme
- Carers Strategy

8. Equalities and diversity

The London Borough of Barking and Dagenham has seen significant changes in its population in recent years[1]. Current trends are expected to continue, leading to a number of challenges for the future:

- The over-85s population is more likely to need an adult social care budget to live independently
- The number of young people turning 18 from 2020 will increase substantially and there is likely to be a corresponding increase in those with a disability

[1] Joint Strategic Needs Assessment

- The local population has significant health problems, above the London average, for conditions such as heart disease, diabetes and respiratory disease
- Many migrants are coming from poorer countries and are likely therefore to be in poorer health. Changes in the ethnic profile could result in a higher than anticipated increase in the disease burden than is currently predicted
- High morbidity levels
- Increasing levels of dementia.

At the same time, the local authority and its partners are facing reductions in the level of resources year on year. The net adult social care budget 2014/15 was £39,826,000. This includes care and support services purchased by the Council, funding given to people to buy their own support, and in-house services. The adult social care budget was reduced by 7% between 2012/13 to 2013/14 and a further 10% between 2013/14 and 2014/15.

None of these factors should detract from the requirement to support wellbeing and the need to develop personalised preventative approaches.

This means that a new approach is required to ensure the council and its partners have a clear understanding of their roles and responsibilities, and meet the requirements of the Care Act 2014.

9. Next steps

1. Consult on the proposed preventative approach following comments and endorsement by the Health and Wellbeing Board.
2. Build the approach into our public health priorities for action and the Health and Wellbeing Strategy.
3. Use the consultation as the basis for prioritising development of “commissioning for prevention” priorities.
4. Develop the “commissioning for prevention” methodology and scoring system along with a simple process for partners to use to apply to commissioning and contracting. Revise current contracts and develop new contracts to emphasise the preventative approach throughout the care or service pathway.
5. A series of information seminars and briefing sessions will be held to refine the prevention approach and simultaneously amend existing activity.
6. An action plan to review progress based on the above will be presented at the Health and Wellbeing Board in November 2015.

10. Appendices

Appendix 1: Prevention

Appendix 2: Wellbeing

11. Document control

Version 1	**Status** *April 2015 [Draft]*	**Author** *Ian Winter CBE, Care Act Programme Lead*
Document objectives: To set out the London Borough of Barking and Dagenham's approach to prevention, ensuring that this is compliant with the requirements of the Care Act 2014		
Intended recipients: Health and wellbeing board; staff in statutory and voluntary sector partner organisations, Council Members		
Monitoring arrangements: The framework will be monitored through the performance management framework reporting to the H&WBB on a quarterly basis		
Approving body and date approved Awaiting approval of Health and Wellbeing Board		
Date of issue	*April 2015*	
Scheduled review date	*April 2017*	
Lead officer *(contact person for the future)*	*Ian Winter CBE, Care Act Programme Lead*	
Path and file name	*S:\AB Shared\Care Act 2014\Commissioning\Prevention*	

APPENDIX 1: PREVENTION

Promoting wellbeing means developing prevention

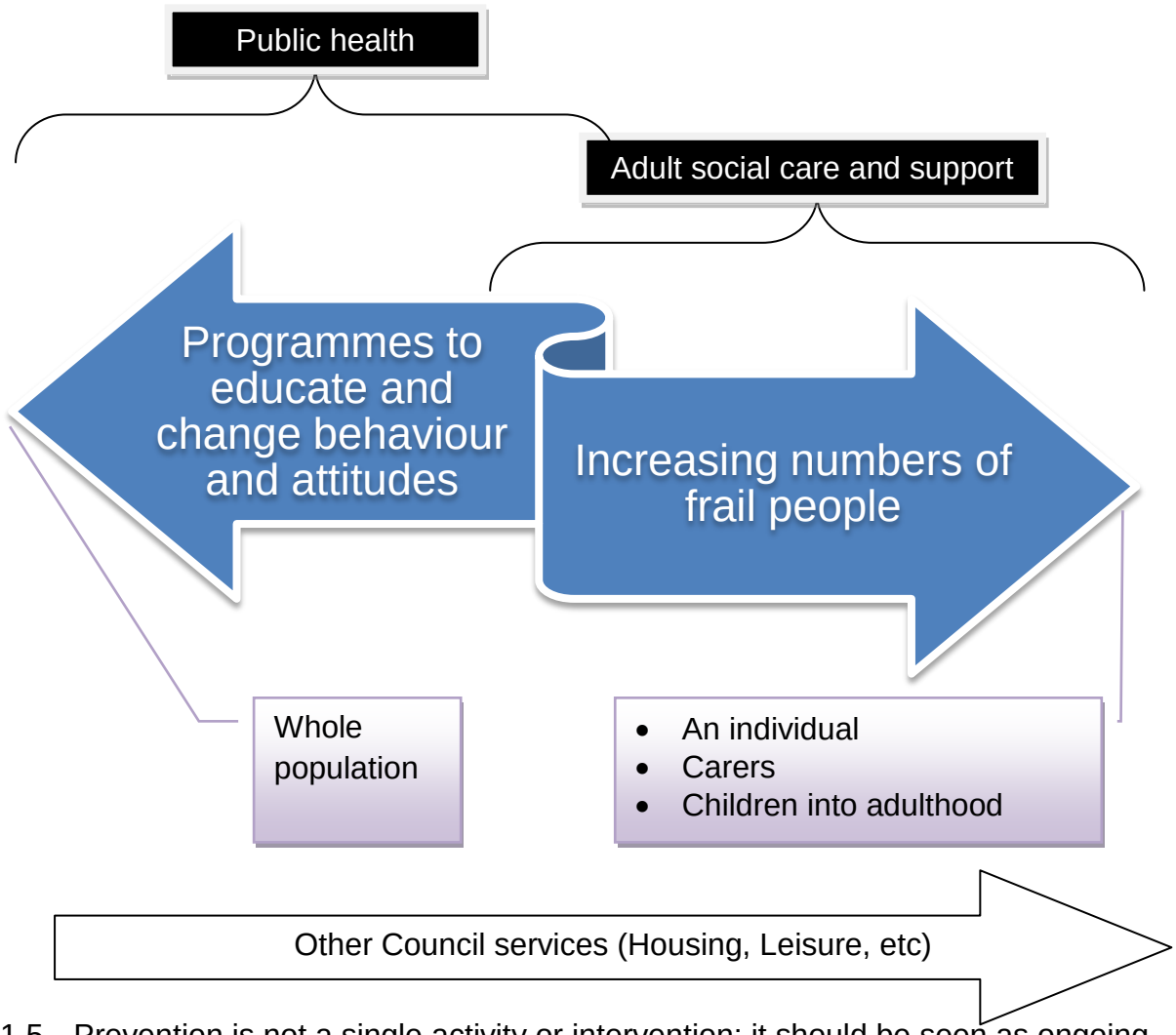
1.1. At the very heart of the Care Act, and as the most important element of supporting health and wellbeing, are actions and activities that help to develop prevention. This is not about waiting to respond when people reach a crisis point. To meet the challenges of the future it will be vital that the care and support system works as early as possible to support individuals, helps people retain or maintain their skills and confidence, and prevents needs escalating or helps to delay deterioration wherever possible.

1.2. The local authority's responsibility for prevention applies to all adults including:

- People who do not have any current needs for care and support, but may have in the near future
- Adults with needs for care and support, whether their needs are eligible or met by the local authority or not
- Carers, including those who may be about to take on a caring role or who do not currently have any needs for support, and those with needs for support which may not be being met by the local authority or other organisation.

1.3. There is no single definition of what constitutes prevention. It can range from wide scale whole population measures aimed at promoting health to more targeted individual interventions for one person or a particular group, or lessening the impact of caring on a carer's health and wellbeing. The Council through its Public Health responsibilities and adult services care and support carries the primary responsibility for developing and maintaining prevention services.

1.4. The diagram overleaf illustrates the extensive breadth and scope of the Council's responsibilities.



1.5. Prevention is not a single activity or intervention; it should be seen as ongoing and with the capacity for it to be varied according to circumstances.

1.6. Prevention has three core elements set out in the Care Act:

i. Promoting wellbeing

These are aimed at individuals who may have no current health or care and support needs but for whom services, facilities or resources may help an individual, or their carer, avoid developing needs for care and support. It is much more about maintaining independence and reasonable health and promoting wellbeing.

Examples

- The Ageing Well programme has been introduced with an annual membership of £52 per year for residents of the London Borough of Barking and Dagenham who are aged 60 years or over, the equivalent of £1 per week. This membership allows individuals to access the borough's leisure centres and activities at no extra cost, Monday to Friday, up until 5pm and all weekend. Individuals will have access to swimming, gym, classes and badminton. In addition there are a range of weekly physical activities,

cultural and social activities at a range of venues across the borough in six Active Age centres and a range of community venues and parks across the borough that individuals as well as a number of events activities across the borough all included in this membership.

- Carers of Barking and Dagenham provide information and advice to carers to support them in their caring responsibilities. The support groups and advice enable carers to sustain their caring role.
- Information and activities to support a healthy lifestyle such as walks, bike rides, and so on. This information can be online or from hubs such as libraries and children's centres.
- Information available online about minor or common illnesses and practical information on self-diagnosis and how to use over the counter medicine.
- A self-help directory with contact details of local services
- A comprehensive list of national helplines

ii. Prevention to reduce needs

These are more targeted interventions aimed at individuals who have an increased risk of developing needs and where the provision of services, resources or facilities may help slow down or reduce any further deterioration or prevent other needs from developing.

Examples

- The model developed across clusters 1-3 where people with a personal budget use the support of their personal assistants to attend a weekly activity facilitated by the cluster managers. The activity includes a healthy lunch and dance and fitness activities provided by two local micro enterprises and other information around services and opportunities. The average weekly attendance is 10-20 people with a personal budget, and reduces isolation as well as improving the quality of life for the residents.
- In 2013 the Council opened the Relish café in Barking for the community. The café provides an opportunity for adults with a learning disability to gain work experience and interaction with the public to prepare them for further employment opportunities.
- Stop smoking support
- Health checks via pharmacies and GPs

iii. Prevention to delay the impact of increasing social care or health needs

These are activities aimed at minimising the effect of disability or the deterioration of people's conditions where they have an established or complex health conditions (including progressive conditions such as dementia). People may also be supported to regain skills and confidence and manage or reduce need where possible.

These services could also include helping improve the wellbeing of carers by enabling them to continue to have a life of their own alongside their caring role.

Examples

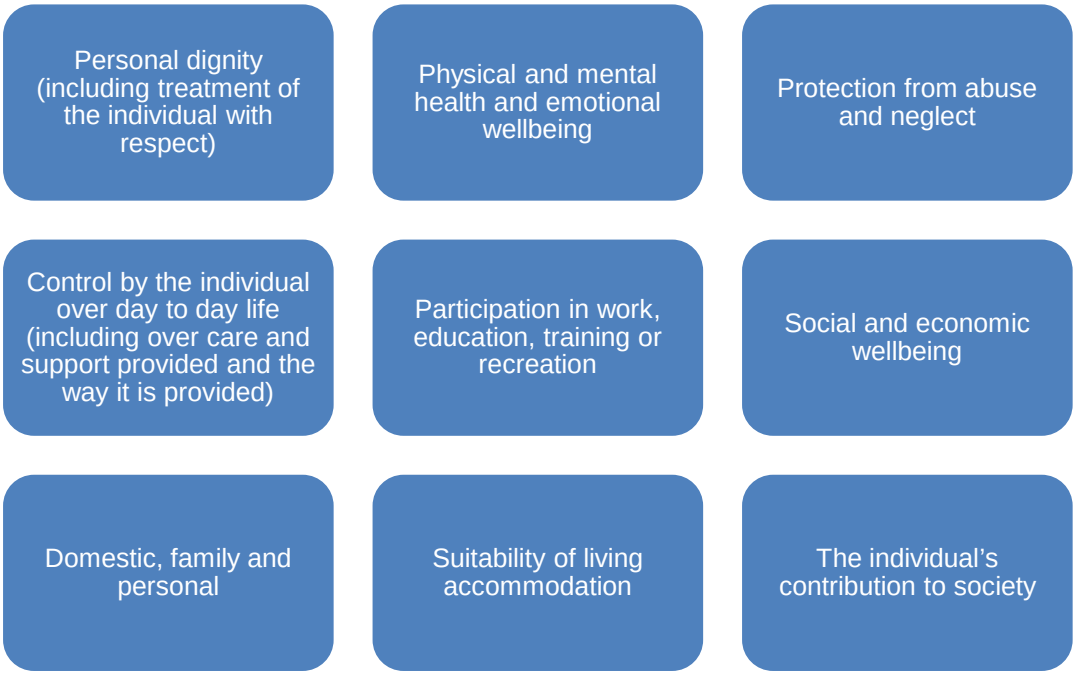
- Social care is delivered through close **working with GPs within six 'cluster groups'**. Each cluster is made up of social workers, support planners, community matrons, district nurses and occupational therapists based around a group of GP practices, and means that people receive better co-ordinated and planned care from both health services and the Council.
- The Council has worked to create a **Joint Assessment and Discharge (JAD) team** with the neighbouring borough of Havering. This service was launched in June 2014 and aims to improve the way people leave hospital into community-based support or to go back to their homes. This is part of our aim for more people to get support they need in the community and their own home rather than in hospital or residential settings.
- Carers of Barking and Dagenham provide a specialist dementia service called **Memory Lane** which provides support for those suffering from dementia and peer support for their carers.

APPENDIX 2: WELLBEING

Wellbeing is an important building block

1.1. Wellbeing is a very broad concept. The Care Act 2014 sets out the following areas:

The key areas of wellbeing



1.2. Promoting wellbeing as set out in the Act is at its most relevant to people with care and support needs and their carers. Promoting wellbeing should be considered at every point of involvement with the individual and will start by giving good information and advice and then continue through any assessment, care planning or review.

1.3. This means that there must be a shift from the local authority setting a particular service to meet needs. Everyone's needs are different and personal to them. So this is not about fitting the person into services, but rather taking a whole view of the individual and how their needs can be best met, and what they want to achieve.

1.4. One individual's wellbeing needs may be very different to another's. So the approach has to be about which elements of wellbeing matter most to the individual concerned. All decisions made by the local authority should be driven by the wellbeing of the individual. Wellbeing is also about resilience, in this individuals and communities are all different.

1.5. Independent living is a core part of the wellbeing principle and this includes individuals having as much control as possible of their day to day life, the suitability of living accommodation and their contribution to society –crucially, this requires local authorities to consider each person's views, wishes, feelings and beliefs.

1.6. Wellbeing is not abstract or jargon. It is something that affects all of us no matter what our circumstances and must now be considered central to the work of the local authority, the decisions of Elected Members and the commissioning and provision of services**.**

HEALTH AND WELLBEING BOARD

12 MAY 2015

Title:	**Mental Health Needs Assessment**
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: All	**Key Decision: No**
Report Author: Sue Lloyd, Consultant in Public Health	**Contact Details:** Tel: 020 8227 2799 E-mail: sue.lloyd@lbbd.gov.uk

Sponsor:

Gill Mills, Chairperson, Mental Health subgroup Health and Wellbeing Board.

Matthew Cole, Director of Public Health

Summary:

There has been an increasing focus on mental health in the London Borough of Barking and Dagenham (LBBD) and from national government. As part of the substructure arrangements for the Health and Wellbeing Board, the establishment of a Mental Health Group was agreed in April 2013. This has responsibility for developing plans for the joint improvement of mental health treatment and care services in Barking and Dagenham (London Borough of Barking and Dagenham 2013).

Nationally there is a renewed focus on mental health with national government launching a mental health strategy *No Health Without Mental Health* in 2011 and *Closing the Gap: Priorities for Essential Change in Mental Health* in 2014.

In Barking and Dagenham a lot has been done and is being done to improve mental health services for citizens across health and social care. Examples include Barking and Dagenham Council has awarded a tender for Independent Mental Capacity Advocacy and Independent Mental Health Advocacy; and specialist employment service. Access to talking services (IAPT) have been improved, there is no waiting list.

From the needs assessment it is clear that we do not know how many children and adults in the borough are mentally ill. The data on children is based on national estimates and there is a gap between the number of children we'd expect to be treated for mental illness and the number who are treated. In the borough we need a clearer understanding of who our mentally ill children are and we need to ensure that once diagnosed that these children have access to appropriate mental health services.

In the borough we have clearer information on the numbers of adults with common and enduring and severe mental illness. The data on adults is based on the numbers treated. There is a gap between the number of adults that we would expect to be diagnosed and the numbers that are diagnosed. This is the case for depression and severe and enduring

mental illness. There are adults in Barking and Dagenham who have mental illness that has not been diagnosed and treated.

Also from the needs assessment there are other actions that would further improve services.

- Barking and Dagenham practices could be improved based on impendent models of good practice.
- Citizens would have more life satisfaction if they had better general mental health this could be achieved by promoting positive mental health. This should start in childhood.
- Common mental illness like depression is at a high level in the borough and people who go to primary care are not always diagnosed early. This means that they are not treated early enough even through the talking therapy service (IAPT) have very short waiting times. It also means that citizens are not signposted appropriately to supporting services.
- Severe and enduring mental illnesses like schizophrenia are at high levels in the borough. People are being treated successfully in the community but people are not diagnosed soon enough. Also people being treated are not always clear about their ultimate outcome or the transfer plan back to primary care. This creates uncertainty and lack of confidence for people who are ill and practitioners.
- It's clear that GPs are not always confident in diagnosing common or severe and enduring mental illnesses. This means that citizens are not always treated early or appropriately to meet their need. It also means that GPs are not always confident of accepting patients with stable conditions back to their care.
- There may be unmet need care need. Employed people on Care Programme Approach is low in Barking and Dagenham compared with the England average however, these people are more likely to be in stable and appropriate accomodation.

After reviewing the needs assessment the mental health sub-group of the Health and Wellbeing Board agreed a set of 25 recommendations (Appendix 1). From theserecommendations the vision for improving mental health and adelivery plan will be presented to the July meeting of the Health and Wellbeing Board.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Discuss and comment on the recommendations made by the Mental Health Subgroup of the Health and Wellbeing Board

(ii) Task the Mental Health Subgroup to incorporate the views of the Board into the vision and Mental Health delivery plan which is being presented to the Board at its July meeting.

Reason(s)

The recommendations of the Mental Health Needs Assessment are based on a robust analysis of the mental health needs of the population of Barking and Dagenham. The needs assessment was undertaken in partnership with the Health and Wellbeing Mental Health Subgroup and Delta Consulting. The recommendations are agreed by the mental health sub-group of the Health and Wellbeing Board and will support the delivery of a delivery plan to be presented to the HWB in July 2015.

1. Introduction and background

1.1 Nationally there is a renewed focus on mental health with national government launching a mental health strategy *No Health Without Mental Health* in 2011 and *Closing the Gap: Priorities for Essential Change in Mental Health* in 2014.

1.2 Central to *Closing the Gap: Priorities for Essential Change in Mental Health* is **parity of esteem** between mental health services and physical health services.

1.3 The Mental Health Needs Assessment was done to better understand the local picture of mental health need and the vision for improving services:

- Understand the prevalence of mental illness in Barking and Dagenham and patterns of future need.
- Consult with key stakeholders including careers to obtain a wide range of views on current services and unmet needs.
- Produce an agreed set of recommendations and supporting actions that can be used to improve the state of mental health care in the borough.

1.4 There has been an increasing focus on mental health in the London Borough of Barking and Dagenham (LBBD). As part of the substructure arrangements for the Health and Wellbeing Board, the establishment of a Mental Health Group was agreed in April 2013.

1.5 The sub-group has responsibility for developing plans for the joint improvement of mental health treatment and care services in Barking and Dagenham and this needs assessment provides background information to define the vision and to inform the delivery plan.

1.6 After reviewing the needs assessment the mental health sub-group of the Health and Wellbeing Board agreed a set of 25 recommendations. From these the recommendations and delivery plan will be presented to the July meeting of the Health and Wellbeing Board.

2. Methodology and consultation

2.1. Delta Public Health Consulting worked closely with the health intelligence team and used the Joint Strategic Needs Assessment (JSNA) as well as other service representatives to access relevant demographic, epidemiological and service data.

2.2. Engagement with adult service users and carers was through two co-production events one held in October (on World Mental Health Day) and one in November 2014. The events attracted 105 attendees including 24 service users and 8 carers.

2.3. Engagement with children and young people was through one event held in November 2014 which was attended by 15 children and young people.

2.4. An on-line questionnaire was distributed and completed by 36 people. Of these 10 identified themselves as service users.

2.5. Face-to-face and telephone interviews were held with 12 services managers in health and social care, 8 service managers in other agencies, 7 strategic health and social care managers and 3 service users or carers.

2.6. UK models of good practice were identified.

2.7. Two interim draft reports were presented to the Health and Wellbeing Mental Health Sub-groups.

3. Report highlights

3.1. From the needs assessment it is clear that in the Barking and Dagenham **we do not know exactly how many children and adults in the borough are mentally ill**. This is not a position unique to Barking and Dagenham, but a national one.

3.2. **The data on children is based on national estimates and there is a gap between the number of children we'd expect to be treated for mental illness and the number who are treated**. In the borough we need a clearer understanding of who our mentally ill children are and we need to ensure that once diagnosed that these children have access to appropriate mental health services.

3.3. **In the borough we have clearer information on the numbers of adults with common and enduring and severe mental illness, but there are adults in Barking and Dagenham who have mental illness that has not been diagnosed and treated.** The data on adults is based on the numbers treated. There is a gap between the number of adults that we would expect to be diagnosed and the numbers that are diagnosed. This is the case for depression and severe and enduring mental illness.

3.4. **In 2014 Barking and Dagenham residents reported the lowest scores for life satisfaction and highest scores for anxiety when compared with statistical neighbours**. Wards in the borough that appear to have particularly low reported wellbeing are Chadwell Health, Village, Goresbrook, and Heath. The ward reporting the most positive wellbeing was Longbridge. Because feelings of wellbeing are closely linked with mental health people who have low feelings of wellbeing are more at risk of common mental illnesses like anxiety and depression. Also adults who are mentally ill can have a negative impact on the mental health of their children.

3.5. **In 2012 4,500 boys and girls in Barking and Dagenham had a significant mental health condition**. Of the children who had mental health issues boys are more likely to have behaviour and hyperactive disorders and girls are likely to have emotional disorders. Across England it is estimated that one in ten children and young people aged between 5–16 have a clinically diagnosed mental disorder. It's likely that the Barking and Dagenham figure is close to the England figure of one in ten children but this is not absolutely accurate because actual numbers of children diagnosed are not recorded for our borough.

3.6. **In 2014 three in every twenty adults in Barking and Dagenham had a common mental health disorder**. Common disorders include neurosis, phobias, depression, general anxiety, obsessive compulsive disorder, panic disorders and other mental health problems. This is similar to England rates and there were 19,567 people in the borough with common mental health disorders. Evidence from GP Quality Outcome

Framework scores suggest that not all cases of common mental illness are diagnosed. Of those who are diagnosed more women than men had common mental health disorders and there are also higher rates of mental health disorders in black and Asian communities than in white communities.

3.7. **In 2014 fifty-two people in Barking and Dagenham were diagnosed with severe mental illness, this is higher than the England average.** We would have expected thirty-two people to be diagnosed. Severe and enduring mental illnesses with psychosis include schizophrenia, bipolar depression and psychotic depression.

3.8. **The council is helping residents to stay well and resilient** by providing support through children's centres and to adults the Mental Health First Aid initiative. Children's centres are widely distributed through the borough but the Mental Health First Aid programme reached 466 people. These were trained in mental health first aid and as part of the course they were asked to do out reach and to talk to other about mental health.

3.9. Residents who need mental health services are served by GPs, NELFT and NELFT Child and Adolescent Mental Health Services. Drug and Alcohol services are commissioned by the council and the CCG. Independent Mental Health Advocacy and Independent Mental Capacity Advocacy, personal budgets, day opportunities and support into employment and other services are commissioned by adult social care.

4. Key feedback about services in Barking and Dagenham:

4.1. **Are the needs of children with mental health disorders met?**

Our children and adolescents wait only a short period between referral and assessment. Rapid access to CAMHS is essential because this gives children and adolescents access to the treatment pathway and also provides support to carers. We do know that more than half (64%) of children and young people are assessed within one week of being referred and nearly all are assessed within three weeks.

4.2. **It is likely that some children with diagnosable mental health disorders are not being picked up and treated in Barking and Dagenham**. In 2012 it was calculated that 4,500 children in Barking and Dagenham had a clinically diagnosable mental health disorder. Of these 562 were seen in CAMHS – Tier 3/4, an unknown number were seen by paediatricians, early intervention psychosis service or eating disorder services. Another 200 young people were seen by The Listening Zone (Tier 2 and 3). This suggests that some children and adolescents may be lost to the system and we do not currently know who these children are or how they are being supported, or if they are being supported.

4.3. **Are the needs of adults with common mental health disorders met?**

Access to health and social care services is important to people with common mental illness in Barking and Dagenham because services enable the individual to continue being an active member of society. This done by providing early support to services e.g. talking therapy (IAPT), sign posting to services and access to support through the voluntary sector. In registering common mental illness **it's likely that some GP practices are missing cases of depression.** The number of cases of depression

reported by GP practices varies across the borough. Some GP practices report many more cases than expected and other GP practices report many less cases than expected. Talking therapy is effective in the treatment of common mental health disorders and **access to talking therapy in the borough is rapid, there are however big differences in the number of referrals to talking therapy between the ethnic populations in the borough.** A person referred to talking therapy is usually seen within two weeks of referral. People of white background are more likely to be referred to talking therapy compared to residents of mixed origin, Asian or Black residents. Because people from Asian and Black populations are more likely to have a common mental illness and so it we should have seen more referrals from these groups than from White groups. **Therefore it's likely that some diagnoses are being missed in these populations.**

4.4 **Are the needs of adults with severe and enduring mental illness met?**

Access to health and social care services is important to people with severe and enduring mental illness because services enable the individual to be an active member of society. In part this is achieved by supporting daily living, for example, providing support to employers, and advice on housing. This is also achieved by providing quick access to health support – GPs, mental health services and home treatment; access to health support e.g. community psychiatric nurse.

Barking and Dagenham's severe mental illness profile (Public Health England) shows a range of indicators for which the local value is low in comparison with England. These are:

i. Number of people with severe and enduring mental illness known to GPs (QOF).
ii. People in contact with mental health services.
iii. Mental health admissions to and discharges from hospital.
iv. Exemptions from mental health checks.
v. Care Programme Approach adults in employment.
vi. Access to psychological therapy for those with psychosis.
vii. Social care mental health clients in residential care or receiving home care aged 18-64.

4.5 **It's clear from the profile that not everyone who needs support for severe and endure mental health care accesses support**, Barking and Dagenham do not have the expected numbers of people being treated and it is likely that some people who need support and treatment aren't getting it. This could be up to 450 people.

There are some reports of a lack of a clear post-discharge care for stable patients with severe and enduring mental illness. This may lead to lack of confidence in primary care managing these patients. There some unconfirmed cases where people could be discharged from the care of NELFT but because of these issues thay have not been discharged.

There may be unmet need beyond clinical care. Employed people on Care Programme Approach is low in Barking and Dagenham compared with the England average; however, these people are more likely to be in stable and appropriate accomodation.

Finally one in three patients who attended A&E in a 2013 survey had a chronic mental illness, suggesting that people with this type of illness are more likely to use A&E. This is an issue that is being targetted in A&E by a social worker specifically employed to support individuals who need support.

4.6 **Key findings**

A lot has been done and is being done to improve mental health services for citizens across health and social care in Barking and Dagenham, examples include Barking and Dagenham Council has awarded a tender for Independent Mental Capacity Advocacy and Independent Mental Health Advocacy; and specialist employment service. Access to talking services (IAPT) have been improved, there is no waiting list. From the needs assessment there are other actions that would further improve services.

- The partnership needs to take action based on best practice to close the gap between the numbers of people who have mental illness in the borough and those who are accessing treatment.
- Models of good practice have been identified in the needs assessment. These models can be used to guide improvements in Barking and Dagenham practice.
- Citizens would have more life satisfaction if they had better general mental health this could be achieved by promoting positive mental health. This should start in childhood.
- Common mental illness like depression is at a high level in the borough and people who go to primary care are not always diagnosed early. This means that they are not treated early enough even through the talking therapy service (IAPT) have very short waiting times. It also means that citizens are not signposted appropriately to supporting services.
- Severe and enduring mental illnesses like schizophrenia are at high levels in the borough. People are being treated successfully in the community but people are not diagnosed soon enough. Also people being treated are not always clear about their ultimate outcome or the transfer plan back to primary care. This creates uncertainty and lack of confidence for people who are ill and practitioners.
- It's clear that GPs are not always confident in diagnosing common or severe and enduring mental illnesses. This means that citizens are not always treated early or appropriately to meet their need. It also means that GPs are not always confident of accepting patients with stable conditions back to their care.
- There may be unmet need care need. Employed people on Care Programme Approach is low in Barking and Dagenham compared with the England average however, these people are more likely to be in stable and appropriate accomodation.

Based on the findings of the mental health needs assessment of the Mental Health Sub Group agreed a set of 25 recommendations (attached as Appendix 1). The assessment also concluded that there is significant strategic development to address mental health needs of adults and children underway across the Barking and Dagenham public sector at a time when services face resource constraints and ever increasing demand. Any opportunity to make investments in mental health services should ensure that an offer is developed that supports the holistic needs of a range of patients, and has an 'open door' policy.

5. Recommendations

The Health and Wellbeing Board is recommended to:

(i) Discuss and comment on the recommendations made by the Mental Health Subgroup of the Health and Wellbeing Board

(ii) Task the Mental Health Subgroup to incorporate the views of the Board into the vision and Mental Health delivery plan which is being presented to the Board at its July meeting.

6. Mandatory implications

6.1. Joint Strategic Needs Assessment (JSNA)

The needs assessment uses the analysis from the JSNA and offers new information that will be embedded in the refresh.

Along with the information included in mental health section of the JSNA, in order to ensure a robust systematic approach is taken to improving both mental health and appropriate support services in the borough, the following workstreams need to be integrated

- The findings of this Mental Health Needs Assessment
- Health and Adult Services Select Committee action plan
- "Closing the Gap" assessment and remedial action
- The 2013 Annual Public Health Report recommendations
- The Barking and Dagenham Integrated Care Coalition's 5 year strategy plan recommendations

This will be co-ordinated through the Mental Health Subgroup of the Health and Wellbeing Board.

6.2 Health and Wellbeing Strategy

If agreed and taken forward, the recommendations from the report will contribute to a number of the Health and Wellbeing Strategy outcomes:

- Residents are supported to make informed choices about their health and wellbeing to take up opportunities for self help in changing lifestyles such as giving up smoking and maintaining a healthy weight. This also involves fostering a sense of independence rather than dependence.
- Every resident experiences a seamless service.
- Service providers have and use person centred skills across their services that makes every contact with a health professional count to improve health.
- More older people feel healthy, active and included.
- Early diagnosis and increased awareness of signs and symptoms of disease will enable residents to live their lives confidently, in better health for longer.

6.3 Integration

The implications for integration are highlighted in the report and will be taken forward by Health and Wellbeing Mental Health Subgroup.

7. Financial implications

There are no financial implications directly arising from the recommendations in this report as they are to generally be met from within existing resources.

Since November 2011 there has been a Section 75 agreement between London Borough of Barking and Dagenham and North East London NHS Foundation Trust (NELFT), integrating the functions and funding of mental health and social services. The Mental Health service budget for local authority services in 2014/15 was £3.434m, which included a social care grant allocation of £0.5m. The Mental Health service for health funded services is £7.346m. The 2015/16 budgets have been based on the 2014/15 allocations.

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

8. Legal implications

There are no implications from this report which intends to implement recommendations from the MHNA report finalised in March 2015, which I have not seen.

Implications completed by: Dawn Pelle, Adult Care Lawyer.

9. List of attachments:

— Appendix 1: Mental health needs assessment recommendations

This page is intentionally left blank

Health and Wellbeing Board

12 May 2015

These recommendations are presented by the Mental Health Sub-group based on the needs assessment and have been written in agreement with Delta Consulting. It's proposed that these recommendations form the basis of the vision and the delivery plan which will be presented to the Health and Wellbeing Board in July 2015. They are presented to the Health and Wellbeing Board for discussion and comment.

Mental Health Needs Assessment: Recommendations

This section uses the **twelve themes** agreed at events to provide structure to a series of **twenty-five recommendations**. These are presented in ranked order of the priority given to them by participants at the second event.

The action plan follows the recommendations

10.1.1 THEME: ***Overcoming isolation and low confidence; lack of availability of activities during the day and encouragement of self-help; lack of employment and volunteering opportunities***

Recommendation 1: People with mental illness in Barking and Dagenham need greater holistic support for their recovery. Commissioners across health and social care should explore service models offered in Sandwell and in Lambeth which offer support for finding work, getting into education, welfare benefits advice, accessing social and leisure activities and finding people with similar interests, and getting advice on housing and tenancy, to identify and implement an enhanced offer for Barking and Dagenham.

Recommendation 2: Vulnerable adults (those without a mental illness diagnosis) in Barking and Dagenham need greater support for their wellbeing so that problems relating to their social and economic situation do not 'tip over' into greater need. This recommendation should be embedded in the LA's current initiative around adult wellbeing, so that it takes account of the need to promote and protect positive mental health and wellbeing.

Recommendation 3: Meaningful and appropriately-supported service user and carer engagement should be a priority for the Mental Health Subgroup.

7.1.1. THEME: ***Lack of emphasis on prevention of mental illness and promotion of wellbeing in communities, addressing poor social and home environments***

Recommendation 4: Children and young people in Barking and Dagenham need greater awareness and tools for protecting their mental health, for promoting positive mental health, and for reducing stigma relating to mental health disorders. Commissioners across education, health and social care should ensure that promotion of positive mental health and, for example, the five ways to wellbeing, are embedded throughout local children and young people's strategies. It should be noted that the content of such development differs substantially from mental health first aid. Best practice in commissioning children's mental health services should be considered (Mental Health Foundation 2014) and efforts should be made to continue to engage with children and young people on mental health commissioning.

Recommendation 5: Action taken under the Emotional wellbeing, psychological wellbeing and resilience strategy for children and young people, 2011-2013, should be reviewed with a view to developing a new strategy.

See Recommendation 2 also.

7.1.2. THEME: ***Lack of peer support as a means of helping recovery and as additional capacity***

Recommendation 6: Commissioners across health and social care should agree to invest in the development and establishment of a peer support programme in mental health, seeking advice from Lambeth colleagues as appropriate. The programme should have sufficient capacity to offer meaningful access to mental health service users across the borough, and provide funded coordination and appropriate training and development for those in peer support roles.

7.1.3. THEME: ***Lack of consistency in GPs' and other primary care professionals' skills and knowledge; and poor coordination between primary and secondary care***

Recommendation 7: As part of the primary care improvement plan, GPs and other primary care professionals should be supported to undertake training and development in mental health. Ways of encouraging those who do not see that they have a specialist role in mental health should be identified, and a broad view should be taken of those professionals who

would benefit from such development. For example, practice nurses as well as GPs should attend training for clinicians, and other members of the primary care team such as practice managers should attend appropriate training such as Mental Health First Aid.

Recommendation 8: General practices with particularly low QOF recorded rates of depression and of SMI cases on the mental health register should be targeted for specific support and ongoing monitoring, highlighting likely numbers of patients with mental illness who may not be receiving adequate treatment. This activity should be embedded in CCG Corporate Objectives and commissioning plans, as appropriate; and reflected in commissioning of primary care, currently with NHS England.

7.1.4. THEME: ***People presenting in crisis at A&E with mental health problems (some known, some unknown), and lack of coordination between agencies after hours***

Recommendation 9: The support available for those with severe and enduring mental illness post-discharge from NELFT, and particularly on discharge from an inpatient bed, should be clarified for service users/carers, and across the health and social care system, including within the housing sector.

Recommendation 10: The audit of Barking and Dagenham patients presenting at A&E should be repeated, with the addition of qualitative data collection and follow up for those who have established mental illness diagnosis as well as those who are presenting for the first time with symptoms of mental illness, to understand better whether each patient's needs could have been met more appropriately elsewhere. The audit should cover both business hours and out of hours/weekends.

Recommendation 11: A systematic method of recording and monitoring the referral routes into BDAAT and the eventual pathways and outcomes relating to those who are not ultimately managed by NELFT services should be developed and implemented. This would include casemix and equalities monitoring. The objective would be to identify the needs of those who do not meet treatment criteria.

Recommendation 12: In order to raise awareness of different parts of the health and social care response to mental illness, and to break down silos, staff representatives from across the health and social care system (including housing) should be identified to form a learning network which would have scheduled face to face meetings to share information and approaches. This should be launched with facilitation but continue to self

facilitate. This should be linked to staff Continuing Professional Development.

7.1.5. *THEME:* ***Lack of agreed approach for children and young people moving into adult mental health services***

Recommendation 13: A local clinical pathway should be developed, implemented and publicised which identifies the care to be provided for the various CAMHS client groups, as they move into adult services if appropriate. This should include the support to be given during transition and clarify arrangements for those whose care will change as a result of transition. Service user and carer engagement should be central to the development of the pathway.

7.1.6. THEME: ***Lack of flexible and personalized approaches – standard care pathways seen as 'one size fits all'***

Recommendation 14: Commissioning and provision of support for people with mental illness should recognise the importance of personalisation, choice and flexibility in care. Providers need to identify in which practical ways the principles of personalisation; choice and flexibility can be implemented into the care individuals receive.

Recommendation 15: Commissioning and provision of support for people with mental illness should recognise that people access services in different ways. For example, whilst initiatives such as Big White Wall are innovative and may suit the lifestyles of particular groups of people, many service users do not access internet-based interventions. In planning service developments, alternatives should be considered and agreed.

7.1.7. THEME: ***People with mental illness who have inadequate accommodation for their needs***

Recommendation 16: Where hostel residents are referred with conditions that do not necessarily meet criteria for immediate support from NELFT, there needs to be some support put in place. Commissioners and providers should explore the Sandwell and Lambeth models of holistic support (see Recommendation 1) to identify ways in which the needs of this population group can be met.

Recommendation 17: The potential for personal health budgets to assist with securing the most appropriate accommodation for a person's needs should be explored, and pursued.

7.1.8. THEME: ***Dual diagnosis – services for people who have both mental health problems and alcohol/drugs problems, both adults and children/young people***

Recommendation 18: The service response for those who have 'dual diagnosis' should be clarified and, if necessary, a clear care pathway developed, implemented and publicised across the health and social care system, including housing, and with service users, carers and the public.

Also see Recommendation 13.

7.1.9. THEME: ***Lack of support for those without diagnosable mental health problems (e.g. personality disorder, hoarding behaviour, socially isolated)***

Recommendation 19: Commissioners and providers should ensure that future holistic support offered to those with diagnosed mental illness is also accessible for individuals who do not necessarily have a mental illness diagnosis. The Sandwell Esteem Team principle of 'never turning a patient away' should be emulated by the future service offer in Barking and Dagenham.

See also Recommendation 1.

Recommendation 20: Commissioners and providers should consider developing a specific strategy to respond to those with personality disorder, as has been undertaken in North East Essex for example (North East Essex CCG 2014).

7.1.10. THEME: ***Lack of consistent information and awareness of services which respond to mental illness (both professionals and public)***

Recommendation 21: IAPT services should be publicised to the Barking and Dagenham community in a manner that normalises these services, and targets those population groups (men, older people and some BME groups - Black and South Asian populations - for example) who have relatively low referral rates. This campaign should have a presence across the health and social care system (including general practices, and housing). Ongoing

marketing of services should seek service user/carer input, particularly from those groups with low referral rates.

Recommendation 22: Commissioners and providers should ensure that all web-based and printed information regarding mental health services for adults and for children and young people is consistent and up to date. Consideration could be given to deploying 'mystery shoppers' (from the service user and carer community, and from youth forums) to check information and telephone numbers.

Recommendation 23: The *Time to Change* website and free resources should be promoted throughout the health and social care system, including on websites, and consideration should be given to using its logo on email footers.

See also Recommendations 4, 7, 12, 13 and 25.

Recommendation 24: The Mental Health Subgroup should identify how it can become *the essential forum* for strategic partners who are involved in responding to mental illness, right across the system, so that all who need to improve and monitor the system response are engaged consistently, together.

7.1.11. THEME: ***Inequality in levels of acceptance of mental illness/stigma in some minority communities, likely access problems in particular groups such as Black and Minority Ethnic groups, LGBT, armed forces and those without IT literacy***

Recommendation 25: LBBD should explore the potential for the new Council Mental Health Champion to work to reduce stigma across the Barking and Dagenham population, using opportunities through the local media for example. Support for this role should also be sought from the Centre for Mental Health (Centre for Mental Health 2013).

See also see recommendation 21

HEALTH AND WELLBEING BOARD

12 MAY 2015

Title: Health and Wellbeing Outcomes Framework Performance Report – Quarter 4 (2014/15)	
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: NO**
Report Author: Susan Lloyd, Consultant in Public Health Mark Tyrie, Senior Public Health Analyst	**Contact Details:** Tel: 020 8227 3914 Email: mark.tyrie@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	

Summary:

The Quarter 4 data shows the following improvements:

- A&E attendances have decreased between February and March. This follows the opening of the extended hours services.
- Non-elective admissions for January – February were above target, and in the year to-date non-elective admissions were below target indicating that demand is being managed.
- In March there was an average of 167 ambulance conveyances per day to BHRUT compared to 179 in February a decrease of 12 per day (6.7%).
- Improvements in Chlamydia screening uptake were made in quarter 4 (132), with an increase, compared to the previous two quarters in number of positive screening tests detected. Detection rates were significantly higher than London and England rates.
- Numbers of NHS Health Check received by eligible residents has increased and is now above target at 15.3%.
- There were significant reductions in the IAPT referral waiting times, with figures for those waiting more than 28 days from contact to treatment, down from 22 in quarter 1, to 5 patients by Quarter 4, a decline also seen in previous quarters. There is not a nationally set target for IAPT waiting times, although it is stipulated that adequate service provision must be provided to ensure access for all who need treatment within 28 days of first contact.
- Children and young people accessing CAMHS services was up 16% compared to the previous quarter (635), an increase observed since the beginning of the financial year.
- The percentage of children receiving a face-to-face visit from a health visitor within 14 days of birth has improved from 81.5% to 85.1% from 2014/15 Q2 to 2014/15

Q4. National targets have not yet been set for face-to-face health visits to allow comparisons. However, we would expect this to be a 100% of mothers.

Quarter 4 data shows the following need improvements:

- Immunity of our population is not as good as it could be but better than the London average. Uptake of childhood immunisations for children 5 years old decreased for MMR2 and for DTaP. NHS England and partners have agreed an action plan to improve immunisation uptake.
- Overall teenage conception rates is on a decline, consistent with the trends across London and nationally, although our rates (40.1/1000 female population aged 15-17), based on Q3 2013/14 figures remain higher compared to these areas – 21.5/1000 and 24.4 respectively. The Borough continues to run a comprehensive sexual health education and advice service & to support mothers who chose to give birth under 18 years.
- Since the beginning of the financial year, annual health checks of looked after children have decreased. Compared to the first quarter of the 2014/15 (84.2%), checks were down nearly 10 percentage points by Q3 (74.8%), which is lower than both London (84%) and England's rates (88%). National targets have not yet been set for this indicator.
- Number of four week smoking quitters remains 14% below target; however, this is a national trend. BabyClear has been introduced to support quitting in mothers.
- Published reports from the Care Quality Commission inspections for the quarter are summarised for the information of the Board. Alexander Court Care Centre has six breaches of the Health and Social Care Act 2012 in its most recent inspection.
- The reported number of children seen by a health visitor for their 2-2.5 year review fell from 46.4% in 2014/15 Q2 to 30.3% in Q4. It's been suggested that this is a reporting systems issue; however, it is important that provider have an opportunity to address this issue. National targets have not yet been set for face-to-face health visits to allow comparisons. However, our aspiration would that 100% of children are seen.

Two NHS Trusts that serve our population are currently in special measures, Barking, Havering and Redbridge University Hospitals NHS Trust with a particular focus on Queen's Hospital, and Barts Health NHS Trust. Both Trusts have action plans in place and are being supported to improve the healthcare provided to patients.

Recommendation(s)

Members of the Board are recommended to:

- Review the overarching dashboard, and raise any questions with lead officers, lead agencies or the chairs of subgroups as Board members see fit.
- Note the 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 immunisation uptake, teenage conception, Chlamydia screening, smoking quitters, NHS Health Check, delayed transfers of care, A&E attendance, and CQC inspections.

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. Introduction

1.1. The Health & Wellbeing Board has a wide remit, and it is therefore important to ensure that the Board has an overview across this breadth of activity.

1.2. A number of significant issues the Board may wish to discuss are the performance against target for:

- Immunisations at 5 years (DTaP/IPV and MMR2)
- Under 18 conception rate
- Four week smoking quitters
- Alexander Court Care Centre having six breaches of the Health and Social Care Act
- Improvement in the % of patients seen at A and E within 4 hours
- Support to BHRUT, particularly Queens, and Barts Health NHS Trust that are in special measures
- Reported numbers of children seen by health visitors for their 2 – 2.5 year review

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 4

2.1. **Appendix A** contains a dashboard summary of performance in Quarter 4 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. Barking and Dagenham council now have access to HES data to support the provision of health and social care services.

4. 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, and cancer screening.

4.3. Indicators 1 and 2: Immunisation

The immunity of our young population is not as good as it could be but better than the London average. Barking and Dagenham's uptake is higher than London averages for both MMR2 and DTaP/IPV. There has been a decrease in uptake of the DTaP/IPV and MMR2 vaccines. DTaP/IPV vaccine uptake dropped from 83.3% in Q2 to 80.9% in Q3. MMR2 uptake dropped from 82.2% in Q2 to 78.8% in Q3. These figures are all below the population wide target of 95% that would give herd immunity. NHS England and partners have agreed an action plan to improve immunisation uptake. LBBD and NHS Barking and Dagenham CCG have been consulted in the development of the plan.

4.4. Indicator 7: Under 18 conception rate

Barking and Dagenham continues to have the highest conception rate in London. The most recent information that is available is for Q3 2013/14 when the average conception rate was 40.10 for every 1000 females aged 15-17; this compares poorly against the London average of 21.48 and the England average of 24.35. Although the borough's conception rates are high, there is a general downward trend for both under 18 conceptions and for abortions to those aged under 18, with both falling by over a third between 2007 and 2013. This shows that while there still remains work to be done in reducing rates for conceptions towards regional averages, positive sexual health messages to appear to be having effect.

There is a national target for under 18 conceptions to fall by 50% in each local authority from 1998. At present, Barking & Dagenham's rate has fallen by 26.6%. Until recently, the borough had been close to achieving this goal but the recent upturn has widened the gap.

The borough has an extensive programme of sexual health education, advice and services available to support under 18's. We also have a complete programme of support for young women who chose to become mothers under 18 years old.

4.5. Indicator 9: Four week smoking quitters

The four week quitter figure measures the number of individuals who have successfully quit for four weeks. There have been 166 quitters to date in this quarter. This is below target.

The quarterly target for quitters is 175 (minimum), and in quarters one, two and three were below target (142, 161 & 134 quitters), to date quarter four has produced

166 quitters. It should be noted that there has been a national downturn in the number of reported quitters. It is thought that this is due to increase in use of e-cigarettes, and the hard-to-reach nature of smokers who have not quit previously, this is yet to proven.

Of the 603 people who did quit, 10 were pregnant, and 141 were in the Routine & Manual category.

With Barking and Dagenham having one of the highest rates of women smoking at the time of delivery, with 10.0% of all deliveries in 2013/14 to women who were smoking, special focus has been given to increasing the number of pregnant women using the smoking cessations service.

The Council has taken three actions to improve the smoking health outcomes for Barking and Dagenham residents.

1. The specialist Stop Smoking service, North 51 have put in place a remedial action plan to increase the number of quit
2. The national stop smoking campaign was enhanced in Barking and Dagenham to give a high profile to the importance of quitting. Planning for future campaigns is also due to start.
3. The BabyClear programme is about to start which should see an increase in the numbers of referrals from pregnant women into the stop smoking service.

There have been difficulties with recruiting to the stop smoking service manager position. The service has therefore recruited the services of a recruitment agency to identify and place the vacant position.

Difficulties in making payments to practices and pharmacies are being resolved and visits made in order to galvanise action and increase the number of quits. North 51 (the stop smoking service) will be setting up a robust payments system in conjunction with the council finance team in order to ensure these problems do not continue to arise.

Areas of improvement

4.6. Indicator 8: Number of positive chlamydia screening tests

The chlamydia indicator is a simple measure of the number of positive tests from the screening process, compared with the expected numbers of positive tests.
The trend in positive results in the first two quarters was an improvement compared to the target, this trend reversed in the third quarter. In quarter four, there has been an upturn back towards the target, with each month seeing progressively higher numbers of positives as a result of mitigation measures put in place.
Although the number of positives remains below target, Barking and Dagenham has a higher chlamydia detection rate than the national average, and a statistically significantly higher detection rate than neighbours Havering, and Redbridge.
At the monthly sexual health contract meeting on 26th March, BHRUT submitted a list of actions to take for the improvements in levels of chlamydia screening and HIV testing uptake for 2015/16. The Council invited BHRUT to complete a performance

improvement action plan. A meeting is also scheduled with Terence Higgins Trust for 28 April 2015 to put in place a remedial action plan that will include increased training for staff at sites with high positivity but low activity, and sites that were not conducting screening.

4.7. Indicator 11: NHS Health Check Received

Quarters 2, 3 and 4 of 2014/15 have seen an upturn in performance, with uptake increased from Quarter 1's level of 2.4% (807) to 4.0% (1,425), 4.5% (1,603) and 4.4% (1,567) respectively, an annual performance of 15.3%. Quarter 4 figures compare very favourably with the equivalent quarters in the previous year and to national and regional averages and puts the borough above the previously set national annual target of 15%.

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.

4.8. Indicator 20: A and E attendances less than 4 hours from arrival to admission transfer or discharge

Q3 saw a downturn in performance with on 80.5% of attendances meeting the target. Q4 has seen that downturn reversed with 88.8% of attendances meeting the target. Performance has improved significantly; however, BHRUT is performing below the national and regional averages for 2014/15 Q4, with 88.8% seen in less than four hours compared to 91.8% in England and 92.6% in London. BHRUT is performing better than Barts Health NHS Trust though, who saw 88.3% within four hours in Q4.

5. CQC (Care Quality Commission) Inspections in Quarter 4 2014/15

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. In March, the Care Quality Commission published 65 reports across England on the quality of care provided by GP practices that have been inspected under its new approach.

Following recent inspections by specialist teams, 58 of the practices were rated as Good, one was rated as Outstanding, four were rated as "requires Improvement and two were rates as Inadequate. A further 36 reports on the quality of care provided by adult social care services across London were published in April. 19 of these care homes and homecare agencies have been rated as Good, 13 have been rated

Requires Improvement and four have been rated Inadequate. One of the care homes was located within Barking and Dagenham, with Hart Lodge being one of those rated as 'good'.

Under CQC's new programme of inspections, all of England's adult social care services are being given a rating according to whether they are safe, effective, caring, responsive and well led.

Hospitals in special measures

5.1. Barking, Havering and Redbridge University Hospitals NHS Trust

Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) is currently in special measures. The CQC has warned BHRUT that they must make immediate improvement within a set timescale particularly at Queen's Hospital. CQC has issued a formal warning to the trust following an unannounced inspection at which it failed to meet two of the three national standards which were reviewed. Inspectors found that Barking, Havering and Redbridge University Hospitals NHS Trust was failing to meet two standards at Queen's Hospital:

- Care and welfare of people who use services
- Staffing

The Trust is being supported to deliver an action plan for improvement. This action plan is available on the CQC website http://www.cqc.org.uk/provider/RF4/reports

5.2. Bart's Health NHS Trust

The NHS Trust Development Authority (NHS TDA) placed Barts Health NHS Trust into special measures on 17th March 2015. This follows the Care Quality Commission's (CQC) publication of its report into the Whipps Cross Hospital site. The report raised a number of serious concerns including:

- Insufficient staffing levels to provide safe care, high use of agency staff and low staff morale
- A persisting culture of bullying and harassment
- Bed occupancy that is too high
- A failure to meet national waiting time targets

`Updates on under-performing organisations - rated as either "Inadequate" or "improvements required"

5.3. Liberty Centre – overall inadequate

Following inspection on 31st March 2015, Liberty Centre care home was marked down on both being well led and safe. It was also marked down on as effectiveness, responsiveness and caring. The care home was therefore rated as both "Inadequate" and "improvements required" based on these scores.
Care Management is carrying out reviews on each service user and exploring best interest regarding ongoing attendance at Liberty Day service. This commenced on 7

April.

At the time of publication, Quality Assurance were carrying out a compliance/monitoring visit.

Social care commissioning is to source alternative provision in readiness should the compliance report evidence unacceptable or service reviews indicate an alternative provision is required.

Other authorities with individuals placed with the Provider within the borough have been advised of the CQC alert and other authorities have been informed of the decision undertaken by the London Borough of Barking to carry out a compliance/quality assurance visit and to review our service users. They have been recommended to do the same.

A follow up meeting will take place in 2 weeks after the compliance/quality assurance visit and reviews. The council will make a decision based on the findings.

5.4. Abbeyfield East London Extra Care Society – 2 standards not met

There were sixty staff working in the home, however two thirds had not completed safeguarding training. This suggested that staff were unable to identify the different types of abuse, and therefore appropriate responses to safeguarding concerns. It was also noted that two thirds had not completed the infection control training - staff were unable to identify the different types of infection and respond appropriately to infection control precautions to minimise cross- infection.

Following the CQC concerns about management and infection control, an action plan was put in place, but did not address all issues. A further inspection took place in February 2015. A further quality assurance action plan was put in place to address findings from the inspection in Feb 2015 – as of March 2015; the provider is working to the action plan and completed 75% of actions. Regular monthly monitoring visits have been in place since July 2014.

5.5. Bennetts Castle Care Centre – 1 standard not met

It was observed that medicines were not always stored and safely administered, which raised the issues of safety concerns. However, the service had procedures in place for dealing with safeguarding allegations and staff understood their responsibilities with regard to safeguarding adults.

A quality assurance action plan has been put in place covering standards not met alongside CQC action plan. A quality assurance visit took place in February 2015 with a follow up in April 2015 – the provider is currently working to action plan.

5.6. Fern Care Services – 1 standard not met

The service was not always effective. Annual appraisals were not being performed which suggest that care staff were not being formally appraised for the quality of their work. A quality assurance action plan was put in place in March 2015 alongside the CQC action plan.

A further monitoring visit is planned in May 2015 to review the action plan. Currently one client is placed with Fern Care Services – a telephone spot check was carried out in March on this client and there were no concerns raised regarding the care being given.

5.7. Alexander Court Care Centre – 6 breaches of the Health and Social Care Act

The Provider must send a CQC Report that indicates what actions they are going to take to meet these essential standards (No date provided).

Regulations:
1. Care and Welfare of service users
2. Safeguarding service users from abuse
3. Cleanliness and infection control
4. Meeting nutritional needs
5. Safety and suitability of premises
6. Respecting and involving Service users

Although staff knew how to recognise “How to keep Service Users safe” signs, some staff were unaware of the Provider's whistle blowing policy. People were not protected from the risks of inadequate nutrition and dehydration.

Good interactions between service users and staff were identified; however, it was indicated by some users that they were not treated with consideration, or respect, or involved in decisions relating to their care or f treatments staff were rushed and task focused. People were not always protected against the risks of receiving inappropriate or unsafe care.

Draft CQC findings were given to the provider and LBBD in August 2014. An unannounced quality assurance visit took place in August 2014 and an action plan was put in place based on the CQC pre-published report findings. Regular quality assurance visits (monthly) have taken place and action plans adjusted to incorporate additional concerns raised – the provider is currently working to action plan.

There was a change of manager and further changes in April 2015 with the home now awaiting the appointment of an interim.
Monthly quality assurance visits will continue to monitor progress with action plan.

6 Urgent Care Board

Appendix D contains detailed information from the Urgent Care Board Dashboard on initiative including the Barking Havering and Rebridge University Hospitals NHS Trust (BHRUT) Improvement Plan and the operational resilience schemes**.**

During 2014/15, rather than being measured against the national standard, Barking and Dagenham was being measured against an improvement trajectory; however, as we move into 2015/16, this improvement trajectory is no longer in use and services will once again be measured against the national standard. Through 2014/15 there have been improvements in the resilience of A&E services, particularly in the days after poor performance was seen. Whereas previously it would take a number of days for the whole system to recover, now this is happening within the next day or two days.

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. Meanwhile, new A&E waiting time figures show performance against the four-hour target of 95% has worsened in the New Year. The last three months of 2014 also saw the worst waits figures for a decade.

Q3 saw a downturn in performance with on 80.5% of attendances meeting the target. Q4 has seen that downturn reversed with 88.8% of attendances meeting the target. Performance has improved significantly, however BHRUT is performing below the national average for 2014/15 Quarter 4, with 88.8% seen in less than four hours compared to 91.8% in England.

6.2. A&E Attendances

Activity has decreased against planned
BHRUT A&E attendances – Numbers of people attending A&E have decreased between January and February. This is possibly due to the opening of extended hours services.

Less people than expected attended A& E in January, February and March 2015. This is in line with BHR 5 year strategy. Total A&E attendances across the BHR CCG area was 7.7% less than expected - 15,349 patients compared to 16,626 planned for patients. At individual CCGs levels, Barking and Dagenham was down, 9.1% (4.839 actual against 5,326 planned), Havering CCG down 6% (6378 actual against 6,782 planned), and Redbridge was down 8.5% (4.133 against 4,518 planned).

In the same period Together First Ltd began operating the extended hours services across Barking, Havering and Redbridge (BHR). It is too early to assess if the reduction in attendance is due to seasonal variation or the impact of the Together First services.

BHR CCGs financial year to January 2015 activity vs. plan
In the rolling the year to January total attendances at the BHRUT for BHR CCG patients was 0.8% below plan (162,818 actual vs. 164,115 planned). At individual CCG level, Barking and Dagenham CCG attendances were 2.6% below plan (51,218 actual vs. 52,574 planned).

Increases in use of Urgent Care Centres
Overall the demand at Urgent Care Centre sites were up 3.2% in February compared to the previous month and between January 2015 and February 2015,which was reflected in increased demand at Queens, 28.2% to 29.6% in February compared to 23.7% to 26.5% in January. In contrast, King George Hospital (KGH) rates were slightly down in February, ranging from 33.6% to 34.9% in February, compared to the previous month. As would be expected there was also an increase in ambulance conveyance to Queens Urgent Care Centre increased by 8.5% in the same period, from 201 in February to 228 in March.

6.3. Community Treatment Team – decrease in referrals between February and March but above target
Referrals into the Community Hub decreased by 6.7% (739) in March compared to previous month (792). Referrals to the service have been consistently above the weekly target of 97 – an average of 185 referrals a week was recorded for the month of March. Acute Hub referrals in the same period marginally went up 1.2% to 259 increased from 256 to 259 representing a 1.2% increase. The weekly average in March was 65, which is higher than the target of 33. All weeks were above target

7. Referral to treatment

7.1. Ambulance Conveyances – February to March increase

The total number of ambulance conveyances to BHRUT went up 3.1% in March, 5180 compared to 5024 in February. Please note this is driven in part by the different number of working days in both months. In March there was an average of 167 conveyances per day compared to 179 in February a decrease of 12 per day (6.7%).

Conveyances to Queens Hospital went up 2.6% from February. Conveyances to King Georges increased by 2.8% in same period respectively from February. Ambulance conveyances to the Queens Urgent Care Centre increased by 8.5% in the same period, from 201 in February to 228 in March.

7.2. Ambulance handovers

The proportion of ambulance handovers within 30 minutes deteriorated at Queens from, 90.8% and 91.3% in March compared to 90.3% - 94.6% in February. This pattern was also reflected at KGH. March figures were between 93.1% - 95.5%compared to 95.8% and 99.5% in February.

BHRUT has not reported any 60-minutes ambulance handovers breaches in the last two months since the 43 (unvalidated) reported in January 2015.
This reflects the change in dispatch time for 999 call handlers from 1 minute to 3 minutes.

7.3. Delayed Transfer of care (DToC) /Discharges – levels unchanged between February and March

The BHRUT average weekly DToC in March were 8.5 patients, a slight decrease from the previous month (9 patients). The month of March also recorded the lowest weekly DToC figure of 4 patients for the financial year in the week ending 15/03/2015.

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

i) Average number of Saturday discharges was unchanged - at 114 in both February and March.

ii) While the average number of Sunday discharges decreased from 93 in February to 80 in March.

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.

7.4. BHR CCGs Non-Elective (emergency) Admissions - increase between December and January but below plan

Between December 2014 and January 2015, non-elective admissions at BHRUT for BHR CCGs increased by 56 (1.5%). There were increases of 0.4% for Barking & Dagenham CCG, for a 7.5% increase for Redbridge CCG, and a decrease of 1.5% for Havering CCG, and when comparing the two months.

The rolling number of non-elective admission to January 2015 showed 36,995 non-elective admissions at BHRUT is below the plan of 37,399 by 404 (1.1%) for BHR CCGs. The current financial year monthly rolling average is 3,700 for the period April to January 2015. This is an increase of 18 non-elective admissions (0.5%) per month when compared to the rolling average of 3,682 for the financial year to December 2014.

7.5. NHS 111 Service

The percentage of calls answered within 60 seconds deteriorated between February and March – from a range of 94.2% - 94.8% in February 2015 to between 86.5% and 94.0% in March 86.5% to 94%, compared with 95% target. The trend - red rated 2 of the 4 weeks in March with the other 2 weeks Amber is in slight contrast to that across the London region rated green in one week and three weeks were rated amber in March.

8. Early Years Health Visitors

8.1. The percentage of children who turned thirty days old during the quarter receiving a face-to-face New Birth Visit from a health visitor within 14 days of birth has improved from 81.5% to 85.1% from 2014/15 Q2 to 2014/15 Q4. The corresponding percentage of those who turned 30 days who received a New Birth Visit more than 14 days after birth remained static in the same period at 9.0%. National targets have not yet been set for face-to-face health visits to allow comparisons, However, we would expect this to be a 100% of mothers.

8.2. There was a slight improvement in the percentage of children receiving their 12

month review by the age of 12 months, with 37.1% receiving a review in 2014/15 Q4 compared with 36.2% in Q2. However, there was a fall in those who turned 15 months in the quarter who received a 12 month review by 15 months, from 66.4% to 62.7%. National targets have not yet been set for face-to-face health visits to allow comparisons. Our aspiration would be that 100% of children are seen.

8.3. The number of children seen by a health visitor for their 2-2.5 year review fell from 46.4% in 2014/15 Q2 to 30.3% in Q4. It's been suggested that this is a reporting systems issue; however, it is important that the provider has an opportunity to address this issue. National targets have not yet been set for face-to-face health visits to allow comparisons. However, our aspiration would be that 100% of children are seen.

9. Mental Health

Appendix E shows details of the performance of Mental Health services within Barking and Dagenham, as carried out by NELFT.

9.1. Improving Access to Psychological Therapies (IAPT)

2,111 patients have been referred for psychological therapies in 2014/15. There were significant reductions in the IAPT referral waiting times, with figures for those waiting more than 28 days from contact to treatment down from 22 in quarter 1 to 9, 6 and 5 patients in Quarters 2, 3 and 4 respectively. 772 people in have completed treatment and are moving to recovery. There is not a nationally set target for IAPT waiting times, although it is stipulated that adequate service provision must be provided to ensure access for all who need treatment within 28 days of first contact.

9.2. Child and Adolescent Mental Health Services (CAMHS)

Children and young people accessing CAMHS services was up 16% compared to the previous quarter (635), an increase observed since the beginning of the financial year.

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. January and February 2015 saw greatly improved figures, with just 10.6% DNA over the two months.
100% of staff have completed level one and two safeguarding training. In Quarter 3 all staff also achieved level three training. 100% of inpatients discharged from hospital received follow up within 7 days in the first three quarters.

9.3. Annual Health checks of Looked - After Children

Since the beginning of the financial year, annual health checks of looked after children has decreased. Compared to the first quarter of the 2014/15 (84.2%), checks were down nearly 10% points by Q3 (74.8%), which is lower compared to London (84%) and England rates (88%).

9.4. Care Programme Approach

In Quarter 1, 1 out of 59 detained patients had an Absent Without Leave episode. There have not been any patients with an Absent Without Leave episode in any of the other three quarters.

The proportion of adults on Care Programme Approach in settled accommodation has increased from 75.6% in Q1 to 88.5% in Q4; this is above the England average measure. The proportion of adults on Care Programme Approach in employment has increased from 2.64% in Q1 to 4.9% in Q4. The Richmond Fellowship continues to support access to employment for individuals on Care Programme Approach.

10. Mandatory implications

10.1. 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.

10.2. 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.

10.3. 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.

10.4. Legal Implications

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

10.5. Financial Implications

There are no financial implications directly arising from this report.

11. 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 4 on providers in the London Borough of Barking and Dagenham.

Appendix D: Urgent Care Board Performance Dashboard – 20/04/2015

Appendix E: Mental Health Dashboard

This page is intentionally left blank

Key

Appendix A: Indicators for HWBB - 2014/15 Q4

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

Title	2012/13	2013/14				2013/14	2014/15				2014/15	DoT	RAG Rating	BENCHMARKING		HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4				England Average	London Average		
1 - Children																	
Percentage of Uptake of Diphtheria, Tetanus and Pertussis (DTaP) Immunisation at 5 years old	85.5%	83.8%	85.4%	82.4%	82.4%	..	82.8%	83.3%	80.9%	..	..	↘	R	88.4%	78.0%	1	PHOF
Year end figures not yet published. Data is published each quarter but when the full year figures are published they adjust for errors in the quarterly data and comprise all the children immunised by the relevant birthday in the whole year. 2014/15 Q4 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%	78.8%	..	..	↘	R	88.5%	80.5%	2	PHOF
Year end figures not yet published. 2014/15 Q4 data not yet published.																	
Prevalence of children in reception year that are obese or overweight	25.9%					26.6%	..	..	..	..	..	↗	R	22.5%	23.1%	3	PHOF
2013/14 data due to be finalised December 2014.																	
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
2 - Adolescence																	
Under 18 conception rate (per 1000) and percentage change against 1998 baseline.	33.1	47.1	38.2	42.9	..	..	..	..	..	..	..	↗	R	24.3	21.8	7	PHOF
Number of positive Chlamydia screening results	585	126	147	127	111	511	141	141	127	132	541	↗	R			8	HWBB OF
(data																	
3 - Adults																	
Number of four week smoking quitters	1480	431	325	233	185	1,174	142	161	134	166	603	→	R			9	HWBB OF
Please not that the most recent quarter is an incomplete figure and will be revised in the next HWBB report.																	

* Data from 2011/12

Key

Appendix A: Indicators for HWBB - 2014/15 Q4

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

Title	2012/13	2013/14				2013/14	2014/15				2014/15	DoT	RAG Rating	BENCHMARKING England Average	BENCHMARKING London Average	HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4							
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%	4.0%	4.5%	4.4%	15.3%	→	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
Q4 figure is not finalised yet and will be updated for next meeting.																	
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	2336.0					..					..	↘	A	2011.0	2242.0	15	BCF/PHOF
Directly age-sex standarised rate per 100,000 poulation 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%	76.7%	75.7%	↗	G	62.1%	67.4%	16	ASCOF
Delayed transfers of care from hospital	3.0					5.5	4.2	4.7	5.4	5.4	4.9	↘	G	9.7	6.9	17	ASCOF
Delayed transfers due to social care	2.4	0.8	1.1	1.2	1.1	1.1	2.22	1.73	2.91	2.2	2.25	↗	G	3.1	2.3	18	ASCOF

* Data from 2011/12

Key

Appendix A: Indicators for HWBB - 2014/15 Q4

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

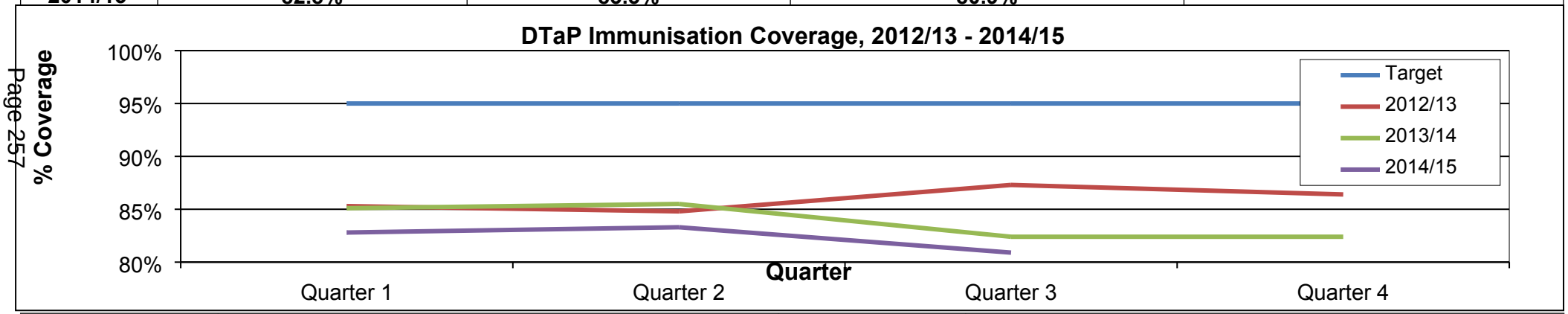
														BENCHMARKING			
Title	2012/13	2013/14				2013/14	2014/15				2014/15	DoT	RAG Rating	England Average	London Average	HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4							
Emergency readmissions within 30 days of discharge from hospital	13.3%*	..	..	..	..	..	..	..	..	..	..	→	A	11.8%	11.8%	19	PHOF
Percentage 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%	88.8%	..	↗	A	91.8%		20	HWBB OF
BHRUT Figure																	
Emergency admissions for ambulatory care sensitive conditions	1,177.8	280.1	247.5	273.5	271.5	1,072.7	..	..	..	..	..	↘	R	799.6	776.9	21	HWBB OF
ISR per 100,000 population																	

* Data from 2011/12

This page is intentionally left blank

Public Health Performance Indicators				April 2015
Childhood Immunisations - DTaP		**Source: Immunisation data from COVER report based on RIO/Child health record**		**Date: 04/15**
Definition	Percentage of children immunised with DTaP vaccination in children at 5 years of age.	**How this indicator works**	Diphtheria, Tetanus, Pertussis/whooping cough given to children aged 2 months up to 5 years old. Reported by COVER based on RIO/Child Health Record.	
What good looks like	We are looking for the coverage percentage to be above the target level throughout the year.	**Why this indicator is important**	The DTaP vaccine is highly effective for the prevention of diphtheria, tetanus, and pertussis -- all of which are serious diseases. Before DTaP, these diseases often led to serious medical problems and even death.	
History with this indicator	2011/12: 79.6% 2012/13: 85.9%			

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
2012/13	**85.3%**	**84.8%**	**87.3%**	**86.4%**
2013/14	**85.1%**	**85.5%**	**82.4%**	**82.4%**
2014/15	**82.8%**	**83.3%**	**80.9%**	



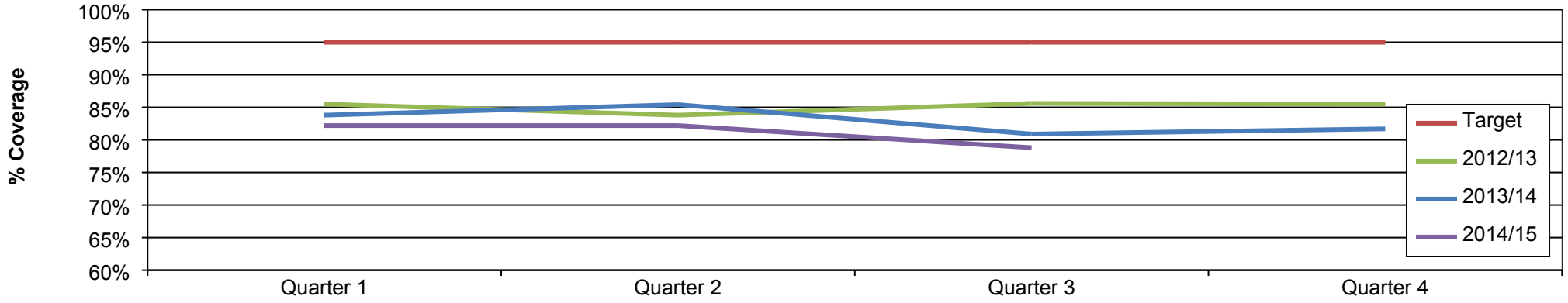
Performance Overview **RAG Rating**	Coverage levels for DTaP have been below target for all three quarters reported so far in 2014/15. Quarter three was 14.1 percentage points below the target of 95%. Quarter 4 data will be available in July 2015.	**Actions to sustain or improve performance**	The local programme is commissioned by NHS England with some Public Health England input. Programme assurance is scrutinised in the Health Protection Committee of the Health & Wellbeing Board and problems fed back to NHS England.
Benchmarking	In 2011/12, uptake rates for DTaP were 79.6%. In 2012/13, uptake rates for DTaP were 85.9%		

Health and Well Being Board			April 2015
Childhood Immunisations – MMR 2	**Source: Immunisation data from COVER report based on RIO/Child health record**		**Date: 04/15**

Definition	Percentage of children given two doses of MMR vaccination.	**How this indicator works**	MMR 2 vaccination is given at 3 years and 4 months to 5 years. Reported by COVER based on RIO/Child Health Record.
What good looks like	Quarterly achievement rates to be above the set target of 95% immunisation coverage.	**Why this indicator is important**	Measles, mumps and rubella are highly infectious, common conditions that can have serious, potentially fatal, complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby and can lead to miscarriage.
History with this indicator	2011/12: 82.80% 2012/13: 85.50%% 2013/14: 81.70%		

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
2012/13	**85.5%**	**83.8%**	**85.6%**	**85.5%**
2013/14	**83.8%**	**85.4%**	**80.9%**	**81.7%**
2014/15	**82.2%**	**82.2%**	**78.8%**	

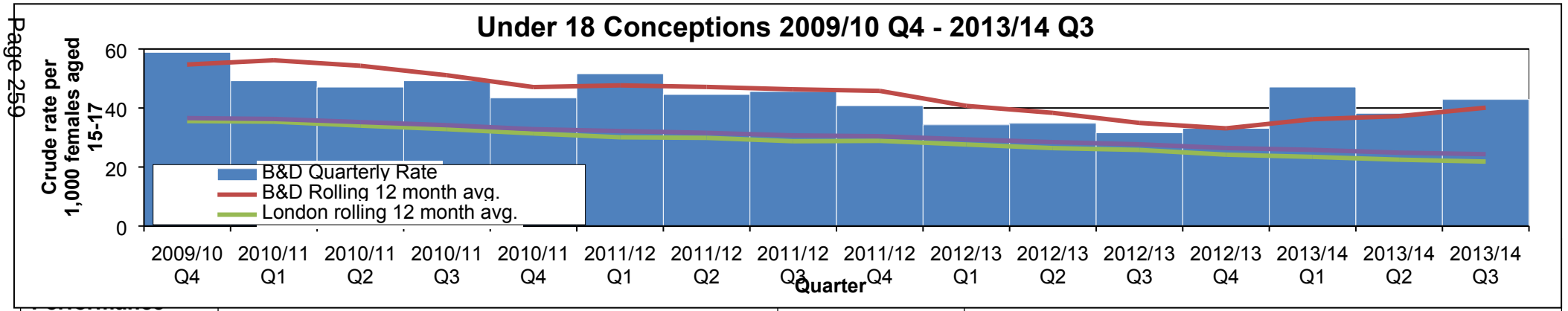
MMR 2 Immunisation Coverage, 2012/13 - 2014/15



Performance Overview **RAG Rating**	Coverage levels for MMR 2 were below target for all four quarters in 2013/14 and continue to be so for the first three quarters of 2014/15, with Quarter 3 being 16.2 percentage points below target. Coverage levels are also below the national and regional averages.	**Actions to sustain or improve performance**	The local programme is commissioned by NHS England with some Public Health England input. Programme assurance is scrutinised in the Health Protection Committee of the Health & Wellbeing Board and problems fed back to NHS England.
Benchmarking	In 2011/12 financial year, uptake rates for MMR 2 were 82.8% and in 2012/13 uptake rates were 85.5%.		

Public Health Performance Indicators			April 2015
Teenage Conceptions		**Source: Office for National Statistics**	**Date: 04/15**
Definition	Conceptions in women aged under 18 per 1,000 females aged 15-17.	**How this indicator works**	This indicator is reported annually by the Office for National Statistics and refers to pregnancy rate among women aged below 18.
What good looks like	For the number of under 18 conceptions to be as low as possible, with the gap to regional and national averages narrowing.	**Why this indicator is important**	Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children.
History with this indicator	2009: 54.7 per 1,000 women aged 15-17 years 2010: 54.9 per 1,000 women aged 15-17 years		

	2011/12 Q1	2011/12 Q2	2011/12 Q3	2011/12 Q4	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4	2013/14 Q1	2013/14 Q2	2013/14 Q3
B&D Quarterly Rate	51.60	44.50	45.40	40.80	34.30	34.80	31.60	33.10	47.10	38.20	42.90
B&D Rolling 12 month avg.	47.67	47.13	46.33	45.80	40.72	38.35	34.94	33.10	36.20	37.24	40.10
London rolling 12 month avg.	30.07	29.88	28.74	28.87	27.62	26.41	25.79	24.18	23.43	22.48	21.48
England rolling 12 month avg.	32.18	31.58	30.70	30.43	29.36	28.43	27.69	26.44	25.81	24.86	24.35



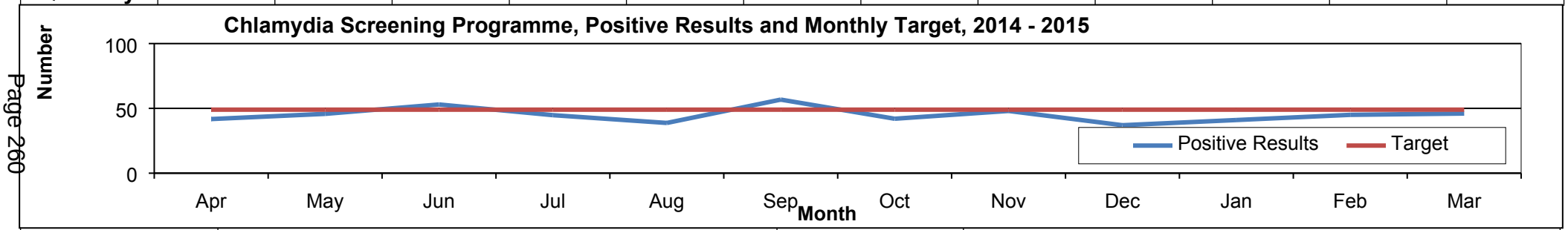
Overview	The rate of under 18 conceptions was showing a generally decreasing trend, with the quarterly-rolling annual average falling from 56.2 at the start of 2011-12 to 33.2 in 2012/13 Q4. However, recently released data for 2013/14 Q1, Q2 and Q3 shows increases away from national and regional averages, with Barking & Dagenham currently having the highest rate in London for the last 12 months of data.	**Further Actions & comments**	Barking and Dagenham remains above the national and London averages (24.4 and 21.5 per 1,000 respectively), who both saw a continued decline in their conception rate.
RAG Rating			
Benchmarking	In 1998 (baseline year), there were 156 conceptions reported among 15-17 year old women in Barking and Dagenham. This was an equivalent of 55 per 1,000 births. See overleaf for further benchmarking information.		

Public Health Performance Indicators — April 2015

Chlamydia Screening Programme — **Source: Terrence Higgins Trust** — **Date: 04/15**

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)		

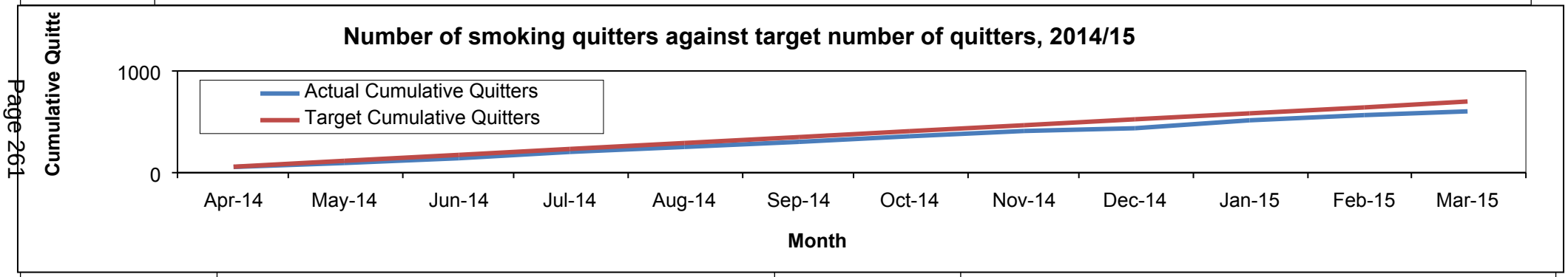
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Positive Results	42	46	53	45	39	57	42	48	37	41	45	46
Target	49	49	49	49	49	49	49	49	49	49	49	49
Quarterly		Quarter 1	141/147		Quarter 2	140/147		Quarter 3	127/147		Quarter 4	132/147



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 downtown though, with 20 fewer positives than the quarterly target. Quarter 4 has seen a gradual increase in the number of positives, but still remaining just below target for all three months.	**Actions to sustain or improve performance**	The team has taken action to improve the health outcomes for Barking and Dagenham residents. At the monthly sexual health contract meeting on 26th March, BHRUT submitted a list of actions in respect to improving Chlamydia screening and HIV testing uptake for 2015/16. The Councils have invited BHRUT to complete a performance improvement action plan. A meeting is scheduled with Terence Higgins Trust on 28 April 2015 to review current performance and put a remedial action plan in place that will include increased training for staff at sites with high positivity but low activity, and sites that were not conducting screening.
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				April 2015
Smoking – Four Week Smoking Quitters			**Source: Smoking Cessation Service**	**Date: 04/15**
Definition	The number of smokers setting an agreed quit date and, when assessed at four weeks, self-reporting as not having smoked in the previous two weeks.	**How this indicator works**	A client is counted as a 'self-reported 4-week quitter' when assessed 4 weeks after the designated quit date, if they declare that they have not smoked, even a single puff of a cigarette, in the past two weeks.	
What good looks like	For the number of quitters to be as high as possible and to be above the target line.	**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	142	161	134	166
Target Quitters	175	175	175	175



Performance Overview	Performance was below target for quarter one and quarter two, with 142 and 160 successful quitters, respectively, against the minimum target of 175 quitters. Quarter three data was also below target with 132 quitters. Quarter four has seen the strongest performance so far, with 166 quitters. The target of 700 is 35% of the targeted number of 2,000 service users quitting. Of the 603 quitters, 10 were pregnant, and 141 were in the Routine & Manual category.	**Actions to sustain or improve performance**	The specialist smoking service Quit 51 have put in place a remedial action plan to increase the number of quitters. The national stop smoking campaign was enhanced in Barking and Dagenham to give a high profile to the importance of quitting. Planning for future campaigns is also due to start. The BabyClear programme is about to start which should see an increase in the numbers of referrals from pregnant women into the stop smoking service.
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.		

This page is intentionally left blank

Provider Name	Location Name	Weblinks	Location Org Type	Report Date	Inspection Date	Result	Comments / Summary
Chosen Services UK Limited	Chosen Services UK Limited	http://www.cqc.org.uk/directory/1-228962162	Social Care Org	Inspection Report published 10	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	**Action needed:** - Safeguarding people who use services from abuse - Cleanliness and infection control - Assessing and monitoring the quality of service provision 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. 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. 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
Bennetts Castle Care Centre	Bennetts Castle Limited	http://www.cqc.org.uk/location/1-117294310	Social Care Org	Inspection Report Published 23 January 2015	01-Oct-14	4 out of 5 standards met	**Action needed:** **-** Promote and practice safe service - Safe storage and aministering of medication The Service was not always safe. Medicines were not always stored and administered safely. The service had procedures in place for dealing with safeguarding allegations and staff understood their responsbilities with regard to safeguarding adults. Risk asssessments were in place which set out how to manage and reduce the risks people faced. People that exhibited behaviours that challenged the service were given appropriate support. The service has enough staff to meet people's needs.

Provider Name	Location Name	Weblinks	Location Org Type	Report Date	Inspection Date	Result	Comments / Summary
Anytime Care 2020	Anytime Recruitment Limited	http://www.cqc.org.uk/sites/default/files/new_reports/AAAB7721.pdf	Social Care Org	Inspection Report Published 05 February 2015	16-Dec-14	**All standards met**	
Fern Care Services Ltd	Fern Care Service Limited	http://www.cqc.org.uk/sites/default/files/new_reports/AAAA2344.pdf	Social Care Org	Inspection Report Published 12 February 2015	24-Jul-14	**4 out of 5 standards met**	**Action Needed:** **-** Formal appraisals for staff to be met. The service was not always effective. Annual appraisals were not being performed which meant care staff were not being formally appraised for the quality of their work. People's care plans were detailed and people told us they were followed by care staff. Care staff told us they recieved regular training and supervision which further monitored whether people were getting effective care.

Provider Name	Location Name	Weblinks	Location Org Type	Report Date	Inspection Date	Result	Comments / Summary
Life Style Care (2011) plc	Alexander Court Care Centre	http://www.cqc.org.uk/sites/default/files/new_reports/AAAA1173.pdf	Social Care Org	Inspection Report Published 16 March 2015	28-Apr-14	**Inspection found 6 breaches of The Health and Social Care Act**	***The Provider must send a CQC Report that says what actions they are going to take to meet these essential standards. (No date provided)*** **Regulations:** 1**.** *Care and Welfare of service users* *2. Safeguarding service users from abuse* *3. Cleanliness and infection control* *4. Meeting nutritional needs* *5. Safety and suitability of premises* *6. Respecting and involoving Service users* Staff knew how to recognise how to keep Service Users safe but some staff when unaware of the provider's whistleblowing policy. People were not protected from the risks of inadequate nutrition and dehydration. Identified good interactions between Service users and staff, however, somepeople were not treated with consideration and respected or involved in decisions relating to their care of treatment. Rushed and task focused. People were not always protected against the risks of recieving inappropriate or unsafe care.
Liberty Centre Limited	Liberty Centre	http://www.cqc.org.uk/directory/1-160181244	Social Care Org	Inspection Report Published 31 March 2015	19&20-Jan-15	**Overall Inadequate**	Out of 5 Standard: Is the service safe?: Inadequate Is the service effective?: Requires Improvement Is the service caring?: Requires Improvement Is the service responsive?: Requires Improvement Is the service well-led?: Inadequate **The enforcement action taken:** Served a warning notice and the provider was told they must become compliant with the Regulations by 29th May 2015.

This page is intentionally left blank

Accident & Emergency

INDICATOR	SITE	07/12/2014	14/12/2014	21/12/2014	28/12/2014	04/01/2015	11/01/2015	18/01/2015	25/01/2015	01/02/2015	08/02/2015	15/02/2015	22/02/2015	01/03/2015	08/03/2015	15/03/2015	22/03/2015	29/03/2015	05/04/2015	TREND	WEEKLY TRAJECTORY	MTD	YTD
All Types	QH	76.64%	68.18%	72.81%	71.67%	66.55%	73.91%	86.92%	82.07%	80.50%	85.21%	88.32%	93.65%	93.16%	91.77%	94.22%	88.73%	86.88%	89.02%	↑		88.19%	80.92%
	KGH	86.47%	79.57%	81.88%	88.52%	80.48%	87.56%	93.87%	97.87%	95.88%	97.03%	96.66%	97.16%	94.36%	93.95%	94.81%	92.34%	92.16%	91.69%	↓		92.06%	91.57%
	BHRUT	80.60%	72.93%	79.29%	78.32%	72.24%	79.37%	89.61%	88.06%	86.52%	89.90%	91.75%	95.07%	93.55%	92.66%	94.46%	90.19%	88.97%	90.10%	↑	95.00%	90.10%	90.10%
	London	91.32%	89.73%	89.01%	91.24%	88.75%	90.40%	92.52%	93.81%	93.24%	93.56%	92.81%	93.14%	92.70%	93.07%	93.37%	93.76%	92.58%	93.18%	↑		93.19%	93.76%
Type 1	QH	75.60%	66.84%	71.71%	71.10%	65.48%	72.88%	86.45%	81.37%	79.85%	84.59%	87.91%	93.57%	92.96%	91.49%	93.98%	88.30%	86.47%	88.63%	↑		87.78%	80.19%
	KGH	78.12%	68.60%	72.68%	82.69%	69.59%	81.13%	90.78%	96.86%	93.73%	95.62%	94.95%	95.68%	91.66%	91.99%	91.85%	88.48%	88.02%	87.98%	↓		88.16%	87.28%
	BHRUT	76.35%	67.40%	75.28%	74.38%	66.74%	75.45%	87.77%	86.06%	84.13%	88.02%	90.18%	94.24%	92.55%	91.65%	93.31%	88.36%	89.93%	88.42%	↓		88.42%	88.42%
	London	86.21%	84.28%	81.98%	85.66%	81.71%	83.95%	87.69%	89.82%	89.00%	89.31%	88.14%	88.73%	87.94%	88.67%	89.24%	89.97%	87.98%	89.11%	↑		88.97%	89.76%

1. Demand & Pre-hospital Care

WEEKLY INDICATORS	SITE	07/12/2014	14/12/2014	21/12/2014	28/12/2014	04/01/2015	11/01/2015	18/01/2015	25/01/2015	01/02/2015	08/02/2015	15/02/2015	22/02/2015	01/03/2015	08/03/2015	15/03/2015	22/03/2015	29/03/2015	05/04/2015	TREND	YTD MEDIAN	TARGET	NOTES
A&E Weekly Activity																					12 Month Rolling Avg	
A&E All Types Attendances including PELC Walk In Centre	QH	3193	3080	3098	2753	2765	2702	2653	2755	2824	2867	2954	2866	2981	2966	3027	3079	3263	3105	↑	0	2936	Data Source: Trust B2 Report. RAG based on YTD Median
	KGH	2150	2203	2246	1795	1911	1801	1680	1693	1819	1884	2067	1938	1951	1968	2102	2077	2041	2129	0	0	2005	
	BHRUT	5343	5283	5344	4548	4676	4503	4333	4448	4643	4751	5021	4804	4932	4934	5129	5156	5304	5234	↑	4980	4956	
UCC Attendances	QH	740	652	668	561	590	553	569	570	652	729	754	710	752	782	764	773	852	837	↓	773		Data Source: Trust PAG dashboard. RAG based on YTD Median
	KGH - PELC	843	827	822	738	727	635	563	546	622	650	721	665	656	682	777	757	714	715	↑	693		Data Source: Trust B2 Report. RAG based on YTD Median
	BHRUT	1583	1479	1490	1299	1317	1188	1132	1116	1274	1379	1475	1375	1408	1464	1541	1530	1566	1552	↓	1479		
Ambulance Conveyances																							
Number of ambulance conveyances	QH	957	859	903	879	839	841	830	865	825	927	863	865	858	853	881	930	941	887	↑	872		Data Source: Trust PAG dashboard. RAG based on YTD Median
	KGH	307	328	368	292	356	336	306	289	297	306	337	334	333	349	337	332	329	309	↑	318		
	QH - Conveyed Directly to Urgent Care Centre	56	40	49	33	35	30	34	41	52	60	56	44	41	55	44	68	61	59	↓	89		
NHS 111 Service - PELC covering BHR CCGs & WF CCG																							
Referral Destination - Ambulance Dispatches		9.3%	9.6%	10.2%	9.1%	10.5%	10.2%	9.8%	10.4%	10.7%	10.3%	10.3%	10.4%	10.7%	10.6%	11.0%	11.5%	9.4%	8.4%	↑	10.5%		Data Source: NHSE Weekly Sitrep Report
Referral Destination - Recommended to attend A&E		8.4%	9.0%	8.7%	7.1%	8.2%	9.2%	9.2%	8.0%	8.6%	7.4%	8.2%	8.9%	9.0%	9.8%	8.5%	8.9%	8.7%	7.5%	↑	8.5%		
Referral Destination - Recommended to attend Primary Care		63.6%	62.4%	62.4%	64.0%	62.4%	61.0%	59.0%	57.7%	59.5%	61.0%	60.6%	60.8%	60.0%	59.7%	60.5%	59.6%	61.7%	65.4%	↑	60.6%		
% calls answered within 60 seconds		91.3%	93.1%	92.4%	95.7%	96.4%	97.7%	97.0%	95.9%	92.8%	94.3%	94.8%	94.3%	94.2%	94.0%	93.1%	87.9%	86.5%	97.3%	↑	95.9%	95%	RAG is based on Winter Period
LONDON - % calls answered within 60 seconds		92.1%	88.5%	89.0%	85.6%	93.2%	98.0%	98.1%	97.6%	91.6%	95.7%	96.2%	96.2%	96.5%	93.7%	95.8%	94.8%	93.5%	97.1%	↑	95.7%	95%	
Community Treatment Team (CTT)																							
Referrals received vs plan	Community Hub	214	195	233	166	223	238	225	179	207	205	212	172	203	198	186	160	189	195	↓	160	97	Data Source: Trust Weekly CTT Dashboard. RAG based on Local Target
	Acute Hub	17	38	38	32	58	67	58	63	56	59	74	56	67	77	50	53	51	79	↑	50	33	
Referrals from LAS		12	10	22	22	29	14	32	10	24	18	30	15	15	14	21	29	25	29	↑	19		Data Source: Trust Weekly CTT Dashboard. RAG based on YTD Median
Barking & Dagenham	Community Hub	68	46	64	47	60	84	58	52	63	55	63	43	59	74	48	40	38	59	↓	45	26	Data Source: Trust Weekly CTT Dashboard. RAG based on Local Target.
	Acute Hub	5	7	6	6	16	16	10	15	7	12	18	16	13	14	9	12	11	25	↑	10	15	
Havering	Community Hub	107	122	112	86	109	113	115	84	99	117	107	86	105	85	102	81	109	87	↓	85	53	
	Acute Hub	11	27	24	22	37	44	38	37	46	40	43	30	45	52	33	32	32	37	↓	31	19	
Redbridge	Community Hub	38	27	53	30	51	39	48	43	42	31	41	42	36	36	36	39	41	48	↑	30	37	
	Acute Hub	0	3	7	2	4	4	6	4	2	5	8	5	5	2	3	3	6	7	→	4	13	

MONTHLY INDICATORS	SITE	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15		TREND	YTD MEDIAN	TARGET	NOTES
Activity (YTD)									YTD MEDIAN	YTD TARGET	
A&E / UCC Attendances (excluding KGH Type 3 attendances)	BHR CCGs @ BHRUT Total	130,811	147,469	162,818				↑		164,115	Data Source: SLAM flex data. RAG Based on Local Target
	Barking & Dagenham CCG	41,224	46,379	51,218				↑		52,575	
	Havering CCG	53,936	61,082	67,460				↓		66,941	
	Redbridge CCG	35,651	40,008	44,140				↑		44,599	
Ambulance Conveyances									YTD MEDIAN		
Blue Light Activity as a percentage of all ambulance conveyances	Queens	11.2%	13.8%	12.1%	10.7%			↑	10.6%		Data Source: LAS. RAG Based on YTD median
	KGH	10.3%	11.9%	11.3%	9.3%			↑	8.9%		
	London	11.4%	13.4%	12.5%	12.0%			↑	10.3%		
Surge Schemes										YTD TARGET	
Appointments Capacity	Barking and Dagenham	2439	2115	2198	2446			↑		3515	RAG Based on Local YTD Target
Appointments Booked		2087	1903.688111	1897	2021			↓			RAG in development
Appointments Capacity	Havering	528	528	528	528			→		528	RAG Based on Local YTD Target
Appointments Booked		605	572	481	387			↓			RAG in development

QUARTERLY INDICATORS	SITE	2014-15 QUARTER 3	2014-15 QUARTER 4		TREND	YTD MEDIAN	TARGET	NOTES
Ambulance Conveyances from BHR Residential and Nursing Homes								
LAS call outs from nursing homes within BHR CCGs	Actual	1465			↓			Data Source: LAS. Trend compared to same quarter in previous year.
	% change from corresponding quarter in previous year	45.8%						
LAS conveyances from nursing homes within BHR CCGs	Actual	1303			↓			
	% change from corresponding quarter in previous year	48.9%						
Ambulance Conveyances from Havering Residential and Nursing Homes								
Patients conveyed to ED via LAS	Actual	428			↓			Data Source: LAS. Trend compared to same quarter in previous year
	% change from corresponding quarter in previous year	35.0%						

2. Hospital Response

WEEKLY INDICATORS	SITE	07/12/2014	14/12/2014	21/12/2014	28/12/2014	04/01/2015	11/01/2015	18/01/2015	25/01/2015	01/02/2015	08/02/2015	15/02/2015	22/02/2015	01/03/2015	08/03/2015	15/03/2015	22/03/2015	29/03/2015	05/04/2015	TREND	YTD MEDIAN	TARGET	NOTES
Urgent Care Centre																							
Queens UCC Utilisation	QH	26.7%	23.9%	25.0%	24.2%	25.2%	23.7%	24.6%	23.8%	26.5%	28.7%	29.6%	28.3%	28.2%	29.5%	29.0%	28.7%	29.5%	31.3%	↑	39.0%	45% - 50%	Data Source: Trust PAG dashboard. RAG Based on Local Target
KGH PELC UCC Utilisation	KGH	39.2%	37.5%	36.6%	41.1%	38.0%	35.3%	33.5%	32.3%	34.2%	34.5%	34.9%	34.3%	33.6%	34.7%	37.0%	36.4%	35.0%	33.6%	↓	34.9%		Data Source: Trust B2 Report. RAG is based on the YTD Median
Activity																					YTD MEDIAN	TARGET	
Non-Elective Admissions	BHRUT	1017	958	966	1025	893	893	922	932	969	1016	1011	962	959	997	1021	980	1017			0		Data Source: Trust Daily Sitrep. RAG Based on YTD Median
Attendance to admission ratio	QH	23.5%	22.9%	22.9%	28.5%	24.4%	25.3%	24.8%	27.4%	24.6%	25.4%	24.2%	25.8%	24.6%	24.2%	25.7%	23.9%	24.7%	24.9%	↓	24.2%		Data Source: Trust PAG dashboard.
	KGH	27.6%	25.5%	25.4%	30.2%	29.9%	32.2%	32.7%	28.4%	30.8%	30.5%	28.8%	25.7%	27.2%	27.5%	29.6%	28.4%	27.1%	25.7%	↑	24.6%		RAG Based on YTD Median
Ambulance Handovers																					YTD MEDIAN	TARGET	
Within 15mins	QH	31.9%	31.4%	36.0%	21.0%	21.0%	27.9%	37.9%	26.0%	30.4%	29.7%	36.1%	37.4%	38.3%	37.9%	34.5%	35.2%	32.4%		↓	35.8%	100%	Data Source: HAS Portal RAG based on LAS Target
	KGH	32.3%	32.1%	39.6%	31.6%	25.3%	32.4%	41.6%	50.0%	56.7%	56.3%	47.3%	50.0%	47.7%	42.9%	39.0%	39.4%	39.4%		→	40.1%		
	London	42.0%	37.3%	48.2%	38.1%	35.0%	39.0%	38.9%	31.7%	43.7%	44.5%	42.1%	42.5%	40.7%	39.4%	42.0%	36.2%	35.2%		↓	45.4%		
Within 30mins	QH	81.7%	75.1%	89.0%	69.0%	62.8%	32.4%	90.9%	86.3%	82.1%	90.3%	91.5%	94.6%	94.5%	90.8%	90.9%	90.9%	91.3%		↑	90.0%		
	KGH	96.5%	91.3%	95.9%	90.2%	87.9%	90.2%	94.4%	99.0%	98.6%	99.5%	95.8%	98.3%	96.9%	95.5%	95.0%	93.1%	93.9%		↑	96.4%		
	London	90.1%	85.6%	95.2%	86.7%	82.6%	86.9%	91.9%	89.3%	91.1%	91.9%	89.9%	91.1%	89.5%	92.2%	90.2%	91.5%	91.7%		↑	93.2%		
Assessment process & specialty response																					YTD MEDIAN	TARGET	
Rapid Assessment & Treatment - Triaged < 30 mins	QH	45.5%	42.8%	45.6%	47.0%	49.4%	47.1%	60.2%	50.6%	52.3%	64.0%	60.6%	58.7%	48.0%	58.6%	53.9%	52.5%	48.1%	59.6%	↑	56.2%	95%	Data Source: Trust PAG dashboard RAG based on Local Target
	KGH	76.1%	74.4%	67.0%	80.6%	78.6%	80.2%	82.2%	89.9%	86.8%	86.6%	84.3%	86.1%	83.1%	82.7%	77.8%	74.6%	79.1%	77.9%	↓	83.1%	95%	
Seen by specialty team < 30min of request	QH	10.9%	11.2%	12.0%	10.5%	10.9%	11.8%	12.3%	13.8%	11.6%	13.9%	14.0%	12.1%	11.7%	11.8%	12.1%	12.1%	11.9%	13.0%	↑	12.1%	80%	
	KGH	25.2%	17.4%	20.9%	25.6%	20.9%	20.3%	24.5%	26.5%	27.4%	26.1%	29.8%	30.4%	29.9%	30.6%	24.3%	26.8%	27.5%	29.5%	↑	25.3%	80%	
Referred to specialty team < 2hrs of registration	QH	41.0%	39.3%	41.7%	40.0%	42.1%	46.6%	48.2%	42.4%	46.3%	53.0%	48.2%	47.8%	43.7%	46.6%	44.1%	41.7%	41.7%	42.6%	↑	42.3%	80%	
	KGH	49.0%	44.8%	49.0%	53.9%	40.2%	48.0%	57.3%	56.2%	53.1%	55.7%	53.1%	58.9%	52.2%	52.0%	53.1%	48.4%	51.3%	44.8%	↓	51.1%	80%	
Non-Elective Length of Stay																					YTD MEDIAN	TARGET	
Non-Elective Length of Stay (days)	QH	5.1	6.9	6.7	6.1	5.8	6.9	5.9	5.8	6.4	6.3	6.7	5.9	6.2	6.3	6.3	6.3	5.8	6.0	↓	6.2	4.45	Data Source: Trust PAG dashboard
	KGH	6.0	5.1	4.5	5.0	5.6	4.9	6.1	4.4	5.7	7.0	4.5	4.3	5.9	4.5	5.1	5.1	4.8	5.5	↓	5.1	4.45	RAG based on Local Target
Longest Wait in ED																							
Longest Wait (minutes)	QH	1308	1730	1469	1671	1636	1353	1268	1375	1447	1341	1278	940	1021	946	1306	1541	1081	981	↑	1313		RAG based on YTD Median
	KGH	1277	1571	1391	1218	1434	1197	1232	982	1444	957	875	1035	1321	1146	1130	1098	1184	1168	↑	1203		RAG based on YTD Median

MONTHLY INDICATORS	SITE	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15		TREND	CUMULATIVE ACTIVITY APR 13 - NOV 13	YTD TARGET	NOTES
Activity											
Elective Admissions (YTD) (all 12 NELCSU CCGs)		4,917	5,479	6,068				↓		5,753	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	29,331	33,135	36,995				↑	37,436	37,399	
	Barking & Dagenham CCG	8,393	9,474	10,559				↓	10,605	10,889	
	Havering CCG	12,792	14,478	16,138				↓	15,386	15,698	
	Redbridge CCG	8,146	9,183	10,298				↓	10,271	10,812	

3. Getting People Home

WEEKLY INDICATORS	SITE	07/12/2014	14/12/2014	21/12/2014	28/12/2014	04/01/2015	11/01/2015	18/01/2015	25/01/2015	01/02/2015	08/02/2015	15/02/2015	22/02/2015	01/03/2015	08/03/2015	15/03/2015	22/03/2015	29/03/2015	05/04/2015	TREND	YTD MEDIAN	TARGET	NOTES
DTOCs & Discharges																							
Delayed Transfers of Care		26	17	23	26	22	16	18	14	8	8	10	11	6	10	4	10	10	10	→	18	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	1.4	1.0	0.4	1.5	2.5	3.0	0.7	0.7	0.7	0.8	0.5	2.4	2.4	1.6	2.1	1.6	2.8	0.9	↑	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	1.5	1.5	0.5	1.7	0.0	3.9	2.1	0.7	0.7	1.4	1.9	1.2	1.0	2.0	1.5	2.3	2.0	2.7	↓	1.50	<2	
	Gray's Court	2.0	2.0	1.3	0.9	6.0	1.3	0.9	1.2	0.7	1.6	2.0	1.5	1.0	1.5	2.3	1.9	4.0	2.9	↑	1.46	<2	
	IRS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	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		40	36	42	10	26	48	44	30	46	38	27	30	36	33	23	31	26		↓	28	16	Data Source: Trust Weekly IRS Dashboard RAG Based on Local Target
% Stepdown from Acute Beds		73%	78%	69%	89%	77%	77%	58%	67%	74%	59%	74%	93%	69%	73%	61%	65%	69%		↑	71%		Data Source: Trust Weekly IRS Dashboard RAG Based on YTD Median
New Referrals	Barking & Dagenham CCG	13	13	8	1	5	14	10	5	8	10	9	9	8	5	2	8	7		↓	7	4	Data Source: Trust Weekly IRS Dashboard RAG Based on Local Target
	Havering CCG	15	16	25	7	15	25	19	17	23	20	12	15	18	17	15	17	9		↓	12	7	
	Redbridge CCG	12	7	9	2	6	7	13	8	15	8	6	6	10	11	6	6	10		↑	8	5	
% Stepdown from Acute Beds	Barking & Dagenham CCG	77%	77%	88%	0%	80%	71%	30%	80%	50%	60%	67%	100%	50%	60%	100%	75%	57%		↓	75%		Data Source: Trust Weekly IRS Dashboard RAG Based on YTD Median
	Havering CCG	67%	81%	64%	86%	80%	84%	79%	59%	78%	63%	75%	87%	72%	71%	60%	59%	89%		↑	75%		
	Redbridge CCG	75%	71%	67%	100%	67%	67%	50%	75%	80%	50%	83%	100%	80%	82%	50%	67%	60%		↓	73%		

WEEKLY INDICATORS	SITE	07/12/2014	14/12/2014	21/12/2014	28/12/2014	04/01/2015	11/01/2015	18/01/2015	25/01/2015	01/02/2015	08/02/2015	15/02/2015	22/02/2015	01/03/2015	08/03/2015	15/03/2015	22/03/2015	29/03/2015	05/04/2015	TREND	YTD MEDIAN	TARGET	NOTES
7 day working: Elective and Non-Elective discharges (medical and surgical)																					OCTOBER 2013 BASELINE		
Monday	Number of discharges	736	893	996	872	841	759	650	633	606	534	551	555	561	552	528	536	508		↓	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	15.3%	15.5%	16.9%	17.9%	18.2%	20.4%	18.4%	17.4%	16.3%	14.3%	14.4%	14.5%	14.8%	14.4%	14.1%	14.0%	13.2%					
Tuesday	Number of discharges	785	937	954	794	770	621	585	561	588	586	618	616	638	636	640	650	648		↑	612	16.1%	
	% of discharges	16.4%	16.3%	16.2%	16.3%	16.6%	16.7%	16.6%	15.4%	15.8%	15.7%	16.1%	16.1%	16.8%	16.6%	17.1%	16.9%	16.8%					
Wednesday	Number of discharges	791	928	933	768	828	677	644	592	571	574	602	586	568	585	558	592	614		↓	622	16.4%	
	% of discharges	16.5%	16.1%	15.9%	15.8%	17.9%	18.2%	18.3%	16.2%	15.3%	15.4%	15.7%	15.4%	14.9%	15.3%	14.9%	15.4%	15.9%					
Thursday	Number of discharges	781	957	948	776	652	448	443	538	603	654	666	654	650	662	650	660	667		↑	646	17.0%	
	% of discharges	16.3%	16.6%	16.1%	16.0%	14.1%	12.0%	12.6%	14.8%	16.2%	17.5%	17.4%	17.1%	17.1%	17.3%	17.3%	17.2%	17.3%					
Friday	Number of discharges	842	979	1001	808	710	589	580	641	637	638	603	594	578	596	630	649	676		↑	645	17.0%	
	% of discharges	17.6%	17.0%	17.0%	16.6%	15.3%	15.8%	16.5%	17.6%	17.1%	17.1%	15.7%	15.6%	15.2%	15.6%	16.8%	16.9%	17.6%					
Saturday	Number of discharges	505	590	592	467	444	351	359	386	416	436	449	447	443	437	409	434	428		↑	402	10.6%	
	% of discharges	10.5%	10.3%	10.1%	9.6%	9.6%	9.4%	10.2%	10.6%	11.2%	11.7%	11.7%	11.7%	11.7%	11.4%	10.9%	11.3%	11.1%					
Sunday	Number of discharges	355	467	459	373	386	274	263	296	307	314	340	364	362	363	333	314	310		↑	275	7.2%	
	% of discharges	7.4%	8.1%	7.8%	7.7%	8.3%	7.4%	7.5%	8.1%	8.2%	8.4%	8.9%	9.5%	9.5%	9.5%	8.9%	8.2%	8.0%					
Total	Number of discharges	4795	5751	5883	4858	4631	3719	3524	3647	3728	3736	3829	3816	3800	3831	3748	3835	3851		↑	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
Patient Flow Trust Improvement Plan Metrics															
Number (%) Permanent consultants in post	BHRUT				56.00%	56.00%	56.00%	56.00%	56.0%	56.0%	56.0%			90%	This section is currently under development
Number Middle grade in post	BHRUT				5	7.0	6	7	5	6	6			11	
ED admitted performance	BHRUT				66.30%	60.80%	59.00%	49.00%	49.8%	45.6%	56.6%			95%	
ED non admitted performance	BHRUT				91.20%	90.60%	90.40%	88.30%	89.3%	82.0%	91.5%			95%	
Number patients seen in MRU	BHRUT				305	340	440	466	769	886	787			510	
Percentage of Discharges before Midday	BHRUT				12.50%	14.80%	15.06%	18.30%	16.8%	20.3%	20.0%				
Percentage of Discharges after 5pm	BHRUT				31.10%	32.40%	33.03%	32.22%	33.0%	32.6%	34.2%				
Percentage of Patients discharged at 0, 1 and 2 days	Queens				47.85%	48.61%	46.71%	47.60%	52.9%	60.9%	61.8%				
	KGH				56.36%	55.40%	53.64%	48.91%	55.1%	55.8%	60.9%				
% Same Day discharge from MRU/MAU within 24 Hours	Queens				19.60%	21.10%	17.40%	16.50%	19.9%	20.7%	18.7%			50.0%	
	KGH				14.30%	14.00%	14.50%	13.00%	11.5%	11.9%	18.5%			50.0%	
Median Length of Stay	BHRUT				2.25	2.42	2.54	2.54	2.17	2.11	1.98				
% Occupancy	BHRUT				90.6%	87.8%	88.43%	97.10%	95.2%	93.5%	93.1%				
Beds consumed by readmissions	BHRUT				184	139	109	151	195	200	219				
Number of Patients seen in ambulatory Care	BHRUT				357	336	348	392	552	678	716				
Average Days to Complete fastrack	BHRUT				8.0	6.2	5.9	5.6	5.5	5.8	6.1				

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	Total no. of appointments commissioned (Planned)	Barking & Dagenham										352	420	902	13,645	Barking and Dagenham due to open November 2014
	Total no. of Patients Seen (Actual)											93	206	589		
	% of appointments utilised											26%	49%	65%		
	No. of DNA's											6	23	64		
	Source of referral (%)	111										65%	34%	19%		
		A&E										0%	0%	0%		
		UCC										0%	0%	0%		
		WIC										23%	16%	13%		
		Practice										13%	50%	43%		
		Other										0%	0%	26%		
	Total no. of appointments commissioned (Planned)	Havering						420	560	574	658	1424	750	1215	17,085	Activity to be reviewed and adjusted each month, according to demand. Maximum number of appointment contracted, 17,085
	Total no. of Patients Seen (Actual)							34	119	261	396	631	419	809		
	% of appointments utilised							8%	21%	45%	60%	44%	56%	67%		
	No. of DNA's								5	36	57	72	76	103		
	Source of referral (%)	111							34%	50%	42%	43%	41%	41%		
		A&E							0%	1%	0%	0%	0%	0%		
		UCC							0%	0%	0%	0%	0%	0%		
		WIC							0%	0%	0%	0%	0%	0%		
		Practice							0%	50%	57%	57%	59%	59%		
		Other							0%	0%	0%	0%	0%	0%		
	Total no. of appointments commissioned (Planned)	Redbridge						420	560	620	645	974	726	1216	19,270	Activity to be reviewed and adjusted each month according to demand. Maximum number of appointment contract, 19,270.
	Total no. of Patients Seen (Actual)							35	105	301	492	548	500	939		
	% of appointments utilised							8%	19%	49%	76%	56%	69%	77%		
	No. of DNA's								9	33	47	52	48	Mar-00		
	Source of referral (%)	111							70%	55%	49%	45%	43%	39%		
		A&E							21%	5%	5%	1%	1%	0%		
		UCC							0%	1%	2%	0%	0%	3%		
		WIC							0%	0%	0%	0%	0%	0%		
		Practice							0%	39%	44%	53%	56%	59%		
		Other							2%	0%	0%	0%	0%	0%		

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
Over 65 (including Frail Elderly population) with 2 or more LTCs across BHR CCGs	A&E / UCC Attendances															
	Age 65-74	QH	471	447	442	444	454	416	428	375	494	431				
		KGH	202	238	228	189	213	190	223	214	268	196				
		BHRUT	**673**	**685**	**670**	**633**	**667**	**606**	**651**	**589**	**762**	**627**				
	Age 75+	QH	627	699	631	660	645	619	595	596	645	626				
		KGH	302	315	340	307	324	290	273	314	324	303				
		BHRUT	**929**	**1014**	**971**	**967**	**969**	**909**	**868**	**910**	**969**	**929**				
	Age 85+	QH	553	520	519	484	502	484	525	539	595	577				
		KGH	192	234	195	233	235	192	162	22	261	236				
		BHRUT	**745**	**754**	**714**	**717**	**737**	**676**	**687**	**762**	**856**	**813**				
	Non-Elective Admissions by Average Length of Stay															
	Medical/Elderly	Non-Elective Admissions/Emergency Short Stay	QH	86	73	74	87	73	86	74	79	86	56				
			KGH	23	36	33	32	31	39	26	36	32	23				
			BHRUT	**109**	**109**	**107**	**119**	**104**	**125**	**100**	**115**	**118**	**79**				
		Non-Elective Emergency	QH	6326	6032	5697	5860	5230	4937	5906	5356	6383	5509				
			KGH	3391	2987	2666	2459	2498	2959	2664	2984	2950	2997				
			BHRUT	**9717**	**9019**	**8363**	**8319**	**7728**	**7896**	**8570**	**8340**	**9345**	**8506**				
	Surgical	Non-Elective Admissions/Emergency Short Stay	QH	6	8	10	11	11	12	7	13	7	14				
			KGH	41	25	22	37	25	22	20	30	24	29				
			BHRUT	**47**	**33**	**32**	**48**	**36**	**34**	**27**	**43**	**31**	**43**				
		Non-Elective Emergency	QH	752	790	970	658	841	984	1273	730	739	651				
			KGH	1078	1198	1224	1189	1193	944	1090	936	1041	1017				
			BHRUT	**1830**	**1988**	**2194**	**1847**	**2034**	**1928**	**2363**	**1666**	**1780**	**1668**				

SCHEME	PERFORMANCE INDICATOR	Operational Delivery RAG (dates are week ending)			Operational Delivery Actual (dates are week beginning)																								
		13/03/15	20/03/15	03/04/15	06/10/14	13/10/14	20/10/14	27/10/14	03/11/14	10/11/14	17/11/14	24/11/14	01/12/14	08/12/14	15/12/14	22/12/14	29/12/14	05/01/15	12/01/15	19/01/15	26/01/15	02/02/15	09/02/15	16/02/15	23/02/15	02/03/15	09/03/15	16/03/15	23/03/15
Enhanced Psychiatric Liaison	Beds saved																												
CTT/IRS	Beds saved																												
End of Life	Beds saved																												
FOPAL	Beds saved																												
LAS / CTT	Ambulance conveyances avoided				13	10	14	11	13	12	7	15	17	14	16	11	23	24	16	15	21	20	19	14	21	16	13	18	16
Community Pharmacy	Patients seen - risk of readmission																												
Primary Care																													

SCHEME	OPERATIONAL DELIVERY														
	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
Enhanced Psychiatric Liaison			2	***5***	4	***8***	8	***8.7***	10	***14***	10	13	24	***48.7***	***25***
CTT/IRS			6	***8.8***	8	***8.3***	12	***10.5***	12	***12***	12	11	38	***50.6***	***13***
End of Life			1	***0***	3	***5***	6	***7***	6	***8***	6	***8***	16	***28***	***12***
FOPAL			8	***5***	13	***8***	13	***7.5***	15	***11***	15	12.5	49	***44***	***-5***
LAS / CTT	101	***48***	126	***47***	126	***48***	104	***99***	52	***74***	*104*	*63*	509	***316***	***-193***
Community Pharmacy			30	***0***	50	***15***	50	***65***	0	***50***			130	***130***	***0***
Primary Care															

Notes

Implementation Phase - RAG rating definition

Green denotes there is no slippage in the timeline and is on target to deliver KPI's as set out in approved plan.

Amber denotes there is a weeks slippage in the timeline but is on

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.

Delivery Phase - RAG rating definition

Green denotes that the actuals are at or exceed the targets

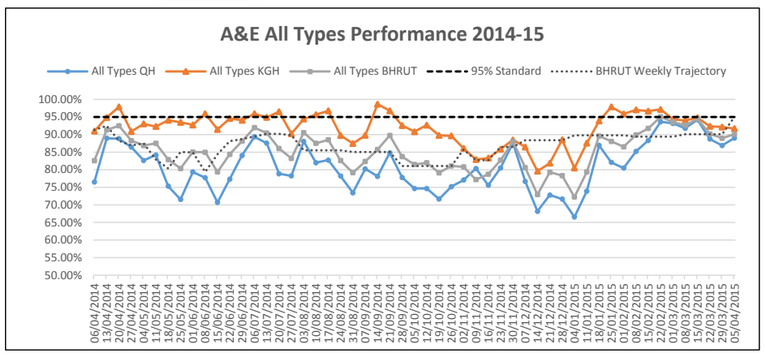
Amber denotes that the target has not been achieved, with the difference being less than 10%

Red denotes that the target has not been achieved, with the difference being 10% or more

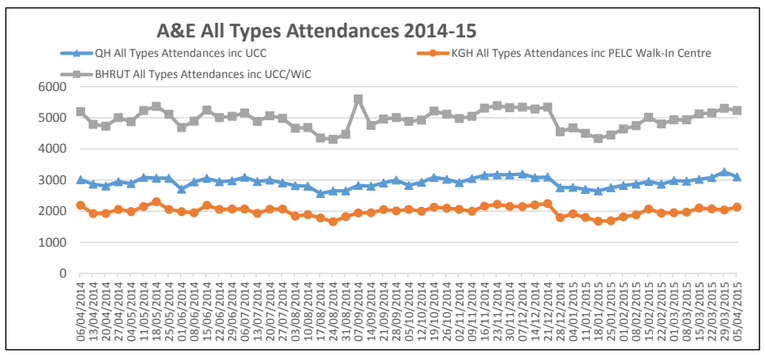
URGENT CARE EXECUTIVE DASHBOARD SUMMARY

Report Production Date: 13/04/2015

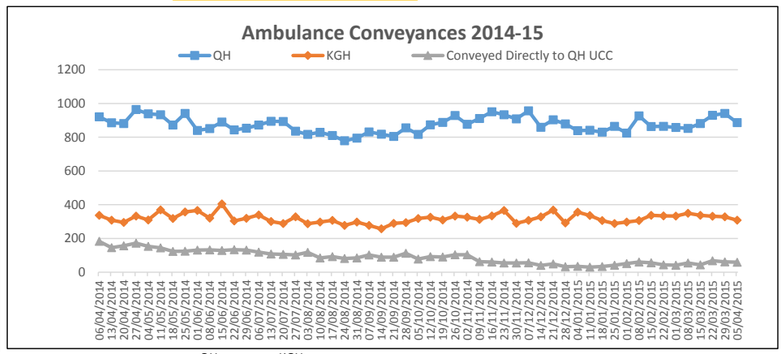
RAG Status:



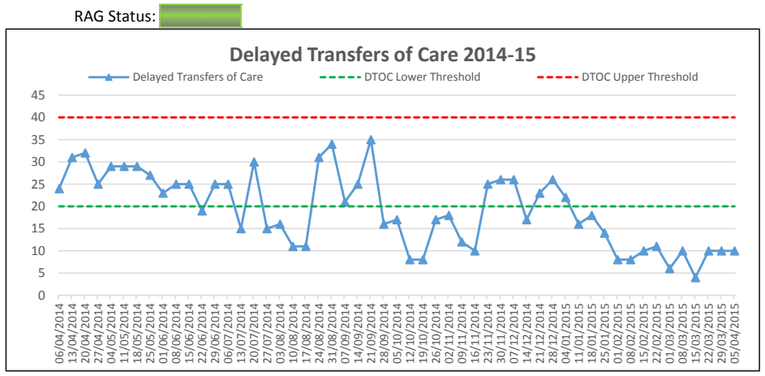
RAG Status: QH KGH BHRUT



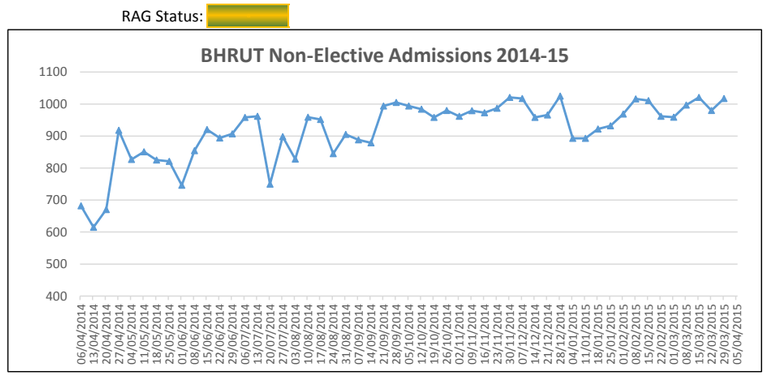
RAG Status: QH KGH BHRUT



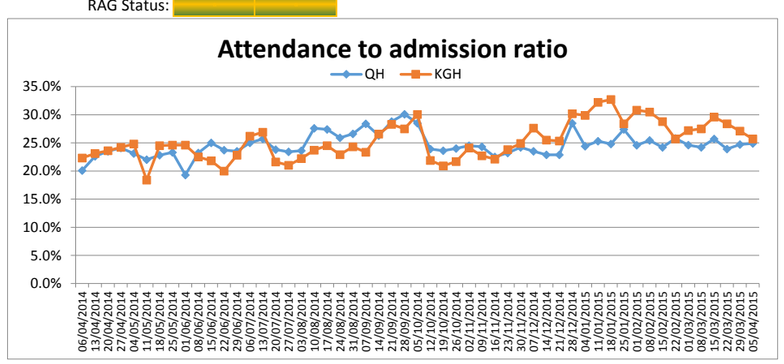
RAG Status:

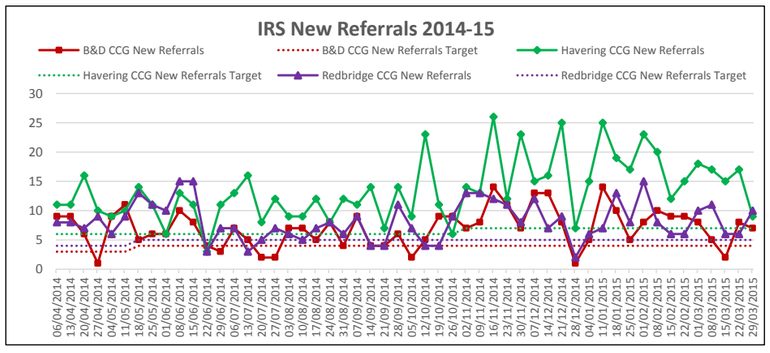


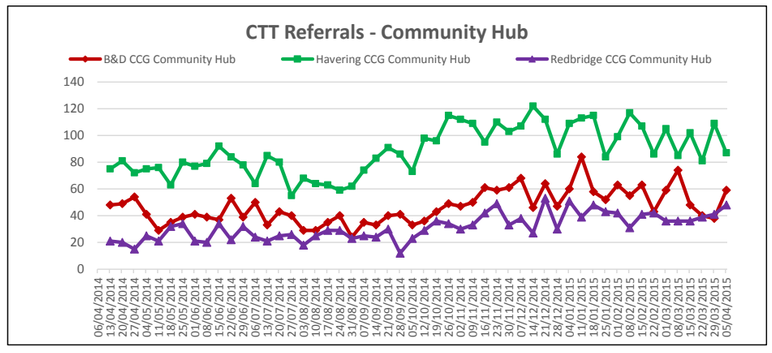
RAG Status:

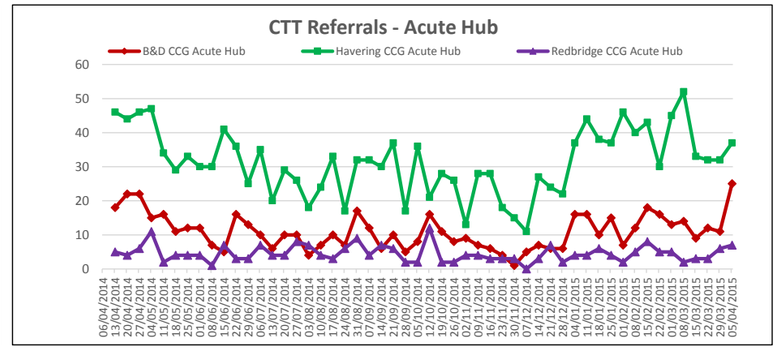


RAG Status: QH KGH









Barking & Dagenham

Indicator	Current Month	Previous Month	YTD Median	Target	Trend
Current Month:		Mar-15			
A&E / UCC Attendances	0	-51218		0	↓
Non-Elective Admissions	0	-10559		0	↓
Current Month:		Mar-15			
IRS New Referrals	30	36	29	16	↓
CTT - Community Hub	259	224	190	104	↑
CTT - Acute Hub	59	53	41	90	↑

Havering

Indicator	Current Month	Previous Month	YTD Median	Target	Trend
Current Month:		Mar-15			
A&E / UCC Attendances	0	-67460		0	↓
Non-Elective Admissions	0	-16138		0	↓
Current Month:		Mar-15			
IRS New Referrals	76	70	54	28	↑
CTT - Community Hub	482	409	362	212	↑
CTT - Acute Hub	194	159	126	76	↑

Redbridge

Indicator	Current Month	Previous Month	YTD Median	Target	Trend
Current Month:		Mar-15			
A&E / UCC Attendances	0	-44140		0	↓
Non-Elective Admissions	0	-10298		0	↓
Current Month:		Mar-15			
IRS New Referrals	43	35	33	20	↑
CTT - Community Hub	188	156	124	148	↑
CTT - Acute Hub	19	20	19	52	↓

This page is intentionally left blank

North East London NHS Foundation Trust
Mental Health Services

2014-15 NELFT Mental Health Services

Barking & Dagenham CCG Information Requirements

CPA Information

No	Requirement	Threshold		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Comments
GEN 1	4 Hour A&E waiting times	95%		98.9%	96.5%	95.9%	97.3%	97.6%	99.0%	99.0%	95.8%	91.0%	94.3%				
GEN 2	Average length of stay for Inpatients (trimmed)	< 25 days	Adults	26.6	17.9	23	25	19.6	33.3	25.9	25.1	24.4	26.6	30			
		< 45 days	Older Adults	49.0	51	no discharges	59	52.0	64	56	54.5	no discharges	19	46			
GEN 3	Delayed Transfer of Care	< 7.5%	Adults	0.0%	2.1%	0.8%	0.4%	0.0%	0.0%	0.8%	7.1%	6.0%	4.1%	3.2%			
			Older Adults	0.0%	0.0%	3.6%	8.1%	10.3%	17.8%	7.0%	0.0%	0.0%	26.3%	0.0%			
GEN 4	% occupancy adult acute wards	90%	Male	94.2%	97.6%	99.9%	91.3%	94.2%	99.2%	98.7%	98.9%	95.8%	101.4%	100.6%			
			Female	77.2%	82.8%	93.5%	94.4%	92.4%	84.2%	87.3%	73.6%	75.9%	79.9%	84.3%			
GEN 5	% occupancy older adult acute wards	90%	Male	73.2%	73.1%	74.8%	60.2%	101%	93.2%	97.7%	84.8%	91.8%	92.1%	75.9%			
			Female	82.9%	80.9%	68.7%	65.5%	95.0%	94.9%	81.0%	82.5%	89.9%	97.2%	102.5%			
GEN 6	Re-referral rate for Tariff in scope services (re referred within 30 days)			13.0%	12.0%	11.9%	11.4%	14.4%	13.3%	11.0%	11.3%	14.2%	11.5%	12.1%			
GEN 7	Proportion of CPA reviews with a corresponding Clustering review			23.1%	19.8%	14.9%	15.8%	18.0%	25.7%	15.7%	12.0%	13.8%	22.9%	23.0%			
GEN 8	Indicator of Accomodation problems			245	240	241	247	236	251	256	246	236	242	238			

No	Requirement	Threshold		Q1			Q2			Q3			Q4			YTD	Comments
GEN 9	Number of readmissions within 28 days of discharge since start of financial year		Adults			5			9			17			20		
			Older Adults			0			0			0			0		
GEN 10	Cumulative % of readmissions within 28 days of discharge since start of financial year		Adults			11.4%			8.2%			11.8%			9.4%		
			Older Adults			0.0%			0.0%			0.0%			0.0%		
GEN 11	Number of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team		Adults			45			56			59			25		
			Older Adults			6			6			3			7		
GEN 12	Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team	95%	Adults			100%			100%			94.9%			100.0%		
			Older Adults			100%			100%			66.7%			100.0%		
GEN 13	Number of patients on CPA discharged from inpatient care who are followed up within 7 days		Adults			20			32			34			18		
			Older Adults			1			7			2			2		
GEN 14	% of patients on CPA discharged from inpatient care who are followed up within 7 days	95%	Adults			100%			100%			100%			100%		
			Older Adults			100%			100%			100%			100%		
			ADULTS														
			Employment status			99.5%			99.5%			99.4%			99.2%		
			Accommodation Status			99.7%			99.4%			99.2%			99.7%		

North East London NHS Foundation Trust
Mental Health Services

2014-15 NELFT Mental Health Services

Barking & Dagenham CCG Information Requirements

CPA Information

No	Requirement	Threshold		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Comments
GEN 15	**Proportion of service users on CPA with a recording of:** **1. Employment Status.** **2. Accommodation status.** **3. Having a HoNOS assessment in the last 12 months.** **4. Having a diagnosis for patients discharged from inpatient care.** **5. Having a formal CPA HoNOS review in the past 12 months.** **6. Having a Crisis Plan.** **7. Having a copy of their care plan**	97% minimum of patients should have this information recorded	Having a HoNos Assessments in the last 12 months			96.4%			97%			96.5%			95.2%		
			Having a diagnosis for patients discharged from inpatient care			86.7%			92%			82.5%			82.6%		
			Having a formal CPA Review in the past 12 months			96.1%			99%			98.3%			98.3%		
			Having a crisis plan			94.8%			95%			95.6%			95.2%		
			A copy of their care plan			99.5%			100%			99.1%			98.9%		
			OLDER ADULTS														
			Employment status			82.9%			78.0%			79.8%			86.6%		
			Accommodation Status			84.7%			79.7%			81.7%			88.7%		
			Having a HoNos Assessments in the last 12 months			99%			96%			98.2%			99.0%		
			Having a diagnosis for patients discharged from inpatient care			100%			91%			50%			0.0%		
			Having a formal CPA Review in the past 12 months			96.1%			100%			99%			96.9%		
			Having a crisis plan			94.4%			88.1%			89.0%			95.9%		
			A copy of their care plan			98.2%			95.8%			93.6%			97.9%		

North East London NHS Foundation Trust
Mental Health Services

2014-15 NELFT Mental Health Services

Barking & Dagenham CCG Information Requirements

CPA Information

No	Requirement	Threshold		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Comments
GEN 16	**Minimum patient identity data to consist of:** **1. NHS Number.** **2. Date of Birth.** **3. Postcode (normal residence).** **4. Current Gender.** **5. Marital Status.** **6. Registered General Practice Code.** **7. Commissioner organisation code** **8. Ethnicity**	97% minimum of patients should have this information recorded	**Adults**														
			NHS Number			100%			100%			100%			100%		
			Date of Birth			100%			100%			100%			100%		
			Postcode (normal residence)			100%			99.8%			100.0%			100%		
			Current Gender			100%			100%			100%			100%		
			Marital Status			99%			99%			99%			99%		
			Registered GP Code			98.1%			99.2%			99.2%			99%		
			Commissioner code			100%			100%			100%			100%		
			Ethnicity			100%			100%			100%			100%		
			Older Adults														
			NHS Number			100%			100%			100%			100%		
			Date of Birth			100%			100%			100%			100%		
			Postcode (normal residence)			100%			100%			100%			100%		
			Current Gender			100%			100%			100%			100%		
			Marital Status			100%			100%			100%			100%		
			Registered GP Code			98.0%			98.1%			97%			97%		
			Commissioner code			100%			100%			100%			100%		
			Ethnicity			100%			100%			100%			100%		
GEN 17	**Number of Patients on Memory services Caseload**					320			251			232			228		
GEN 18	**Number of new patients allocated in Memory Services**					162			124			125			88		
GEN19	**Number of people with a new diagnosis of Dementia**					47			40			39			25		
GEN20	**Number of referrals received by memory service**					164			148			128			93		
GEN21	**Referrals by source for memory services**																
GEN22	**Memory services - Time from referral to assessment (days)**					27.28			26.02			23.98			27.87		
GEN23	**Number of people managed by the memory service with an indivdual care plan**																**Audit Q2 & Q4 reports**
GEN24	**Total early intervention (EI) patients being treated by EI Teams (all patients receiving EI treatment at a point in time)**		EI Caseload			70			75			65			70		
GEN25	**Total number of new patients taken on by Early Intervention Team since the start of the financial year**		New EI cases			15			25			32			39		
GEN26	**Proportion of adults (18-69) on CPA in settled accommodation**		Settled accomodation			75.6%			78.5%			86.8%			88.5%		
GEN27	**Proportion of adults (18-69) on CPA in employment**		In employment			2.64%			3.2%			4.0%			4.9%		

North East London NHS Foundation Trust
Mental Health Services

2014-15 NELFT Mental Health Services

Barking & Dagenham CCG Information Requirements

CPA Information

No	Requirement	Threshold		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Comments
GEN28	The number of episodes of AWOL for the number of patients detained under the MHA 1983		AWoL of Detained Patients			1 of 59			0 of 80			0 of 63			0 of 42		
GEN 29	Number of bed days within 12 months prior to commencing with IMPART, compared to number of bed days during year of IMPART treatment for those discharged in the quarter		Impart bed day comparision						0/0								
GEN 30	Percentage reduction in self harm and suicide attempts comparing first month of treatment with last month of treatment for clients discharged from Impart in the quarter		Impart reduction in self harm						Suicide = 100% Self Harm = 100%								
GEN 31	Number of patients with LD as a primary diagnosis accessing all services by service area		Primary LD diagnosis			98			95			95			95		Agreed annual report to CQRM
GEN 32	Number of patients with LD a as a secondary diagnosis accessing all services by service area		Secondary LD diagnosis			2			2			3			2		Agreed annual report to CQRM
GEN 33	Number of patients with ASC as a primary diagnosis accessing all services by service area		Primary ASC diagnosis			0			0			0			0		Agreed annual report to CQRM
GEN 34	Number of patients with ASC as a secondary diagnosis accessing all services by service area		Secondary ASC Diagnosis			8			8			8			8		Agreed annual report to CQRM

IAPT Information

No	Requirement	Threshold	Borough	Q1			Q2			Q3			Q4			YTD	Comments
GEN 45	Number of people who have been referred to IAPT for psychological therapies during reporting period					721			680			710			600	**2111**	
GEN 46	The number of IAPT active referrals who have waited more than 28 days from referral/first contact to first treatment/first therapeutic session at the end of the quarter					22			9			6			5		

North East London NHS Foundation Trust
Mental Health Services

2014-15 NELFT Mental Health Services

Barking & Dagenham CCG Information Requirements

CPA Information

No	Requirement	Threshold		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Comments
GEN 47	The number of people who have entered psychological therapies (i.e. had first therapeutic session during the reporting quarter)					513			498			570			392		
GEN 48	The number of people who have completed treatment and are moving to recovery					218			203			204			147		
GEN 49	The number of people who have completed treatment who did not achieve clinical caseness at initial assessment					0			0			0			0		
GEN 50	IAPT - The number of people moving off sick pay and benefits during the reporting quarter					44			55			65			37		
GEN 51	The proportion of those referred to IAPT services that enter treatment					71.2%			73.2%			80.3%			65.3%		
GEN 52	Access to psychological therapies services by people from black and minority ethnic groups					28.3%			28.1%			29.4%					

CAMHS Information

No	Requirement	Threshold		Q1			Q2			Q3			Q4			YTD	Comments
GEN 53	CAMHS 2 % DNA rate	Less than 25% moving to 15% by Q4				25.25%			27.2%								
GEN 54	CAMHS 5 Annual Report of service satisfaction, based on chisq questionnaire, by borough camhs tier 3 service																
GEN 55	CAMHS 6 Number of staff completed Safeguarding training: Level 1 Level 2 Level 3					Lvl 1 =4, Lvl 2 = 0 , Lvl 3 =13			Lvl 1 =7, Lvl 2 = 0 , Lvl 3 =19			Lvl 1 =6, Lvl 2 = 0 , Lvl 3 =14					

North East London NHS Foundation Trust
Mental Health Services

2014-15 NELFT Mental Health Services

Barking & Dagenham CCG Information Requirements

CPA Information

No	Requirement	Threshold		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Comments
GEN 56	CAMHS 6 Rate of staff completed Safeguarding training: Level 1 Level 2 Level 3	90%				Lvl 1 =100%, Lvl 2 = 100%, Lvl 3 =86.7%			Lvl 1 =100%, Lvl 2 = 100%, Lvl 3 =86.7%			Lvl 1 =100%, Lvl 2 = n/a, Lvl 3 =100%					
GEN 57	CAMHS 7 Audit quality of transition plans for any yp, where necessary, by borough camhs tier 3 service																
GEN 58	% of referrals accepted					94%			94%			96.4%			85.65%		
GEN 59	Number of referrals redirected by Tier 3 CAMHS					1			2			0			0		
GEN 60	Number of inpatients discharged from hospital receiving follow up within 7 days: Split by F2F and telephone contact					3 discharged - 3 F2F & 0 Telephone			6 discharged - 6 F2F & 0 Telephone			5 discharged - 4 F2F & 1 Telephone			1 discharged - 0 F2F & 0 Telephone		
GEN 61	% of inpatients discharged from hospital receiving follow up within 7 days: Split by F2F and telephone contact	95%				100%			100%			100%			0.0%		
GEN 62	Number of CYP assessment appointments by Tier 3 CAMHS team					212			193			260			137		
GEN 63	Number of CYP whose cases were closed by team					290			262			317			169		
GEN 64	Average number of sessions completed per child/family by Tier 3 CAMHS team					9.2			6.5			6.8			7.0		
GEN 65	Breakdown of destination on case closure by Team by available RIO reporting category																
GEN 66	Participation report annually by borough, including details of how CYP have been involved in service development																
GEN 67	Number (client total) of initial measures completed. By team					104			67			85			47		
GEN 68	%age (client total) of initial measures completed. By team					33.1%			29.1%			31%			27.3%		
GEN 69	Number of follow up mental health measures completed by Team					21			18			15			4		
GEN 70	%age of follow up mental health measures completed by Team					6.7%			7.8%			5.4%			2.3%		

HEALTH AND WELLBEING BOARD

12 MAY 2015

Title: Review of our Learning Disability and Autism Health and Social Care Self Assessments	
Report of the Corporate Director of Adult and Community Services	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: NO**
Report Author: Karel Stevens-Lee Joint Commissioning Manager, Learning Disabilities	**Contact Details:** Tel: 020 8227 2476 Email: Karel.stevens-lee@lbbd.gov.uk

Sponsor:
Anne Bristow, Corporate Director Adult and Community Services

Summary:

The Joint Health and Social Care Learning Disability Self-Assessment Framework (LDSAF) and Joint Health and Social Care Autism Self-Assessment Framework (ASAF) are self-submissions from health and local authorities to recognise the overall needs, experience and wishes of people with a learning disability, autism and their carers.

Both the LDSAF and the ASAF are overseen nationally by NHS England and National ADASS and have a national and regional focus for on-going improvement.

Members of the Learning Disability Partnership Board and officers from across the local health and social care economy agreed the submission for the LDSAF and the ASAF to NHS England and National ADASS on behalf of Barking and Dagenham. The following report summarises the submissions and the work that is being undertaken, led by the Learning Disability Partnership Board (LDPB), to improve areas and services that have been flagged by the self-assessments.

Recommendation(s)

Members of the Board are recommended to:

- Comment upon the submissions that were made for the Learning Disability Self-Assessment Framework (LDSAF) and the Autism Self-Assessment Framework (ASAF).
- Discuss and agree the proposed headline actions to be taken forward to maintain or improve services for people with learning disabilities. The Learning Disability Partnership Board will then expand and take forward these actions at their next meeting on 19 May 2015.

- Note the Action Plan to develop Autism services is reflected in the Adult Autism Strategy and the forthcoming Children's Autism Strategy and that a report will be brought to the Health and Wellbeing Board in the Autumn, giving an update on the progress of the implementation of the strategies.

Reason(s)

The Council has committed to the vision of 'One borough; one community; London's growth opportunity'. The work of the Health and Wellbeing, and the Learning Disability Partnership Board, supports the delivery of this vision and the three Council priorities:

- Encouraging civic pride
- Enabling social responsibility
- Growing the Borough

The LDSAF and the ASAF ask questions relating to many aspects of health and social care for people with learning disabilities and autism. Many of these questions relate directly to the Council's vision and priorities. The self-assessments enable the Borough to review areas and services which require further improvement and put in place actions to progress these improvements.

1. Background – Learning Disability Self-Assessment Framework (LDSAF)

1.1 The Joint Health and Social Care Learning Disability Self-Assessment Framework (LDSAF) began in 2007 as a guide for health and local authorities to recognise the overall needs, experience and wishes of people with a learning disability and their carers. The LDSAF is overseen nationally by NHS England and National ADASS. The development of the current version of the LDSAF was co-ordinated as part of the Winterbourne View Programme.

1.2 The aim of this framework is to provide a single, consistent way of identifying the challenges in caring for the needs of people with learning disabilities, and documenting the extent to which the shared goals of providing care are met locally. The intention is that Learning Disability Partnership Boards, Health and Wellbeing Boards, Clinical Commissioning Groups (CCGs) and Local Authorities (LAs) use the LDSAF to identify the priorities, levers and opportunities to improve care and tackle health and social care inequalities in their areas. The full documentation pack can be found on the Improving Health and Lives (IHAL) website: https://www.improvinghealthandlives.org.uk/projects/jhscsaf2014

2. Introduction

2.1 Each year authorities are tasked with carrying out a self-assessment on how it meets a set of criteria outlined within the LDSAF (please see below) for both children and adults. This year's assessment covers the period 1 April 2013 – 31 March 2014.

2.2 Upon completion and submission of the self-assessment, NHS England and National ADASS collate a national report of all of the submissions which will be

published and used by Ministers to track the progress in providing services to meet the aspirations of *Healthcare for All* and of *Transforming Care: A National Response to Winterbourne View.* NHS England and ADASS will also use the self-assessments to form regional action plans and sector led improvement work programmes.

2.3 Locally, the self-assessment is being used to inform the local authority and health partners on how it meets and plans for the future needs of people with learning disabilities and their carers, as well as inform and support the strategic priorities detailed in the:

- Joint Strategic Needs Assessment
- Health and Wellbeing Strategy
- Commissioning intentions and strategies for both the local authority and the CCG
- Winterbourne View Joint Improvement Plans
- The work programme of the Learning Disability Partnership Board.

2.4 The LDSAF is formed of two stages, the first of which is the collation of data and submission of the self-assessment. The Joint Commissioning Manager for Learning Disabilities led on the collation of the data for the LDSAF with health and social care colleagues from across Children's and Adult Services. The findings were approved by Senior Officers, Learning Disability Partnership Board representatives and the Cabinet Member for Adult Social Care and Health and submitted on 31 January 2015.

2.5 The second stage of the LDSAF is to use the data to build a local improvement action plan. The Integrated Commissioning Manager working with the Learning Disability Partnership Board, local stakeholders and commissioning partners has developed headline actions where the LDSAF rating evidenced that improvements are required or where good practice needs to be embedded and sustained. This is summarised in Section 6 of this report.

3. Collating the Evidence

3.1 The local authority took the lead on the SAF working closely with the CCG, in consultation with Children's Services, Community Learning Disability Team Practitioners, Commissioners, Transport services, Leisure and Arts, Youth Offending, Probation services, as well as service users, carers and providers.

3.2 The SAF is made up of two elements;

The quantitative demographics and data on:

- People receiving various types of services,
- Their age ranges,
- How many people have received health checks,
- Continuing Care,
- People in employment,
- In-patient services,
- Safeguarding and Mental capacity and Depravation of Liberty of Safeguards
- Children of school age and Transition

The other element of the SAF is the more qualitative data and seeks views and comments on how well each area is being met. This section looks at:

- Staying healthy
- Staying safe
- Living well

3.3 Each qualitative measure assessed is rated as fully met, partially met or unmet, represented as RED, AMBER or GREEN as detailed in the national guidance. Each service area has agreed the rating of how they meet the needs of people with a learning disability.

4. Summary of results

4.1 The following table summarises the results of the indicators that were submitted. Where the information is available to compare to last year, the RAG and Direction of Travel (DoT) has been included.

4.2 It should also be noted that some of the indicators have been left blank e.g. A3 because Improving Health and Lives (IHAL) will complete these measures for all localities from the national data source.

	Indicator	RAG 2012/13	Submitted RAG for 2013/14	DoT
A1	Learning Disabilities Quality Outcomes Framework (QOF) register in primary care			↑
A2	Finding and managing long term health conditions: obesity, diabetes, cardiovascular disease, epilepsy			↔
A3	Annual health checks and annual health check registers		IHAL to collate	N/A
A4	Specific health improvement targets (Health Action Plans) are generated at the time of the Annual Health Checks in primary care			↔
A5	National Cancer Screening Programmes (bowel, breast and cervical) for people with learning disabilities		IHAL to collate	N/A
A6	Primary care communication of learning disability status to other healthcare providers			↔

	Indicator	RAG 2012/13	Submitted RAG for 2013/14	DoT
A7	Learning disability liaison function or equivalent process in acute setting			↔
A8	NHS commissioned primary care: dentistry, optometry, community pharmacy, podiatry			↔
A9	Offender health and the Criminal Justice System			↑
B1	Individual health and social care package reviews			↓
B2	Learning disability services contract compliance			↔
B3	Monitor assurances			↔
B4	Adult safeguarding			↔
B5	Self-advocates and carers in training and recruitment			↔
B6	Compassion, dignity and respect. To be answered by self advocates and family - carers			↔
B7	Commissioning strategy impact assessments			↔
B8	Complaints lead to changes			↔

	Indicator	RAG 2012/13	Submitted RAG for 2013/14	DoT
C1	Effective joint working			↑
C2	Local amenities and transport			↑
C3	Arts and culture			↑
C4	Sports and leisure			↔
C5	Employment			↑
C6	Preparing for adulthood			↑
C7	Involvement in service planning and decision making			↑
C8	Carer satisfaction rating. To be answered by family carers			↔
C9	Overall rating for the assessment. To be answered by IHAL	IHAL to collate	IHAL to collate	N/A

5. Key points to note

5.1 There are 26 measures in this year's SAF. The authority is asked to comment on 23 of the measures. In comparison to last year's assessment there were 8 improvements and 14 measures where the rating has remained stable.

5.2 The areas of improvements in the past year were:

- More people with learning disabilities in employment,
- More access to local amenities for people with learning disabilities,
- Greater awareness of learning disabilities within the criminal justice system

- Improved access and participation in Arts and Leisure services
- Improved preparation for adulthood, mainly through the work completed on Education, Health and Care Plans
- Improved joint and effective working.

5.3 These improvements are consistent with the continued Borough-wide focus on improving the wellbeing of people with a learning disability in Barking and Dagenham, through the coordinated work of the Learning Disability Partnership Board and the Council's Fulfilling Lives programme. There have also been closer working relationships between health and social care around learning disabilities and Winterbourne View which has also facilitated these improvements. Additionally, the level of work undertaken by Children's Services since the introduction of the Children and Families Act has improved a number of indicators, but particularly the 'Preparing for Adulthood' indicator.

5.4 There were six measures where the authority remained at an Amber rating. These concerned the provision of health services and provision of advocacy.

5.5 Both the provision of health services and advocacy services are recognised as being in development by service managers and commissioners. We would anticipate improvements following the re-commissioning of advocacy services in line with the Care Act and closer worker with health colleagues. Examples of this include the CLDT training GPs and Practice Nurses on completing Heath Action Plans and greater awareness and promotion of the voluntary transport service offered by the authority to take people to medical appointments.

5.6 There was one measure where the Borough worsened, falling from a green rating to an amber rating. This was the number of people receiving a service that had been reviewed by health and social care. The authority has maintained the same performance of 91% however IHAL have changed the rating criteria, and only scores of 100% will achieve a green rating.

6. LDSAF Action Plan

6.1 The following table summarises the high-level actions that are proposed to be taken forward by stakeholders to ensure that the Borough maintains (where the indicator is rated as green) or improves the provision and experience of people with learning disabilities and their carers against the LDSAF indicators.

6.2 The Learning Disability Partnership Board will discuss the LDSAF Action Plan at their next meeting (19 May) and will look to expand and develop these headline actions to produce a detailed action plan to be taken forward by all partners. The LDPB will then regularly monitor the progress of the implementation of the Action Plan at their meetings.

	Indicator	RAG 2012/13	RAG 2013/14	DoT	How we will maintain or improve performance	LD SAF 'Green' Target	Lead	Timescale
A1	Learning Disabilities Quality Outcomes Framework (QOF) register in primary care			↑	Although this is a 'green' indicator, it is proposed that further work should be carried out with GPs to ensure patient codes are recorded to meet national and local data sets for learning disabilities. Additionally, learning disability registers held by health and social care to be reviewed and validated to ensure that accuracy is maintained.	*LD registers reflect prevalence data AND data is stratified in every required data set (e.g. age / complexity / autism diagnosis / black and minority ethnicities etc.).*	Joint Commissioning Manager, Learning Disabilities	**June 2015**
A2	Finding and managing long term health conditions, obesity, diabetes, cardiovascular disease and epilepsy			↔	Joint Commissioning Manager and CCG to liaise with GP surgeries to ensure all PWLD have had all necessary health checks and have a treatment plan in place. Health check take-up and treatment plans to be monitored at the Clinical Quarterly review meetings.	*Compare treatment and outcomes for all four conditions (obesity, diabetes, cardiovascular disease and epilepsy) between people with learning disabilities and others in the borough and at a local GP level.*	Joint Commissioning Manager, Learning Disabilities Chief Operating Officer, CCG	**Sept 2015 and quarterly then on**

	Indicator	RAG 2012/13	RAG 2013/14	DoT	How we will maintain or improve performance	LD SAF 'Green' Target	Lead	Timescale
A3	Annual health checks and annual health check registers		IHAL to collate	N/A	See actions for A2. CLDT Team and Joint Commissioning Manager to work with providers of learning disability services to advocate and support users to have health checks. This will include relationship building between the local GP surgeries and provider organisations and ensuring that staff are aware of what the health checks are and when they need to be completed by.	*All PWLD have an annual health check and GPs have a check register*	CLDT Manager and Joint Commissioning Manager	**Jan 2016**
A4	Specific health improvement targets (Health Action Plans) are generated at the time of the Annual Health Checks in primary care			↔	Although this is a 'green' indicator, Health Action Plan (HAP) take-up could be further improved by the CCG Practice Improvement lead liaising with GP surgeries to ensure all PWLD have HAPs in place. This will be monitored at the Clinical Quarterly review meetings. CLDT will assist GPs on completing HAP for users with	*70% or more of Annual Health Checks generate specific health improvement targets*	Joint Commissioning Manager & CCG Practice Improvement Lead CLDT Team Manager	**Sept 2015 and quarterly then on**

	Indicator	RAG 2012/13	RAG 2013/14	DoT	How we will maintain or improve performance	LD SAF 'Green' Target	Lead	Timescale
					complex care needs.			
A5	National Cancer Screening Programmes (bowel, breast and cervical) for people with learning disabilities		IHAL to collate	N/A	CCG Practice Improvement Lead to liaise with GP surgeries to ensure PWLD have a cancer screening where required. This will be monitored at the Clinical Quarterly review meetings	*Screening takes place for the same proportion (+ or – 5%) of eligible people with learning disabilities as the general population (23%).*	Joint Commissioning Manager % CCG Practice Improvement Lead	**Sept 2015 and quarterly then on**
A6	Primary care communication of learning disability status to other healthcare providers			↔	CCG Practice Improvement Lead and Joint Commissioning Manager to liaise with GP surgeries, NELFT and BHRUT to ensure that learning disability status is recorded and monitored via Clinical Quarterly review meetings. The CLDT Nurse to co-ordinate between CLDT and hospital staff to ensure reasonable adjustments are made.	*Secondary care and other healthcare providers can evidence that they have a system for identifying LD status on referrals based upon the LD identification in primary care and acting on any reasonable adjustments suggested.* *There is evidence that both an individual's capacity and consent are inherent to the system employed.*	CCG Practice Improvement Lead Joint Commissioning Manager, LD CLDT Nurse	**Sept 2015 and quarterly then on**

	Indicator	RAG 2012/13	RAG 2013/14	DoT	How we will maintain or improve performance	LD SAF 'Green' Target	Lead	Timescale
A7	Learning disability liaison function or equivalent process in acute setting			↔	Due to the 'green' rating, it is proposed that progress on this indicator is maintained. There is already a designated Learning Disability Liaison Nurse employed by BHRUT that co-ordinates the health needs of PWLD in acute, hospital and community settings. The Learning Disability Liaison Nurse reports back to an executive board on all matters of safeguarding, specific issues of concerns and the general status of services.	*Designated learning disability function in place or equivalent process, aligned with known learning disability activity data in the provider sites and there is broader assurance through executive board leadership and formal reporting/ monitoring routes.*	Learning Disability Liaison Nurse	**Ongoing, review progress in February 2016**
A8	NHS commissioned primary care: dentistry, optometry, community pharmacy, podiatry			↔	The CLDT nurse to co-ordinate between CLDT and hospital staff, including the LD Liaison Nurse, to ensure reasonable adjustments are made. CCG Commissioning to liaise with dentistry, optometry, community pharmacy, podiatry to ensure reasonable adjustments are made and	*All people with learning disability accessing/using services are known and patient experience is captured. All of these services are able to provide evidence of reasonable adjustments and plans for service improvement.*	CLDT Manager Learning Disability Liaison Nurse, CLDT Joint Commissioning Manager, Learning	**Sept 2015 and quarterly then on**

	Indicator	RAG 2012/13	RAG 2013/14	DoT	How we will maintain or improve performance	LD SAF 'Green' Target	Lead	Timescale
					monitor via Clinical Quarterly review meetings		Disabilities	
A9	Offender health and the Criminal Justice System			↑	The Learning Disability Partnership Board to facilitate the continued improvement in the working relationship between Health and Social Care and Offender and Probation services, including: • LD Week to include a theme on keeping safe, inviting along community safety partners to input and take part. • Invite the Group Manager, Community Safety and Offender Management, and Probation and Offender services to attend the LDPB as advisory members. • The LDPB to hold a themed meeting on the criminal justice system	*Local Commissioners have and act on data about the numbers and prevalence of people with a learning disability in the criminal justice system.* *Local commissioners have a working relationship with regional, specialist prison health commissioners* *There is good information about the health needs of people with LD in local prisons and wider criminal justice system and a clear plan about how such needs are to be met* *Prisoners and young offenders with LD have had an annual health check which*	LDPB Chair Interim Group Manager - Community Safety and Offender Management	**November 2015**

	Indicator	RAG 2012/13	RAG 2013/14	DoT	How we will maintain or improve performance	LD SAF 'Green' Target	Lead	Timescale
					and keeping safe in 2015/16.	*generates a health action plan, or are scheduled to have one in the coming 6 months.*		
B1	Individual health and social care package reviews			↓	CLDT will prioritise reviews over the next year to ensure all reviews are carried out for people with learning disabilities. This will be monitored through the LDPB performance framework on a quarterly basis.	*Evidence of 100% of all care packages including personal budgets reviewed within the 12 months are covered by this self-assessment.*	Group Manager Intensive Support	**March 2016**
B2	Learning disability services contract compliance			↔	Due to the 'green' rating, it is proposed that progress on this indicator is maintained. The local authority and the CCG will continue to review contracts over a scheduled year. The outcomes of service reviews are reported on the monthly "call over" report to Senior Managers. Progress on the supported living contracts are also regularly given at the LDPB.	*Evidence of 100% of health and social care commissioned services for people with learning disability: 1) have had full scheduled annual contract reviews; 2) demonstrate a diverse range of indicators and outcomes supporting quality assurance and including un announced visits. Evidence that the number regularly reviewed is reported at executive board level in both health and social*	Joint Commissioning Manager, Learning Disabilities	**Ongoing, review progress in February 2016**

	Indicator	RAG 2012/13	RAG 2013/14	DoT	How we will maintain or improve performance	LD SAF 'Green' Target	Lead	Timescale
						care.		
B3	Monitor assurances			↔	Due to the 'green' rating, it is proposed that progress on this indicator is maintained. BHRUT has a Learning Disability Action plan, which is monitored internally at the BHRUT LD Committee, Quality and Safety Committee, Safeguarding Adults Committee and exceptions raised to Trust Board.	*Commissioners review and monitor returns and review actual evidence used by Foundation Trusts in agreeing ratings. Evidence that commissioners are aware of and working with non-Foundation Trusts in their progress towards monitor compliance.*	Manager, Clinical Support Unit	**Ongoing, review in February 2016**
B4	Adult safeguarding			↔	Due to the 'green' rating, it is proposed that progress on this indicator is maintained. LA and CCG Commissioning to further improve the recording and auditing of Safeguarding governance across health and social care.	*Comprehensive evidence of robust, transparent and sustainable governance arrangements in place overseen by a Safeguarding Adults Board* *Every learning disability provider service has assured their board and*	LA Safeguarding Lead	**Ongoing, review in February 2016**

	Indicator	RAG 2012/13	RAG 2013/14	DoT	How we will maintain or improve performance	LD SAF 'Green' Target	Lead	Timescale
						others that quality, safety and safeguarding for people with learning disabilities is a clinical and strategic priority within all services. Also to ensure that there are action plans for and evidence of change.		
B5	Self-advocates and carers in training and recruitment			↔	The Joint Commissioning Manager to work with the local authority, CCG and Providers to increase the involvement of service users and carers in recruitment practices for relevant members of staff. Commissioner to ensure that all health and social care providers, as well as providers of learning disability services, access disability equality training.	*Learning disability services evidence involving people with learning disabilities and families in recruitment and training. Commissioners of universal services can provide evidence of contracting for learning disability awareness training (for example as part of Disability Equality training).*	Joint Commissioning Manager, Learning Disabilities	**Ongoing, review in February 2016**
B6	Compassion, dignity and respect. To be answered by self advocates			↔	LA and CCG and providers ensure questionnaires and surveys reflects this indicator.	*Family carers and people with a learning disability agree that all providers employ staff that demonstrate compassion*	Joint Commissioning Manager, Learning	**Ongoing, review in February 2016**

	Indicator	RAG 2012/13	RAG 2013/14	DoT	How we will maintain or improve performance	LD SAF 'Green' Target	Lead	Timescale
	and family - carers					*dignity and respect.*	Disabilities	
B7	Commissioning strategy impact assessments			↔	Due to the 'green' rating, it is proposed that progress on this indicator is maintained. Commissioning intentions with impact assessments to continue to be presented to the Learning Disability Partnership Board.	*Impact assessments and strategies have been developed with and presented to people who use services and their families.*	Joint Commissioning Manager, Learning Disabilities	**Ongoing, review in February 2016**
B8	Complaints lead to changes			↔	Due to the 'green' rating, it is proposed that progress on this indicator is maintained. Joint Commissioning Manager to work with providers to continue to ensure that all complaints are actioned and actions are fed back to the recipient. Continue with regular Quality Assurance reviews to monitor complaints and incidents in commissioned services and put action plans in place where necessary.	*90% or more of commissioned services can demonstrate improvements based on the use of feedback from people who use services, (e.g. complaints, surveys and quality checking). There is evidence of effective use of a whistleblowing policy where appropriate.*	Joint Commissioning Manager, Learning Disabilities .	**Ongoing, review in February 2016**

	Indicator	RAG 2012/13	RAG 2013/14	DoT	How we will maintain or improve performance	LD SAF 'Green' Target	Lead	Timescale
C1	Effective joint working			↑	Section 75 agreements for commissioning and the learning disability integrated service are being finalised. Once finalised, the agreements will be monitored through the Learning Disability Partnership Board and an operational manager's meeting.	*There are well functioning formal partnership agreements and arrangements between health and social care organisations. There is clear evidence of single point of health and social care leadership, joint commissioning strategies and or pooled budgets, integrated health and social care teams.*	Joint Commissioning Manager, Learning Disabilities	**June 2015**
C2	Local amenities and transport			↑	Due to the 'green' rating, it is proposed that progress on this indicator is maintained. Group Manager, Learning Disabilities to ensure that there is continued engagement with transport and environmental services to improve facilities for PWLD, as part of the Fulfilling Lives programme.	*Extensive and equitably distributed examples of people with learning disability having access to reasonably adjusted local transport services, changing places and safe places, (or similar schemes), in public venues and evidence that such schemes are*	Group Manager, Learning Disabilities	**Ongoing, review in February 2016**

	Indicator	RAG 2012/13	RAG 2013/14	DoT	How we will maintain or improve performance	LD SAF 'Green' Target	Lead	Timescale
						communicated effectively.		
C3	Arts and culture			↑	Due to the 'green' rating, it is proposed that progress on this indicator is maintained. Continued engagement with Arts & Culture services to improve facilities for PWLD. The Learning Disability Partnership Board will review this progress in February 2016.	*Extensive and equitably distributed examples of people with learning disabilities having access to reasonably adjusted facilities and services that enable them to use amenities such as cinema, music venues, theatre, festivals and that the accessibility of such events and venues are communicated effectively.*	Group Manager Heritage, services	**Ongoing, review in February 2016**
C4	Sports and leisure			↔	Due to the 'green' rating, it is proposed that progress on this indicator is maintained. Continued engagement with Sports & Leisure services to improve facilities for PWLD. The Learning Disability Partnership Board will review this progress in February 2016.	*Extensive and equitably geographically distributed examples of people with learning disability having access to reasonably adjusted sports and leisure activities and venues for example use of local parks, leisure centres, swimming pools and walking groups.*	Group Manager Community Sport & Art	**Ongoing, review in February 2016**

	Indicator	RAG 2012/13	RAG 2013/14	DoT	How we will maintain or improve performance	LD SAF 'Green' Target	Lead	Timescale
						Designated participation facilitators with learning disability expertise are available. There is evidence that such facilities and services are communicated effectively.		
C5	Employment			↑	Due to the 'green' rating, it is proposed that progress on this indicator is maintained. The Group Manager, Learning Disabilities to review the LD innovation grant which focussed on Employment opportunities for PWLD and ensure that data continues to be recorded for PWLD in employment. The Joint Commissioning Manager for learning disabilities to explore opportunities for embedding employment opportunities within future LD service specifications.	*Clear published local strategy for supporting people with learning disabilities into paid employment.* *Relevant data is available and collected and shows the strategy is achieving its aims.*	Group Manager - Learning Disabilities Joint Commissioning Manager, Learning Disabilities	**Ongoing, review in February 2016**

	Indicator	RAG 2012/13	RAG 2013/14	DoT	How we will maintain or improve performance	LD SAF 'Green' Target	Lead	Timescale
C6	Preparing for adulthood			↑	Due to the 'green' rating, it is proposed that progress on this indicator is maintained. Partnerships to continue between Adults, Children, Health and Housing services to plan and meet the needs of young people with learning disabilities preparing for adulthood. Group Manager, Housing Strategy to develop the Vulnerable People's Housing Strategy, which includes people with learning disabilities. Regular updates to continue to be brought to the LDPB.	*There is a monitored strategy, service pathways and multi-agency involvement across education, health and social care. There is evidence of clear preparing for adulthood services or functions that have joint health and social care scrutiny and ownership across children and adult services.*	Group Manager – Intensive Support Group Manager Housing	**Ongoing, review in February 2016**
C7	Involvement in service planning and decision making			↑	Due to the 'green' rating, it is proposed that progress on this indicator is maintained. Joint Commissioning Manager to continue to work with providers to ensure that service users are involved in decision-making and shaping services. Commissioner to involve	*Clear evidence of co-production in universal services and learning disability services. The commissioners use this to inform commissioning practice.*	Joint Commissioning Manager, Learning Disabilities	**Ongoing, review in February 2016**

	Indicator	RAG 2012/13	RAG 2013/14	DoT	How we will maintain or improve performance	LD SAF 'Green' Target	Lead	Timescale
					service users and carers in tender exercises where appropriate.			
C8	Carer satisfaction rating. To be answered by family carers			↔	Implementation of the Carers' Strategy 2015 and changes to commissioned carers' services. LA and CCG and providers to ensure questionnaires, surveys reflects a satisfaction rating.	*Most carers are satisfied that their needs were being met.*	Integrated Commissioning Manager responsible for carers' services. Joint Commissioning Manager, Learning Disabilities	**March 2016**

7. Autism Self Assessment Framework

Background – Autism Self Assessment Framework (ASAF)

7.1 The Governments' first ever Adults Autism Strategy was launched in 2010. It detailed the duties of developments that the local authority and CCG should implement for Adults with Autism. These were:

- improved training of frontline professionals in autism;
- the recommendation to develop local autism teams;
- actions for better planning and commissioning of services, including involving people with autism and their parents/carers;
- actions for improving access to diagnosis and post-diagnostic support;
- leadership structures at national, regional and local levels for delivery;
- proposals for reviewing the strategy to make sure that it is working.

7.2 In 2014 the strategy was updated and reaffirms the importance of the previous duties of improving the lives of people with Autism. The duties have not changed greatly but they offer greater clarity based on service user and previous ASAF feedback on the local priorities of need. These are:

- increasing awareness and understanding of autism;
- developing clear, consistent pathways for the diagnosis of autism;
- improving access for adults with autism to services and support;
- helping adults with autism into work; and
- enabling local partners to develop relevant services.

7.3 This year's Autism Self Assessment was conducted in a questionnaire style and our submission was greatly facilitated by the work that has been undertaken to update the Adult Autism Strategy and the forthcoming Children's Autism Strategy. As Board Members will remember, the Adult Autism Strategy was presented at the Health and Wellbeing Board in December 2014 and the Children's Autism Strategy is due to be presented in summer 2015.

7.4 The Autism Self Assessment looked at the following areas:

- Planning
- Training
- Diagnosis
- Care and support
- Housing & accommodation
- Employment,
- The Criminal Justice system
- Advocacy
- Local good practice.

7.5 The collation of evidence for this autism assessment was jointly led by the Integrated Commissioning Manager and the Group Manager, Learning Disabilities. Both officers worked with stakeholders from across health and social care and the voluntary sector. The ASAF was agreed by Senior Officers and the Cabinet Member for Adult Social Care and Health in February 2015 and submitted on 9 March 2015.

7.6 Summary table of rating

Service Area	Indicator	RAG 2012/13	Proposed RAG 2014/15	DoT
Planning	Autism included in the local JSNA?			↑
Planning	Have you now started to collect data on those people referred to and/or accessing social care and/or health care and does your information system report data on people with a diagnosis of autism, including as a secondary condition.			↑
Planning	What data collection sources do you use?			↔
Planning	Is your local Clinical Commissioning Group or Clinical Commissioning Groups (including the support service) engaged in the planning and implementation of the strategy in your local area?			↔
Planning	How have you and your partners engaged people with autism and their carers in planning?			↔
Planning	Have reasonable adjustments been made to general council services to improve access and support for people with autism			↑
Planning	In your area have reasonable adjustments been promoted to enable people with autism to access public services?	New question no comparator		N/A
Planning	How do your transition processes from Children's services to Adult services take into account the particular needs of young people with autism?			↔

Service Area	Indicator	RAG 2012/13	Proposed RAG 2014/15	DoT
Planning	How does your planning take into account the particular needs of older people with autism?			↑
Training	Is autism awareness training being/been made available to all staff working in health and social care?			↑
Training	Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments?			↑
Diagnosis	Have you got an established local autism diagnostic pathway			↔
Diagnosis	Can people diagnosed with autism access post diagnostic specific or reasonably adjusted psychology assessments?	New question no comparator		N/A
Diagnosis	Can people diagnosed with autism access post diagnostic specific or reasonably adjusted speech and language therapy assessments?	New question no comparator		N/A
Care and Support	Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?			↔
Care and Support	Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an appropriately trained advocate?			↔

Service Area	Indicator	RAG 2012/13	Proposed RAG 2014/15	DoT
Care and Support	How would you assess the level of information about local support across the area being accessible to people with autism?			↔
Care and Support	Where appropriate are carers of people assessed as having autism and eligible for social care support offered assessments?	New question no comparator		N/A
Housing and accommodation	Does the local housing strategy specifically identify Autism?			↓(see7.7)
Employment	How have you promoted in your area the employment of people on the Autistic Spectrum?			↔
Employment	Do autism transition processes to adult services have an employment focus?			↔
Criminal Justice System	Are the Criminal Justice Services (police, probation and, if relevant, court services) engaged with you as key partners in planning for adults with autism?			↔

7.7 This year's Autism SAF asked "*Does the local housing strategy specifically identify Autism?)*. The current Housing strategy does identify Learning Disabilities but does not mention Autism specifically. A new Vulnerable People's Housing Strategy is being developed that will identify the needs of people with Autism in line with the Autism Strategy. This is being monitored through the Learning Disability Partnership Board.

7.8 Due to the fact that the Adult Autism Strategy and the upcoming Children's Autism Strategy reviews all of the areas which were detailed in the ASAF, it is felt that both Strategies will enable the Council and its' partners to provide improvements in the areas identified in the ASAF.

7.9 The Learning Disability Partnership Board will continue to monitor the implementation of the Adult Autism Strategy and receive feedback on the Children's Autism Strategy once it is presented to the Health and Wellbeing Board. A progress update on the implementation of the Strategy will be brought to the Health and Wellbeing Board in Autumn 2015.

8. Mandatory Implications

8.1 Joint Strategic Needs Assessment

This report is grounded on the most recent findings and recommendations of the JSNA.

8.2 Health and Wellbeing Strategy

The refreshed strategy and delivery plan cover the recommendations and points made in the review.

8.3 Integration

The LDSAF Action Plan, as well as the Adult and Children's Autism Strategies, have been developed in conjunction with partners. The actions within the LDSAF Action Plan and the Strategies will be delivered by the organisations identified within the Plan and monitored by the multi-agency Learning Disability Partnership Board.

8.4 Financial Implications

There are no additional financial implications directly arising from this report. A further report is to be presented in the Autumn on an action plan to develop Autism services. If additional resources are needed, this later report will need clearly to identify whether development of health or of local authority services is needed, and where offsetting services can be achieved.

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

8.5 Legal Implications

There are no legal implications.

Implications completed by: Dawn Pelle, Adult Care Lawyer, Legal and Democratic Services

9. Public Background Papers Used in the Preparation of the Report:

Adult Autism Strategy (presented to the Health and Wellbeing Board, December 2014)

10. List of Appendices:

None

HEALTH AND WELLBEING BOARD

12 MAY 2015

Title: Review of Governance Arrangements Of The Sub Structure Of The Health And Wellbeing Board	
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 and Cabinet Member for Adult Social Care and Health

Summary:

The Health and Wellbeing Board has now entered its third statutory year. As the 12 May meeting is the first meeting of this new year, it is timely to review the governance arrangements of the Board.

It is proposed that the sub-structure of the Health and Wellbeing Board remains broadly the same, with some changes to the focus and arrangement of the Integrated Care Sub-Group as set out below. The Health and Wellbeing Board is asked to review and agree these changes, as well as re-confirm the membership of each of the sub-groups of the Board.

Recommendation(s)

Members of the Board are recommended to:

- Discuss and agree the proposed changes to the Integrated Care Sub-Group as set out in the report below.
- Review and confirm the sub-group membership attached at Appendix 1.

Reason(s)

The Council has committed to the vision of 'One borough; one community; London's growth opportunity'. The Health and Wellbeing Board and its sub-structure supports the delivery of this vision and the three Council priorities:

- Encouraging civic pride
- Enabling social responsibility
- Growing the Borough

The Board's sub-structure also enables the delivery of the Health and Wellbeing Strategy and Outcomes Framework and each of the Board's sub-groups have been part of the consultation process on the 2015 version of the Strategy and outcomes. The Strategy will be discussed elsewhere on the agenda at the May 2015 meeting.

1. Introduction

1.1 Over the last two years, the Health and Wellbeing Board has developed its governance arrangements and sub-structure to meet the key priorities of the Board, as set out in the Health and Wellbeing Strategy.

1.2 Each of the groups meet regularly and have a membership which is reflective of the organisations that form the Health and Wellbeing Board, as well as other interested and appropriate parties.

1.3 The sub-groups report to each Health and Wellbeing Board meeting via a Sub-Group Report and escalate any issues to the Board as appropriate. The sub-groups have been defining their workplans over the last 18 – 24 months and are now regularly developing, inputting to and presenting substantive reports to the Board meetings.

1.4 As at May 2015, the focus and remit of each of the sub-groups included the following:

Executive Planning Group

1.5 This group consists of each of the chairs of the sub-groups and oversees performance review, agenda planning, business management and development activity for the Board.

1.6 The Executive Planning Group has proposed no changes to its terms of reference or focus of its activity for 2015/16.

Children & Maternity Sub-Group

1.7 This group focuses on the children's integration agenda, including maternity services. The group held a development session in July 2014 and selected 12 priorities for the sub-group, which are incorporated into the sub-group's workplan. The priorities, as recorded in the minutes of the February 2015 meeting, are:

- Improving Health outcomes for children with SEND
- Integrated Early years
  (to include maternity, breastfeeding, early years development, HV transition, immunisations. Currently separate priorities for children's health and Maternity board)
- Improving Health outcomes for Looked After Children, Care Leavers and Youth Offenders
- Childhood Obesity
- Children's Mental Health and Wellbeing
- Teenage pregnancy and Sexual Health
- Urgent care
  (with particular reference to reducing paediatric attendances at A&E)

1.8 The Children and Maternity sub-group has proposed no changes to its terms of reference or focus of its activity for 2015/16.

Public Health Programmes Board

1.9 The Public Health Programmes Board co-ordinates preventive activity, performance manages the public health elements of the Health & Wellbeing Strategy and co-ordinates exception reports to the Health and Wellbeing Board. The Health Protection Committee, Obesity Task and Finish Group and the Integrated Sexual Health & Reproductive Board also feed into the Public Health Programmes Board.

1.10 The Public Health Programmes Board has proposed no changes to its terms of reference or focus of its activity for 2015/16.

Learning Disability Partnership Board (LDPB)

1.11 The LDPB is a development of the previous Learning Disability Partnership Board and the Transitions Board, focusing on both children and adults. The LDPB oversees the delivery of the Winterbourne View concordat and the development of the commissioning and service delivery Section 75 agreements for learning disabilities. The group also oversee the delivery of the Autism Strategy and will be overseeing the delivery of the Learning Disability Self Assessment Framework (LDSAF) action plan, elsewhere on this Board's agenda. In the future the LDPB will also oversee the Independent Living Strategy which is currently under development.

1.12 The LDPB has three representative groups underneath it – a Service User Forum, a Provider Forum and a Carer Forum. These groups discuss and comment upon items that go to the LDPB, and escalate issues facing people with learning disabilities and autism to the Board. A representative from each of the representative groups sits on the LDPB and attends each of the meetings. There are two service user representatives on the LDPB.

1.13 The LDPB has proposed no changes to its terms of reference or focus of its activity for 2015/16. However, it is worth noting that it is provided with a specific role in relation to the operation of the Section 75 arrangements for commissioning LD services, which will centre on ensuring that the decisions made with respect to the agreement fit with wider borough strategy for these services.

Mental Health Sub-Group

1.14 The Mental Health Sub-Group leads on partnership work on IAPT, as well as emotional health and wellbeing promotion programmes and other mental health service developments. The sub-group are developing an overarching Mental Health Delivery Plan, which incorporates all recommended actions from previous mental health-related action plans into a single document.

1.15 Through monitoring the synthesised actions within the delivery plan, the mental health sub group will be able to ensure that mental health services for Barking and Dagenham residents are commissioned and provided to meet their needs. The Mental Health Delivery Plan will be discussed at the July Health and Wellbeing Board.

1.16 The Mental Health sub-group has proposed no changes to its terms of reference or focus of its activity for 2015/16.

Integrated Care Sub-Group

1.17 The Integrated Care Sub-Group shapes Barking & Dagenham's engagement with the Integrated Care Coalition, and programme-manages the practical implementation of improved integrated service delivery for older people and those with long-term conditions. Recently, the group have been responsible for coordinating and developing the Borough's Better Care Fund submission and scheme implementation.

1.18 It is proposed that the focus and arrangement of the group changes from May 2015 and this is set out in more detail below.

2. Proposed changes to the Integrated Care Sub-Group

2.1 As stated above, the objectives of the Integrated Care Sub-Group were originally to shape the Board's engagement with the BHR Integrated Care Coalition, as well as oversee the delivery of improved services for older people and adults with long-term conditions. However, the focus of the Sub-Group has shifted over the last 18 months to the Better Care Fund (BCF). This has included the development and finalisation of the BCF submission and overseeing the beginning stages of implementation of the eleven BCF schemes, including the Section 75 agreement governing the Fund.

2.2 The Joint Executive Management Group (JEMG) has now been established through the Section 75 agreement governing the Better Care Fund. It also has a reporting line to the Health & Wellbeing Board and it provides performance oversight of the Better Care Fund schemes and the pooled fund management arrangements. Running this group in shadow form through the latter half of 2014/15 has provided the opportunity to reflect on its relationship with the Integrated Care Sub-Group,

suggesting a clearer focus on the Sub-Group's original terms of reference, in essence the strategic oversight and development of integrated care services for older people and adults with long-term conditions in Barking and Dagenham.

2.3 From May 2015, it is proposed that the Integrated Care Sub-Group will be responsible for the following:

- **Shaping the deliverables of the eleven BCF schemes.** Where the JEMG identifies performance for the BCF that is slipping or is unacceptable, and that a wider review of the operation of a scheme is required, then the Integrated Care Sub-Group will explore the issues and shape improvements. The Sub-Group will also be responsible for wider input into the development and implementation of the BCF from residents and partners.

- **Develop, scope and shape integrated services and projects** for older people and adults with long term conditions. This will include working up the ideas from the Health and Wellbeing Board development session on 16 April 2015, and focusing on issues such as dementia (with the Mental Health sub-group), end of life care, diabetes, and carers.

- **Undertaking borough-based analysis, response and input into BHR-wide programmes and Boards.** As part of this, the Integrated Care Sub-Group will maintain links on behalf of the Health and Wellbeing Board with the Integrated Care Coalition, the System Resilience Group and the Primary Care Transformation Board.

2.4 It is envisaged that there would be a close relationship between the JEMG and the Integrated Care Sub-Group, and arrangements are being considered for having the Integrated Care Sub-Group as a direct follow-on from the meetings of JEMG to emphasise these links.

2.5 The Health and Wellbeing Board are asked to discuss the proposal above and agree the renewed focus for the Integrated Care Sub-Group.

3. Membership

3.1 The membership of each of the sub-groups, including the Integrated Care Sub-Group, from May 2015 can be found attached at Appendix 1. Members of the Health and Wellbeing Board are asked to review and confirm the membership arrangements of the sub-groups and make any amendments as required.

4. Mandatory Implications

4.1 Joint Strategic Needs Assessment

The priorities and governance arrangements have been informed by recent findings and recommendations of the JSNA.

4.2 Health and Wellbeing Strategy

The refreshed Health and Wellbeing Strategy priority areas are reflected in the governance arrangements. Priorities are aligned to the governance structure as set out in the in the Strategy, with deliverables aligned to the Sub Groups through the Health and Wellbeing Strategy Delivery Plan.

4.3 Integration

The sub-structure of the Health and Wellbeing Board is multi-agency, with each of the sub-groups consisting of members from across the representative organisations of the Health and Wellbeing Board. Each of the sub-groups are working to drive forward the integration agenda and deliver the priorities as set out in the Health and Wellbeing Strategy.

4.4 Financial Implications

There are no financial implications directly arising from the proposals contained in this report.

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

4.5 Legal Implications

There are no legal implications directly arising from the proposals contained in this report.

Implications completed by: Dawn Pelle - Adult Care Lawyer, Legal and Democratic Services

5. Public Background Papers Used in the Preparation of the Report:

None

6. List of Appendices:

Appendix 1: Sub-group membership

Health & Wellbeing Board

Executive Planning Group

Chaired by Anne Bristow, Corporate Director of Adult and Community Services
Membership includes chairs of each sub-group

Children & Maternity Group

Chair: Sharon Morrow, Chief Operating Officer (B&D CCG)

- Meena Kishinani, Divisional Director, Strategic Commissioning and Safeguarding, (LBBD)
- Jane Hargreaves, Divisional Director, Education, (LBBD)
- Glynis Rogers, Divisional Director, Commissioning and Partnerships, (LBBD)
- Marion Gibbon, Consultant in Public Health, (LBBD)
- Toby Kinder, Group Manager Early Intervention, (LBBD)
- Anne Graham, Divisional Director, Complex Needs and Social Care, (LBBD)
- Vikki Rix, Policy and Performance Manager, (LBBD)
- Dr R Burack, Clinical Lead, (B&D CCG)
- Gemma Hughes/Sarah D'Souza, Deputy Chief Operating Officer , (B&D CCG)
- Diane Jones, Deputy Nurse Director, (BHRUT)
- Gill Mills, Integrated Care Director, (NELFT)
- Wendy Matthews, Director, Midwifery, (BHRUT)
- Manisha Modhvadia, (Healthwatch)
- Carl Blackburn, (CVS)

Public Health Programmes Board

Chair: Matthew Cole, Director of Public Health, (LBBD)

- Meena Kishinani, Divisional Director, Strategic Commissioning and Safeguarding, (LBBD)
- Robin Payne, Divisional Director, Environment and Enforcement Services, (LBBD)
- Glynis Rogers, Divisional Director, Commissioning and Partnerships, (LBBD)
- Sharon Morrow, Chief Operating Officer, (B&D CCG)

Integrated Care Sub-Group

Chair: Sharon Morrow, Chief Operating Officer, (B&D CCG)

- Matthew Cole, Director of Public Health, (LBBD)
- Sarah D'Souza/Gemma Hughes, Deputy Chief Operating officer (B&D CCG)
- Dr Jagan John, Clinical Director (B&D CCG)
- Dr Ayo Ahonkhai, Clinical Lead for Care of the Elderly, (BHRUT)
- Lorraine Goldberg, (Healthwatch)
- Bruce Morris, Divisional Director, Adult Social Care, (LBBD)
- David Millen, Integrated Care Delivery Manager, (LBBD)
- Tudur Williams, Group Manager, Assessment and Care Planning, (LBBD)
- Gill Mills, Integrated Care Director, (NELFT)
- Linda Dinis, Assistant Director of Adult Services, (NELFT)
- Julie Myles, Integrated Community Services Manager, (NELFT)
- Asif Bachlani, Consultant Psychiatrist, (NELFT)
- Sangita Lall, Deputy Director Integrated Care (NELFT)
- Monga Mafu, Integrated Care Programme Manager (B&D CCG)

Learning Disability Partnership Board

Chair: Glynis Rogers, Divisional Director, Commissioning and Partnerships (LBBD)

- Karen West-Whylie, Group Manager, Learning Disabilities, (LBBD)
- Bill Brittain, Group Manager, Integrated Care Services, (LBBD)
- Baljeet Nagra, Group Manager, Children with Disabilities and SEN, (LBBD)
- Chris Bush, Commissioning and Projects Manager, (LBBD)
- Karen Slater, Cluster Manager, (LBBD)
- Karel Stevens-Lee, Commissioning Manager, (LBBD)
- *Kevin Sole, Assistant Director Mental Health Services, (NELFT)
- Jane Norris, Team Manager, (LBBD)
- *Monica Needs, Market Development Manager, (LBBD)
- *Heather Woolard, Safeguarding Lead and Named safeguarding Nurse, (BHRUT)
- Marie Kearns, (Healthwatch)
- Mitchell Gardner, (Service User Representative)
- Kim Millard, (Service User Representative)
- Tbc, (Carer Representative)
- Lorraine Goldberg, Provider Representative, (Carers of Barking and Dagenham)
- Tbc, Provider Representative
- Tbc, Provider Representative
- *Tbc, Public Health (LBBD)

Mental Health Sub-Group

Chair: Gill Mills, Integrated Care Director, (NELFT)

- Sarah D'Souza/Gemma Hughes, Deputy Chief Operating Officer (B&D CCG), (B&D CCG)
- Matthew Cole, Director of Public health (LBBD)
- Ann Graham, Divisional Director, Complex Needs and Social Care, (LBBD)
- Richard Vann, (Healthwatch)
- Magda Smith, Associate Medical Director, (BHRUT)
- Nicholas Hurst, (NELFT Public Governor)
- Chris Bush, Commissioning and Projects Manager, (LBBD)
- Baljeet Nagra, Group Manager, Children with Disabilities and SEN, (LBBD)
- Janet Zamornii, (Department of Works and Pensions)
- Lorraine Goldberg, (Carers' Centre)
- Louise Hider, Health and Social Care integration Manager, (LBBD)
- M ark Tyson, Group Manager, Integration and Commissioning (LBBD)
- Michael Fenn, Commissioning Manager, (LBBD)
- Olu Oye-Bamgbose, (NELFT)
- Srikumar Sivasubramaniam, (NELFT)
- Gary Learmonth, (Metropolitan Police)
- Lindsay Royan, (NELFT)
- Asif Bachlani, Associated Medical Director & Consultant Psychiatrist, (NELFT)
- Kevin Sole, Assistant Director Mental Health Services, (NELFT)
- Raj Kumar, (B&D CCG)
- Christine Brand, (Service User Rep)
- Anthony Maher, (Service User Rep)

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

12 MAY 2015

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 an update on the Systems Resilience Group meetings held on the 23 March and 20 April 2015.

It is clear that the Joint Assessment and Discharge (JAD) played a key part in our operational resilience delivery over the winter period through its support to improve the usage of acute beds in both minimising delays when people are ready to leave hospital, through early planning and intervention and in the deployment of support worker staff at the front end of the hospital to support admission avoidance. Discharges supported by the JAD are averaged at 100 people a week with positive use of services such as crisis response which are able to provide temporary support focused upon returning people home and optimising their independence and health, improving their experience of support, avoiding readmissions and where appropriate, planning time for how on-going needs might be best met. Over the winter period the JAD consistently exceeded its targets for avoidable admissions into acute care. Funding provided through operational resilience planning has enabled a level of activity that would otherwise be unsustainable for Social Care Budgets. With the cessation of operational resilience funding on the 31st March (end of winter planning period) activity has been scaled back, with the exception of agreement for short term funding carried forward to support the provision of two Social Workers at the front end of the hospital supporting the avoidance of unnecessary admissions and access to diversionary services and support.

Given both the demonstrable benefits of the JAD and the question of resources, and sustainability we have begun a review of the JAD service culminating in a workshop scheduled for the 3rd of June with key stakeholders. This review will enable partners to

consider areas such as:

- Roles and functions
- 7 day working
- Care Act discharge regulations
- Resources and activity levels and
- Future hosting arrangements.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

- Consider the updates and their impact on Barking and Dagenham and provide comments or feedback to Conor Burke, Accountable Officer to be passed on to the 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.

3 List of Appendices

System Resilience Group Briefings:

— Appendix 1: 23 March 2015

— Appendix2: 20 April 2015

This page is intentionally left blank

System Resilience Group (SRG) Briefing	Meeting dated – 23 March 2015
	Venue – 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	Areas/issues discussed
SRG dashboard:	Members were updated on the key areas from the dashboard report.
Trust improvement plan	Members received an update on the Trust Improvement Plan and were advised that the CQC report is due by end of May.
Programme Board update/scheme review:	Members received an update on the progress of the S1 and S2 schemes. Members were briefed on the plans in place for the Easter weekend.
Schemes requiring termination/mainstreaming recommendation	Members agreed the need for a review of the JAD service and this will be completed in conjunction with the discharge workshop with a recommendation coming to the June SRG. Community beds will be kept open until 30th April 2015.
Discharge and flow update	Further to the last SRG, members agreed to hold the discharge workshop post Easter.
Feedback from the Frailty workshop:	Members were advised that the recommendations from the Frailty workshop would be turned into an action which will be reported back to the March meeting following review at the Integrated Care Steering group.
London U&EC network footprint options appraisal	Members were asked to submit their comments and suggestions by the end of the week around the Urgent & Emergency Care networks.
RTT Improvement Plan:	Members received a brief update on the progress of the RTT Improvement Plan.
Cancer Improvement Plan:	Members received a brief update on the progress of the Cancer Improvement Plan.
Forward planner:	Members agreed to use the May SRG meeting as a planning for 15/16 workshop.
AOB:	None.
Next meeting:	Monday 20th April 2015 2pm – 4pm, Boardroom A, Becketts House Ilford IG1 2QX

This page is intentionally left blank

System Resilience Group (SRG) Briefing	Meeting dated – 20 April 2015
	Venue – Becketts House, Ilford
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	Areas/issues discussed
SRG dashboard:	Members were updated on the key areas from the dashboard report.
Workforce update:	Proposal to come to the June SRG meeting which sets out a strategic plan for workforce that members will need to consider / agree.
Planning for 2015/16:	Completion of the winter resilience review template to come to the SRG meeting in May for approval/sign off.
Scheme review by exception:	Members received an update on the schemes which are underperforming.
S1 and S2 schemes requiring mainstreaming recommendation:	Members were advised that the May SRG workshop will focus on planning for 15/16, including recommendations on mainstreaming of winter schemes.
Discharge and flow update:	Report to come to the May meeting on progress of the discharge workshop.
Frailty Workshop - action plan update:	Members received a brief update on the progress of the Frailty action plan.
RTT Improvement Plan:	Members received a brief update on the progress of the RTT Improvement Plan.
Cancer Improvement Plan:	Members received a brief update on the progress of the Cancer Improvement Plan.
AOB:	Members were advised the urgent care procurement process will re-launch. It was agreed to extend the workshop on 18 May.
Next meeting:	Monday 18 May 2015 2pm – 5pm, Boardroom A, Becketts House Ilford IG1 2QX

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

12 MAY 2015

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: • Note the contents of sub-group reports set out in the appendices and comment on the items that have been escalated to the Board by the sub-groups.	

List of Appendices

- Appendix 1: Mental Health Sub-Group
- Appendix 2: Learning Disability Partnership Board
- Appendix 3: Integrated Care Sub-Group
- Appendix 4: Public Health Programmes Board
- Appendix 5: Children and Maternity Sub-Group

This page is intentionally left blank

Mental Health Sub-Group

Chair: Gillian Mills, Integrated Care Director (Barking and Dagenham), NELFT

Items to be escalated to the Health & Wellbeing Board

(a) None to note.

Performance

Meeting Attendance

40%

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

(a) Final version of the Mental Health Needs Assessment (MHNA) presented by Public Health Consultant and discussion regarding the 12 recommendations contained within the document
(b) Development of the Draft Mental Health Strategic Delivery Plan presented detailing the synthesised actions from the Closing the Gap; Crisis Care Concordat; Scrutiny Review; and reports. The framework of the Delivery Plan is structured on the 12 MHNA recommendations. Discussion regarding an update paper to a future Health and Wellbeing Board
(c) Draft Joint Health and Wellbeing Strategy and Delivery Plan refresh considered and noted that this will inform future performance reporting.
(d) Update received regarding the North East London Recovery College. Discussion about how this would link with B&D ambition to develop Peer Support as part of the recovery pathway

Action and Priorities for the coming period

1. Visit by sub group members to Lambeth to observe how Peer Support operates there.
2. Presenting the Mental Health Needs Assessment with the Children and Maternity sub group and the Integrated Care sub group, to ensure recommended actions relating to children and young people and in relation to mental health out of hospital are taken forward by these groups.

Contact:

Julie Allen, PA to Integrated Care Director (NELFT)

Tel: 0300 555 1201 ext 65067; **E-mail:** Julie.allen@nelft.nhs.uk

This page is intentionally left blank

APPENDIX 2

Learning Disability Partnership Board

Chair: Glynis Rogers, Divisional Director Partnerships and Public Protection

Items to be escalated to the Health & Wellbeing Board

(a) None

Performance:

There are no issues with performance of the board other than the issues noted below in attendance.

Meeting Attendance

Meeting attendance in March 2015 has continued to be problematic in some areas and this is being actively followed up by a letter from the Chair; last meeting attendance was 45%.

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

(a) The LDPB received feedback from all of the forums.

(b) A report was received regarding the contractual plans for advocacy services and future service development.

(c) Discussed the continuing work to agree the S.75 arrangement for learning disability services.

(d) The LDPB agreed the action plan for the autism strategy and noted the indicators for the first quarters delivery

(e) Agreed with housing how the development for the independent living strategy will be managed to ensure the needs of service users and carers are considered and incorporated into future plans.

Action and Priorities for the coming period

(a) End of Life Care for people with learning disabilities

(b) Recruit a new representative from the Provider forum to the Learning Disability Partnership board; three people have expressed an interest and elections from providers are under way.

(c) Commissioning intentions for LD.

(d) Qtr 4 performance

Contact: Karen West-Whylie – GM Learning Disabilities

Tel: 020 8 724 2791; **Email:** karen.west-whylie@lbbd.gov.uk

This page is intentionally left blank

APPENDIX 3

Integrated Care Sub-Group

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

Meeting Attendance

23 March 2015: 21% (4 out of 19)

Performance

The Better Care Fund programme update to provide assurance on programme delivery of all work streams and enablers.

Milestones update in March:

- Mental Health Outside Hospital –
  The Richmond fellowship contract has been extended.
  MH Social workers initiative evaluation is still to be agreed.
- Integrated Care Commissioning –
  Section 75 agreement is being finalised for sign off.
  13 April 2015 JEMC meeting held in shadow state.
- End of Life Care –
  Commissioning options report is being drafted.
- Dementia Support –
  LBBD to link with Public Health and CCG to update Dementia Action Plan and progress actions. Improvement in dementia diagnosis rate noted.

Metrics update in March:

- Non Elective Admissions –
  Q3 data shows increase in MAR data of Admission. SUS data show only a small increase in admissions. Sub-group has requested a Deep Dive into the data to understand the causes and areas of admission pressure.
- Admission in Residential/Nursing care –
  Admissions from August to November have been performing well below the 10 admissions per month. However from December the number went up to 14.
- Delayed Transfers Of Care –
  DTOC rate in January has gone slightly down to 188.
  Social care attributed delays are larger this month compared to December.
  Most of the delays were due to patients awaiting residential home placements
  Performance continues to be lower that the England average DTOC of 280.
- No data to report on other the 2 Metrics(Reablement & Patient survey)

Risks:

- Non Elective Admissions performance at Q3 will form the benchmark for yr2 BCF performance.

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

- The previous two meetings of the Integrated Care Sub Group (January and February 2015) were cancelled.
- The Group received a report on the outcome of the Long Term Condition Team consultation.
- The Group reviewed and commented on the admissions data dashboard and risk update reports.
- The Group received a report on the progress of the Dementia Action Plan.

- The Group received a report and discussed further development of the Prevention Strategy and to recognise district nursing, social workers and the LTC team resources.
- The Group noted the Carers Strategy previously endorsed by the HWBB on 17 March 2015
- The Group noted the Care Act report previously presented to the HWBB on 17 March 2015
- The Group reviewed and discussed the BCF dashboard and risk register.

Action and Priorities for the coming period

- A deep dive into non-elective admissions data will be undertaken to understand the causes and areas of admission pressure.
- LBBD to link with Public Health and CCG to update Dementia Action Plan and progress actions.
- Co-ordinate work with GP practices as part of the Carers Strategy action plan to identify carers.
- Further work required linking the Care Act to the Better Care Fund.
- Invite Alzheimer's Society to deliver a Dementia Friends Session at the next meeting.

Items to be escalated to the Health & Wellbeing Board

None

Contact: Eileen Williams, Project Support, Barking and Dagenham CCG
Tel: 0203 644 2383 Email: eileen.williams@barkingdagenhamccg.nhs.uk

Public Health Programmes Board

Chair: Matthew Cole Director of Public Health

Items to be escalated to the Health & Wellbeing Board

None

Performance

Integrated Sexual Health and Reproductive Board meeting on 24/04/2015 cancelled due to apologies

Public Health Programmes Board – 11/03/2015 was cancelled due to apologies

Health Protection Committee met on 10/04/2015

Meeting Attendance

Attendance at the meetings is continuing to be difficult.

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

(a) **Update on Ebola:** Numbers are going down in December we were reporting 500 cases per week in affected countries now only 20-40 new cases have been reported

(b) **Immunisation:** Immunisation data for B&D is good and is incorporated into the Q4 Board Performance report. NHS England recovery plan being pull together.

(c) **Scarlett Fever:** There is a national problem with scarlet fever

(d) **Good News Stories:** Care Homes etc improving on infections

(e) **Mosquitoes:** Discussion took place around mosquitoes on the Thames View Estate raised by Cllr. Turner. Action plan in place

Action and Priorities for the coming period

Contact: Pauline Corsan

Tel: 0208 227 3953 ; **Email:** pauline.corsan@lbbd.gov.uk

This page is intentionally left blank

APPENDIX 5

Children and Maternity Group

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

Performance
As per HWB performance indicators for CMG
New indicators based on Delivery Plan under development

Meeting Attendance

10th March 2015 – 66% (10 out of 15)

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

- Issues identified around timing of Looked After Children assessments for further work by Joint Children's Commissioner with colleagues in health and social care to address.
- Sub-Group members reviewed and commented on draft HWB delivery plan and related sub-group indicators by 1st May.
- Special Educational Needs and Disabilities strategy considered with pathways and criteria from panel to be circulated to group for any further comments.
- Updated safeguarding/LAC arrangements were circulated to members of the sub-group for information.
- Healthwatch to consider CMG priority areas in developing their plan for 15/16.
- Integrated early years model to be developed for review at future meeting
- Sexual Health Board report presented to group in particular in respect of teenage pregnancy work and young people's sexual health issues.

Action and Priorities for the coming period

- Develop early years model
- Consider children's mental health priorities in light of MHNA
- Review Infant feeding Strategy
- Feed into HWB Delivery Plan development
- Feed into Obesity Summit
- Work with Healthwatch to develop annual plan

Items to be escalated to the Health & Wellbeing Board

None

Contact: bdccg@barkingdagenhamccg.nhs.uk

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

12 MAY 2015

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.	

This page is intentionally left blank

Chair's Report

12 May 2015

In this edition of my Chair's Report, I talk about our recent Health and Wellbeing board development session and provide updates on the Independent Living Fund and the Care Act.
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

Health and Wellbeing Board Development Session

The Health and Wellbeing Board held a development afternoon on Thursday 16 April with the theme 'Making Integration Real'. The session was well attended by Board members, partners, sub-group members and colleagues and lots of positive feedback was received.

Attendees welcomed two very special guest speakers. Anna Carlbom, Medical Officer Nurse/Esther Coordinator from Sweden talked about an innovative integration model called the 'Esther Project'. Cathy Williams, Interim Chief Operating Officer from Torbay and Southern Devon Health and Care Trust also attended and talked about integration between the PCT and Adult Social Care Services. More information about the two models can be found by visiting:

http://www.ihi.org/resources/Pages/ImprovementStories/ImprovingPatientFlowTheEstherProjectinSweden.aspx

http://www.torbaycaretrust.nhs.uk/aboutus/Pages/TheTorbayModel-MrsSmith.aspx

A question and answer session took place with Cathy and Anna, giving attendees the chance to ask more specific questions. After a short break, the second half of the Development Session focused on the Better Care Fund and taking forward integration in Barking and Dagenham. This part of the agenda was introduced by a presentation from Glynis Rogers and Sharon Morrow on the Better Care Fund. Two community matrons, a social worker and a GP gave presentations focusing on their experiences of integrated care.

The afternoon concluded with attendees taking part in workshops on tables. Each table was asked to consider the following:

- What would be the local integrated care experience for Esther and Mrs Smith?
- What are the top 5 principles that we must apply to all new service delivery.
- Outline one proposal capable of being implemented during the next 12 – 18 months that would make a real difference.

The workshops encouraged some good discussions and lively debate which were fed back to the wider group at the end of the day. The Integrated Care Sub-Group will now consider how the proposals from the workshops will now be taken forward.

Abbey Leisure Centre's set to #makeachange!

There's something for everyone at the new Abbey Leisure Centre, for fitness, fun and relaxation. The Abbey luxury spa, pool, gym and The Idol soft play installation have all been receiving plaudits.

You can find out more at www.lbbd.gov.uk/leisure and http://www.theabbeyspa.co.uk/. There are prizes every month for the best #makeachange pledges on twitter and facebook. Don't forget the hashtag!

Care Act Update

We have reached our critical milestone for Care Act implementation. The Care Act 2014 is now operational and has been since 01 April 2015.This marks an important period of adapting to new ways of working and meeting our new legal obligations. It will take time to embed changes and we will be developing and further refining our practice in 2015/16. We are looking ahead to the changes that will be introduced from April 2016 and making plans to implement the funding reforms and appeals system. The H&WBB can expect further reports.

Quick Cards

Care Act QuickCards have been developed to help practitioners keep at the front of their minds the new requirements and changes to policy and practice. The QuickCards follow the adult social care customer journey in line with the pathway from initial contact to determination of eligibility. They cover key parts of the Act and provide prompts and reminders about the detail of the Statutory Guidance, as well as relevant parts of local policies and procedures that must be considered. The QuickCards are not a substitute for the Care Act or for the Care and Support Statutory Guidance but practitioners should find them to be a useful resource and point of reference as we adjust to new arrangements. Hardcopies of the QuickCards have been distributed to relevant teams and staff; to get hold of a copy, please contact: glen.oldfield@lbbd.gov.uk.

Care & Support Hub

The Care and Support Hub has been updated with a number of new features/functions following feedback from service users, providers and staff to make the Hub more user friendly, as well as Care Act compliant. These include:

- Addition of "shortlist" and "print page" functions to every advice and guidance page, enabling you to tailor information and either email or print it. This will automatically produce a customised PDF with our logo and date.
- Step-by-step guide to getting care and support locally – this had been added as a link in the welcome section of the homepage; it includes key definitions and a link to the Think Local Act Personal jargon buster
- Addition of an "Is this information correct?" button – please use this to tell us when information is incorrect
- Google translate – we have signed up to this free translation service and this is now embedded into all web pages
- Information has been added about looking for independent financial advice, people who pay for their own care (known as self funders) and deferred payment agreements

Please promote the hub as the definitive source of information about local care and support services and contact Glen Oldfield if you feel there should be any amendments/additions.

Independent Living Fund (ILF)

The Independent Living Fund was set up in 1988 to fund support for disabled people with high support needs, enabling them to live in the community rather than move into residential care. It provides support to 19,000 disabled people with the highest levels of need at a cost of about £320 million. The money is generally used to enable people to live in their own homes and to pay for care, and to employ personal assistants. Many of the beneficiaries would otherwise have to move to residential care homes.

In December 2010 the Government announced the closure of the Fund to new applicants. This will come into effect on 30 July 2015. Local Authorities will receive the funding for the remainder of the financial year 2015/16. This will be paid shortly after the closure of the ILF in one payment. Barking and Dagenham is expecting to receive a total amount of about £400,000.The funding for the following financial year 2016/17 isn't secure and will be decided by central government at a later stage.

In total there are 38 recipients of ILF funding in Barking and Dagenham. On average an ILF recipient in Barking and Dagenham receives a weekly budget of £263 per week. Payments are in addition to the services ILF users are receiving from the Local Authority. A review of all 38 cases is currently in progress. During this process service users will continue to receive the same level of funding. Arrangements are in hand to make payments to the 38 ex- ILF registrants utilising the current direct payment system.

Local Authority Self-Assessment: Transfer of 0-5 Public Health Commissioning responsibilities

To support the transfer of 0-5 commissioning responsibilities, the Local Government Association (LGA) has set up nine Regional Oversight Groups (ROG) to maintain local oversight of the transfer, broker sector led support, and raise issues nationally. They are led by local government representatives and include members from the Public Health England Centre, NHS England and LGA. The local government leads will play a key role in working with the rest of the group to agree a joint and fair assessment of councils' progress, key issues remaining and matching support needs with areas who have already found a solution. The ROGs will provide a progress report to the LGA who will summarise this in to a regional and national progress report which will help national partners to resolve outstanding issues and identify what further support and information is needed at local level.

We have completed and returned the self-assessment exercise, which provided rich information on our progress as well as national oversight. The Borough still has concerns that 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 include:

- 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.
- 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.

North East London Strategic Alliance (NELSA)

The North East London Strategic Alliance (NELSA) is made up of eight North East London Boroughs, including Barking and Dagenham. NELSA have set out their demands for devolution to support improvements for residents and recognise the region's role at the heart of the Capital's economic growth. This is set out in Local London - Driving growth through devolution (PDF) which details how devolution could work.

Leaders and Mayors from Barking and Dagenham, Enfield, Greenwich, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest have taken the first step towards presenting a case for greater devolution of powers from central government and London regional government.

The vision sets out a new approach to decision-making and service delivery to unlock the potential of the boroughs. It follows a successful conference held last month, which saw the boroughs coming to a broad agreement about the need for a new settlement. Some of these new powers set out on a sub-regional level could include:

- A pooled budget for adult skills to give borough partnerships a formal role in information sharing, planning and decision making for this area.
- Budget holding and commissioning for employment services. This would enable councils to tie into existing activity to tackle barriers and causes of unemployment.
- Removing restrictions on borrowing related to housing to enable councils to build more homes.
- A stronger role in transport planning and control over local bus routes.

On a borough level:

- A strengthened role in town centre planning and regulation
- Power to intervene in any schools which are coasting or failing
- Greater powers over incentives and penalties for local businesses. This would help tackle the proliferation of hot food takeaways and cheap, easily accessible alcohol.
- Local authority licensing regimes such as Newham and Waltham Forest Councils' respective private sector licensing schemes.

Further updates will be provided to the Health and Wellbeing Board as the devolution plans progress.

Chair's Report

12 May 2015

News from NHS England

New plans for Mental Health Care

NHS England has welcomed plans for a radical shake up of youth mental health care. Care and Support Minister Mr Lamb has stated that children and young people's mental health services need a complete overhaul to stop vulnerable young people missing out on vital support.

Following an in-depth look at mental health and wellbeing support for children and young people, the Government has set out a blue-print for improving care over the next five years. Tailored support to match the needs of individual children and young people; easier access to care; and better support for families are some of the proposals outlined in a wide ranging report, commissioned by the Government last year.

The Government has also announced a £1.25 billion funding boost for young people's mental health care, including new access and waiting time standards for children's services and plans to make specialist talking therapies available in every area of the country – plans which align with key proposals in the report.

National Review of Maternity Care

NHS England announced details of a major review of the commissioning of NHS maternity services, as promised in the NHS Five Year Forward View. The review will assess current maternity care provision and consider how services should be developed to meet the changing needs of women and babies.

Recent advances in maternity care, changes in the demographics of women having babies, and preferences of where they want to give birth will form a key focus. Terms of reference for the review, state that it will:

- review the UK and international evidence and make recommendations on safe and efficient models of maternity services, including midwife-led units;
- ensure that the NHS supports and enables women to make safe and appropriate choices of maternity care for them and their babies; and
- support NHS staff including midwives to provide responsive care.

Child Sexual Exploitation Awareness Day

The first National Child Sexual Exploitation (CSE) Awareness Day was held in March and was dedicated to raising awareness of this difficult and emotive agenda across all agencies.

Everyone who works in health and care has a significant contribution to make in identifying children and young people at risk of sexual exploitation and supporting the treatment and recovery of those harmed. It is often nurses and other health and care professionals who are in a position to identify those children and young people most at risk.

It is vital as nurses, midwives and health staff that we continue to listen to the voice of children and young people in order to learn from their experiences and improve the services we provide. Their voice is crucial in identifying those at risk of sexual exploitation and stopping this form of abuse.

Health and Wellbeing Board Meeting Dates

Tuesday 7 July 2015, Tuesday 8 September 2015, Tuesday 20 October 2015, Tuesday 8 December 2015, Tuesday 26 January 2016, Tuesday 8 March 2016, Tuesday 26 April 2016, Tuesday 14 June 2016.

All meetings start at 6pm and are held in the conference room of the Barking Learning Centre.

Make a Change - Turning the Tide on Obesity in Barking & Dagenham

A conference is being held on Monday 18th May, 1 – 4.30pm, in the Conference Room at Barking Learning Centre. To book a place contact Christine Reardon on 020 8227 3952 or Christine.reardon@lbbd.gov.uk.

HEALTH AND WELLBEING BOARD

12 May 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:

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.

Attached at **Appendix A** is the Draft July 2015 issue of the Forward Plan for the Health and Wellbeing Board at the time of this agenda's publication.

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 8 June 2015. Any changes or additions to the next issue should be provided before 6.00p.m, on 3 June.

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

List of Appendices
Appendix A – Draft Forward Plan

This page is intentionally left blank

HEALTH and WELLBEING BOARD
FORWARD PLAN

July 2015 Issue

Publication Date: 1 May 2015 (DRAFT July Issue)

THE FORWARD PLAN

Explanatory note:

Key decisions in respect of health-related matters are made by the Health and Wellbeing Board. Key decisions in respect of other Council activities are made by the Council's Cabinet (the main executive decision-making body) or the Assembly (full Council) and can be viewed on the Council's website at http://moderngov.barking-dagenham.gov.uk/mgListPlans.aspx?RPId=180&RD=0. In accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 the full membership of the Health and Wellbeing Board is listed in Appendix 1.

Key Decisions

By law, councils have to publish a document detailing "Key Decisions" that are to be taken by the Cabinet or other committees / persons / bodies that have executive functions. The document, known as the Forward Plan, is required to be published 28 days before the date that the decisions are to be made. Key decisions are defined as:

(i) Those that form the Council's budgetary and policy framework (this is explained in more detail in the Council's Constitution)
(ii) Those that involve 'significant' spending or savings
(iii) Those that have a significant effect on the community

In relation to (ii) above, Barking and Dagenham's definition of 'significant' is spending or savings of £200,000 or more that is not already provided for in the Council's Budget (the setting of the Budget is itself a Key Decision).
In relation to (iii) above, Barking and Dagenham has also extended this definition so that it relates to any decision that is likely to have a significant impact on one or more ward (the legislation refers to this aspect only being relevant where the impact is likely to be on two or more wards).

As part of the Council's commitment to open government it has extended the scope of this document so that it includes all known issues, not just "Key Decisions", that are due to be considered by the decision-making body as far ahead as possible.

Information included in the Forward Plan

In relation to each decision, the Forward Plan includes as much information as is available when it is published, including:

- the matter in respect of which the decision is to be made;
- the decision-making body (Barking and Dagenham does not delegate the taking of key decisions to individual Members or officers)
- the date when the decision is due to be made;

Publicity in connection with Key decisions

Subject to any prohibition or restriction on their disclosure, the documents referred to in relation to each Key Decision are available to the public. Each entry in the Plan gives details of the main officer to contact if you would like some further information on the item. If you would like to view any of the documents listed you should contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@lbbd.gov.uk.

The agendas and reports for the decision-making bodies and other Council meetings open to the public will normally be published at least five clear working days before the meeting. For details about Council meetings and to view the agenda papers go to http://moderngov.barking-dagenham.gov.uk/ieDocHome.asp?Categories and select the committee and meeting that you are interested in.

The Health and Wellbeing Board's Forward Plan will be published on or before the following dates during the 2014 / 2015 Council year, in accordance with the statutory 28-day publication period:

Edition	Publication date
July 2015 edition	8 June 2015
September 2015 edition	11 August 2015
October 2015 edition	21 September 2015
December 2015 edition	10 November 2015
January 2016 edition	29 December 2015
March 2016 edition	9 February 2016
April 2016 edition	29 March 2016
June 2016 edition	17 May 2016

Confidential or Exempt Information

Whilst the majority of the Health and Wellbeing Board's business will be open to the public and media organisations to attend, there will inevitably be some business to be considered that contains, for example, confidential, commercially sensitive or personal information.

This is formal notice under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 that part of the meetings listed in this Forward Plan may be held in private because the agenda and reports for the meeting will contain exempt information under Part 1 of Schedule 12A to the Local Government Act 1972 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it. Representations may be made to the Council about why a particular decision should be open to the public. Any such representations should be made to Alan Dawson, Democratic Services Manager, Civic Centre, Dagenham, Essex RM10 7BN (telephone: 020 8227 2348, email: committees@lbbd.gov.uk).

Key to the table

Column 1 shows the projected date when the decision will be taken and who will be taking it. However, an item shown on the Forward Plan may, for a variety of reasons, be deferred or delayed.

It is suggested, therefore, that anyone with an interest in a particular item, especially if he/she wishes to attend the meeting at which the item is scheduled to be considered, should check within 7 days of the meeting that the item is included on the agenda for that meeting, either by going to http://moderngov.barking-dagenham.gov.uk/ieListMeetings.aspx?CId=669&Year=0 or by contacting contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@lbbd.gov.uk .

Column 2 sets out the title of the report or subject matter and the nature of the decision being sought. For 'key decision' items the title is shown in **bold type** - for all other items the title is shown in normal type. Column 2 also lists the ward(s) in the Borough that the issue relates to.

Column 3 shows whether the issue is expected to be considered in the open part of the meeting or whether it may, in whole or in part, be considered in private and, if so, the reason(s) why.

Column 4 gives the details of the lead officer and / or Board Member who is the sponsor for that item.

Decision taker/ Projected Date	Subject Matter Nature of Decision	Open / Private (and reason if all / part is private)	Sponsor and Lead officer / report author
Health and Wellbeing Board: 7.7.15	Annual Health Protection Profile *[Annual Item]* 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. • 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: 7.7.15	**Children's Autism Strategic Plan** : Community 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. • 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: 7.7.15	**Primary Care Transformation Programme - Update** The Board will be presented with an update on the Primary Care Transformation Programme in Barking, Havering and Redbridge (BHRUT). • Wards Directly Affected: All Wards	Open	Conor Burke, Chief Officer (Tel: 020 8926 5238) (conor.burke@onel.nhs.uk)
Health and Wellbeing Board: 7.7.15	Barking and Dagenham Child Death Overview Panel (CDOP) Annual Report The CDOP Annual report will be presented to the H&WBB for information. • 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: 7.7.15	Substance Misuse in Barking and Dagenham The Board will be provided with an information report to highlight the current situation regarding the misuse of illegal drugs, prescribed and over the counter medication. • Wards Directly Affected: All Wards	Open	Glynis Rogers, Divisional Director, Community and Partnerships (Tel: 020 8227 2827) (glynis.rogers@lbbd.gov.uk)
Health and Wellbeing Board: 7.7.15	Mental Health Delivery Plan The Mental Health sub group developed an overarching Mental Health Delivery Plan, which incorporated all recommended actions from previous action plans into a single document. Through monitoring that the synthesised actions within the delivery plan are being taken forward, the mental health sub group will be able to ensure the mental health services for Barking and Dagenham residents are commissioned and provided to meet their needs. The Board will receive an overview of the delivery plan and the monitoring of the delivery of key actions. • Wards Directly Affected: All Wards	Open	Gillian Mills, Integrated Care Director (Barking and Dagenham), Jacqui Van Rossum, Execuitve Director Integrated Care (London) and Transformation) (Tel: 0300 555 1201), (Tel: 0300 555 1047) (gillian.mills@nelft.nhs.uk), (jacqui.vanrossum@nelft.nhs.uk)
Health and Wellbeing Board: 7.7.15	**Crisis Care Concordat - Action Plan** : Community The Board is required to review and approve the Crisis Care Concordat Action Plan. The Action Plan is based on national policy to improve the way in which people experiencing mental health crisis are supported before during and after the crisis. It has been developed with the Mental Health Sub–Group of the Health and Wellbeing Board, which includes providers, commissioners and service user representatives. • Wards Directly Affected: All Wards	Open	Sharon Morrow, Chief Operating Officer (Tel: 020 3644 2378) (Sharon.Morrow@barkingdagenhamccg.nhs.uk)

Health and Wellbeing Board: 8.9.15	Complaints Report The Board will be presented with the health and wellbeing complaints report, including lessons learnt. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)

APPENDIX 1

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)
Dr Nadeem Moghal, Medical Director (Barking Havering and Redbridge University Hospitals NHS Trust)
Chief Superintendant Sultan Taylor, Borough Commander (Metropolitan Police)
John Atherton, Head of Assurance (NHS England) (non-voting Board Member)