London Borough of Barking & Dagenham
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Notice of Meeting

HEALTH & WELLBEING BOARD

Tuesday, 8 September 2015 - 6:00 pm
Conference Room, Barking Learning Centre, 2 Town Square, Barking, IG11 7NB

Date of publication: 28 August 2015

Chris Naylor
Chief Executive

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Membership

Cllr Maureen Worby (Chair)	(LBBD) Cabinet Member for Adult Social Care and Health
Dr W Mohi (Deputy Chair)	(Barking & Dagenham Clinical Commissioning Group)
Cllr Laila Butt	(LBBD) Cabinet Member for Crime and Enforcement
Cllr Evelyn Carpenter	(LBBD) Cabinet Member for Education and Schools
Cllr Bill Turner	(LBBD) Cabinet Member for Children's 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 7 July 2015 (Pages 3 - 15)

BUSINESS ITEMS

4. Joint Strategic Needs Assessment 2015 - Key Recommendations (Pages 17 - 41)

5. Improving Post - Acute Stroke Care (Stroke Rehabilitation) - the Case for Change (Pages 43 - 97)

6. Urgent and Emergency Care and Vanguard Application (Pages 99 - 120)

7. Review of the Joint Assessment and Discharge (JAD) Service (Pages 121 - 127)

8. Contract - Waiver for Integrated Sexual Health and Chlamydia Screening Coordination Services (Pages 129 - 141)

9. The Care Act 2014: Cap on Care Costs Deferred Until 2020 (Pages 143 - 148)

STANDING ITEMS

10. Systems Resilience Group - Update (Pages 149 - 153)

11. Sub-Group Reports (Pages 155 - 163)

12. Chair's Report (Pages 165 - 170)

13. Forward Plan (Pages 171 - 181)

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

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Our Vision for Barking and Dagenham

One borough; one community; London's growth opportunity

Encouraging civic pride

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

Enabling social responsibility

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

Growing the borough

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

MINUTES OF
HEALTH AND WELLBEING BOARD

Tuesday, 7 July 2015
(6:00 - 8:32 pm)

Present: Cllr Maureen Worby (Chair), Dr Waseem Mohi (Deputy Chair), Anne Bristow, Dr Nadeem Moghal, Chief Superintendant Sultan Taylor, Conor Burke, Cllr Laila Butt, Cllr Evelyn Carpenter, Matthew Cole, Helen Jenner, Cllr Bill Turner, Sharon Morrow, Marie Kearns and Gillian Mills

Also Present: Cllr Eileen Keller

Apologies: John Atherton, Frances Carroll, Dr John and Jacqui Van Rossum

1. Minutes - 12 May 2015

The minutes of the meeting held on 12 May were confirmed as correct.

The Chair advised that she would arrange for the London Ambulance Service (LAS) to be contacted with the hope that they could attend the next meeting of the Board.

2. Declaration of Members' Interests

There were no declarations of interest.

3. Developing a Mental Health Strategy

Mark Tyson, Group Manager Integration and Commissioning, LBBD, introduced the report and explained that it provided both an overview of the current situation and tied together the following two agenda items. There was also widespread national concern about the attention given to mental health services relative to physical health.

Mark advised that the Mental Health Sub- Group had been working to bring together a number of developments around mental health services including prevention, awareness and access to support. In addition, the Council had initiated a process for reviewing the model of delivery of mental health social care services in part as a response to a significant overspend by NELFT in the delivery of those services. The Better Care Fund Joint Executive was also seeking to initiate a review of services in regards to its Mental Health Outside Hospital Scheme as a way of informing future commissioning. In view of this and the challenging financial position of health and social care services, it had become obvious that a clearer strategy across the partners for the development of mental health support was needed. It was intended that Partners work together during August to address the challenges and on the report and paper attached; which was designed to start the discussion about the areas covered. Mark drew the Board's attention to the draft framework, set out on page 28 of the agenda, and the workshops that would be held during August, to look at the issues in more depth through the themes of 'my life', 'my home / community' and 'my care' and possibly commissioning.

The Board raised a number of issues, including:

- The £500,000 NELFT overspend and the discussions being held with NELFT on how this could be managed.

- The difficulties in obtaining accurate data on to the number of individuals being treated and by which services.

- The difficulties in getting people to come forward for support and treatment.

- The importance of putting the service user at the centre of all services and how this must be a core driver for the strategy. The impact on other people within service user's household also needed to be considered by the Partners. The Mental Health Sub-Group had service user involvement and these issues would be discussed there in more detail.

- The Borough currently had some service provision through the Richmond Fellowship contract. There was still a need for more mother and baby patient places.

- The number of suicides in the Borough was small so it was hard to detect trends.

- It was suggested that GP mental health training should be one of the issues considered in the Strategy. Cllr Keller, Chair of Health and Adult Services Select Committee, advised that the Scrutiny Panel on Mental Health had also identified the training of doctors as an issue.

- Mental health and physical health, were often intertwined and resultant from one another.

- A significant number of calls attended by the Police involved mental health issues and officers could attend the same person on a regular basis. The local custody facilities were now excellent and the Police often took people into custody as a place of safety. The Police felt that it was important that the right mental health support services were available and provided promptly, especially with less acute needs as this could avoid more severe symptoms developing, which could then lead to individuals needing to be taken to a place of safety.

- The timeframe required to produce the Strategy.

The Board:

(i) Noted the proposed approach to strategy development outlined in the report, which would conclude with the Mental Health Sub-group being tasked with the development of a partnership mental health strategy for consideration by partners and the Board;

(ii) Encouraged the participation of member organisations and partners in the summer strategy development sessions, and in particular to encourage an

open and creative engagement with the challenge of rethinking mental health services in line with the various policy directives set out, and to use this thinking to shape a future partnership mental health strategy;

(iii) Agreed that whilst it was intended that the results of the work would be presented to the October 2015 meeting of the Health and Wellbeing Board, the work should be done thoroughly, rather than to a pre-set timescale; and,

(iv) Concurred that GP training in Mental Health issues needed to be included in the Strategy.

4. Mental Health Needs Assessment

Matthew Cole, Director of Public Health, introduced the report, which provided information on the mental health needs of the child, adolescent and adult populations of the Borough and recommendations for discussion, with a view to the mental health services in the Borough moving towards parity of esteem with physical health services. Matthew drew the Board's attention to page 31 of the agenda and said that it was a telling statement the number of adults and children with mental health issues was not know, however, even from the data available it was certain that locally there was a much higher incidence of diagnosed psychosis than the England average.

Matthew stressed that this was not a service that was failing. Once people were in the system the outcomes were good. The problems were not getting people to ask for help early on and too few people were being diagnosed early enough at Primary Care level. What partners also needed to look at was a health economy that centred on outcomes. It was clear that the earlier treatment and support was started, the better the outcome was for the individual. It would help to keep young people in school and at home and this would have a significant impact on their future life chances. Keeping people functioning well and in employment also reduced homelessness and family breakdowns.

Discussion was held on how diagnosis and a working diagnosis in the young were recorded and on the possible delays between diagnosis and treatment, especially for the young people. Cllr Carpenter commented on the talking therapies and how access had improved with no significant waiting times to see therapists. Cllr Carpenter raised concern about mental health support for people from ethnic minority communities. NELFT responded that Improving Access to Psychological Therapies (IAPT) access level was 14% against a target of 15%. In addition, the outcome for NELFT was above national average, as the national target was seven days but in LBBD it was 3 days. The local services were one of the best in London.

Discussion was held on the inaccuracies in the data. NELFT advised that data was available and it could be provided and circulated to partners. There was clearly a need to do a matching exercise to see if individuals were being double counted or were missing from different partners' data.

Marie Kearns, Healthwatch, was concerned that there may be a blockage in the system which was causing delays to initial support.

Cllr Turner commented on the A&E presentations and felt that it was clear that

work needed to be done with BHRUT to ensure that there was much more awareness and training of mental health for local A&E staff. He felt it was important that there was a pathway through from A&E without referrals to GPs.

In response to a question from Cllr Turner in regards to the IAPT, Matthew Cole advised that the Clinical Commissioning Group (CCG) did not have any information on patient experience at the moment.

Matthew also advised on a pilot that was being undertaken and that the results of the pilot would be reviewed in October. Dr Moghal said that initial feedback from his colleagues was the pilot was having a positive effect and flows at the door were certainly better since the pilot started and he looked forward to seeing the results of the review.

Having received and discussed the contents of the report,

The Board:

(i) Noted the changes since the April report, and in particular those set out in sections 3.5, 3.6, 3.8, 4,2, 4.3.4.4, 4.5, of the report;

(ii) Directed the Mental Health Sub-Group to produce a detailed Delivery Plan to address mental health prevention, treatment and recovery services for adults and children in the London Borough of Barking and Dagenham;

(iii) Requested six monthly progress and performance reports on the implementation of the Delivery Plan;

(iv) Asked that a detailed understanding of the mental health needs of Barking and Dagenham children and adolescents be delivered through a children and adolescent mental health needs assessment; and

(v) Requested that the Mental Health Sub-Group takes the recommendations of the Mental Health Needs Assessment into account when developing a Mental Health Strategy and looking at the future re-design of mental health services.

5. CCG Mental Health Commissioning priorities and investment 2015/16 - Crisis Care Concordat

Sharon Morrow, Chief Operating Officer, Barking and Dagenham Clinical Commissioning Group (CCG) presented the report and explained that it set out what the CCG needed to do to meet the national standards for Mental Health, which had recently been introduced, and the work that was being done in regards to the new guidance, which included standards for:

- Early Intervention in Psychosis (EIP)
- Improving Access to Psychological Therapies (IAPT)
- Liaison Psychiatry
- Eating Disorders.

Sharon advised the Board that CCG had signed up to the B&D Mental Health

Crisis Concordat and had put an Action Plan into place and that the three borough CCGs had also agreed a commissioning framework for mental health services from September 2014; the priority areas for which were set out in section 1.3 of the report. CCG had also undertaken work with NELFT to ensure the standards were met by April 2016.

Sharon added that positive changes had occurred. In regards to the existing commitment to increase dementia diagnosis rates, the CCG believe that they had met the 67% target this year. The IAPT targets had also been achieved for the year and whilst IAPT now had new waiting time standards to achieve, the waiting times in LBBD were good so there was no expectation of problems in achieving the new standard. The 24/7 cover pilot had also been extended and feedback so far on the pilot had been positive.

Sharon drew the Board's attention to the Action Plan, attached as Appendix A to the report, and stressed that there would be a large amount of work for the Mental Health Sub Group in the coming months.

In response to a question from Cllr Turner, Sharon advised that there was no hard performance target for street triage. Whilst this was still in the early stages it was having an impact and had reduced the number of detainments under S136 of the Mental Health Act 1983. The Police agreed that they were finding the pilot very useful as it allowed officers to obtain information quickly and often reduced detainments under S136 and were pleased to see the pilot had been extended for a further three months. It had the potential to remove unnecessary detentions which was often a default point for the police when people were at crisis. It was noted that where an individual was not already known to Mental Health Services, street triage would undertake a follow-up of the individual seven days later. Anne Bristow commented that the place of safety at Goodmayes was exemplary and how decisions could then be made in regards to what support was needed for the individual. The Police advised that they followed a decision / audit process in their use of S136 detentions; however, due to excellent provision locally police custody was generally used less in the Metropolitan Police area than across the rest of the country. The Police pointed out there was currently discussion on a possible reduction of the hours that people could be held. Helen Jenner stressed that the work that LBBD and the Police were doing together to improve outcomes for the individual was a good news story of real worth.

Dr Mohi commented that the IAPT statistics showed that NELFT had been a better performer and work was now being undertaken to educate GPs on what support was available and to assist GPs to improve the quality of care at their surgeries.

The Chair concluded by commenting that there was a need to bring the three strands together. Once the strategy was in place the Board could then look at the key issues and the data in depth and the role of the Sub Groups in delivery.

The Board:

(i) Noted the new requirements for CCGs in relation to mental health access and waiting time standards;

(ii) Commented on the priorities set out in the paper and associated issues; and

(iii) Approved the Crisis Care Concordat Action Plan at Appendix A to the report.

6. Developing the Dagenham Primary Care Strategy

Sharon Morrow, Chief Operating Officer, Barking and Dagenham Clinical Commissioning Group (CCG) presented the report on the work that had been undertaken in the development of the strategy so far and its context in the national and regional level in regard to the delivery of accessible, proactive and coordinated care for all patients. Sharon explained that in order for the CCG to address the challenges the CCG was working with strategic commissioning partnerships and providers from across Barking and Dagenham towards a clear, coherent and achievable strategy for primary care transformation. The Strategy would outline the vision for primary care services in the Borough over the next five years and Stakeholder engagement was being held throughout the spring and summer, with the results being used to shape the final Strategy. The Strategy would be produced through three phases, the first phase was the development of the strategy through a bottom-up approach, the second phase would be looking at the vision and identifying the challenges and where the partners wished to be in five years time and the third phase would be the embedding and delivery of the strategy taking into account other transformational change programmes relevant to the delivery of planned and unplanned care services.

The challenges would include better IT usage, the need to increase staffing levels at Primary Care level and also reducing wastage. Matthew Cole advised that he attends the Transformation Group and this was looking at how to attract and retain GPs. Support from BHRUT and different ways of partnership working could alleviate pressures and improve expertise in the GP practices.

The Chair reminded the Board that in addition to the 55 to 60 GPs retiring in the near future, the Local Plan had identified the need for 20 more GPs due to the anticipated population growth in the Borough. The Chair added that the three CCGs were separate and she would not wish to see them merged as there was no one size fits all solution and the difference between neighbouring boroughs' needs and priorities could be vast; the documents need to clearly show the needs of LBBD. Dr Mohi agreed that services needed to ensure they had a local theme, were clinically led and met the particular needs of LBBD as the LBBD's needs were not the same as the rest of London or neighbouring boroughs.

Dr Moghal commented that was a need for organisations to keep challenging fortress mentality within their organisations and move towards partnership and relationship working. BHRUT was looking at how it could build on relationships with GPs and improve and contribute to the attractiveness of the area for GPs. BHRUT would report on aspects of this over the coming months.

NHS England was looking at improving GP Practices performance; however the national recommendations needed to be looked at in light of local priorities and needs.

Anne Bristow commented that partners now had the opportunity to think differently. The new development areas in the Borough would enable partners to look collectively at the best way to provided services to those areas and would allow

different ways of working to be trialled.

Cllr Turner raised the issue of growth over recent years and projected growth in resident numbers. The CCG accepted the point that projection had not been good in recent years but that the increases had been faster than anybody had expected, especially the number of children. The CCG accepted they needed to plan ahead more strategically and the Strategy was a way of doing this. Conor Burke commented that this Strategy was the start of more radical ambition of all partners working together to shape the future of Primary Care and health provision in the area.

A member of the public, Christine Brand, advised of a trial and radical way of working that was being held in Fife, Scotland, and this was having some considerable success. Christine was asked to discuss this with Matthew Cole outside of the meeting in order that it could be looked into further.

The Chair concluded by commenting that the public do not always act as partners would want them to, therefore, it was important that partners work with Healthwatch and other patient groups to ensure the services met patients' needs and systems they were willing to follow.

The Board:

(i) Received the report and presentation on the emerging vision and common themes for primary care services in Barking and Dagenham; and

(ii) Noted the work that was being undertaken by the Barking and Dagenham Clinical Commissioning Group (CCG) on the development of a Primary Care Strategy.

7. Annual Health Protection Profile

Vivien Cleary, Acting Head of Public Protection, presented the report and explained that it provided a summary of infectious disease notifications, outbreaks and health protection incidents that were managed by the North East and Central London Health Protection Team during 2014. The full details were set out in the report, including a summary of the health protection challenges and their implications for the Borough.

The Board raised and discussed an number of issues, including:

- Measles - There had been no confirmed cases of measles.

- Pertussis (Whooping Cough) - The incidence of Whooping Cough had reduced, and this was thought to be a direct result of the maternal vaccination programme.

- Tuberculosis (TB) - The incidence of TB had been increasing nationally since the 1980's and its incidence rate had strong links with deprivation, homelessness and overcrowding. The incidence trends in the Borough were shown on page 100 of the report and it could be seen that incidence of TB in the Borough was also rising over the London average. There were often clusters in family units and the rates were higher in the Black and Asian

communities. Work was being undertaken to identify and treat people with latent TB.

Connor Burke suggested that Public Health talk to their peers in Redbridge about targeting adjoining health issue hot spots.

It was noted that the NHS England had agreed to fund the consultant and screening costs.

- Chlamydia - Detection rates and treatment rates were high in the Borough. It was pointed out that this could be as a direct result of the Chlamydia awareness and treatment campaigns in the Borough recently. Overall sexually transmitted infections were also increasing. This indicated that unprotected sexual activity was a continuing problem in the Borough.

- Health Care Associated Infections – MRSA infection rates in the community was higher than average. The Clostridium Difficile infection rate was below the England average, but was one of the higher rates in North East London.

- Immunisation – The results indicated an encouraging turn-around trend in childhood vaccinations. The focus for the future would be in ensuring the follow up vaccinations were undertaken e.g. MMR. Seasonal Influenza and HPV vaccinations had generally not improved but pneumococcal disease vaccinations for the over 65's had achieved 65%.

  Matthew Cole advised that he would shortly undertake visits to the lower performing 21 GP Practices to see what could be done to improve both initial uptake and follow-up vaccination rates.

  Dr Mohi said that Partners need to reach people and encourage them to attend GPs and take up vaccination services. The initial targeting during infancy was good but the impetus and response rates tended to reduce in later years. Public engagement needed to be better.

  Matthew Cole suggested that Health Visitors follow-up the infant vaccinations; it appeared that parents were attending for the first vaccination but not returning for the second and third doses. This may be due to the parents not understanding the need for a multi doses to achieve full protection. Partners need to be explaining this to the public, whilst also undertaking a proactive approach to improve return rates, especially in the BME communities. Matthew added that it was necessary to understand how neighbouring practices, serving similar demographic communities, could be so variable in their performance and what the lower performers could do to improve catchment rates.

The Chair commented that whilst targets may not have been achieved yet, nobody should forget that there had been considerable improvements achieved in the last 5 to 6 years. The number of people participating in unprotected sex was clearly associated with both the sexual infection and teenage pregnancy rates. These had been targeted as major issues and despite this there still had not been a major decline in incidence rates. The engagement and prevention techniques which had worked elsewhere do not seem to have had an effect here.

Having noted and discussed the contents of the report,

The Board:

(i) Requested that NHS England provide quarterly performance reports on the arrangements it has put in place for 2015/16 to increase uptake of immunisation programmes by the eligible population of Barking and Dagenham;

(ii) Requested that Council Officers, together with NHS England and Barking Havering and Redbridge University Hospitals NHS Trust consider the introduction of appropriate HIV rapid testing services, which was in line with national advice;

(iii) Requested that North East London NHS Foundation Trust and local GPs work to ensure 100% uptake of the neonatal Hepatitis B course of 3 primary vaccinations and 1 booster at 12 months; and

(iv) Requested that Health and Social Care Commissioners provide quarterly performance reports on the measures being taken to prevent Health Care Associated Infections within both the hospital and community settings.

8. Inclusive Framework Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND)

Helen Jenner, Corporate Director of Children's' Services, presented the report in conjunction with the Autism Strategy on the agenda. The Inclusive Framework Strategy was an overarching three year strategy, which would eventually have a set of condition specific strategies. The Autism Strategy was the first condition specific strategy. The full details were set out in the reports.

Helen explained that the Borough did not have sufficient specialist provision or buildings to meet children's needs within mainstream schools and this had resulted in children having to be educated out of mainstream school or even out of the Borough. As a result a capital programme had been introduced so that wherever possible existing school buildings were fit for purpose and new premises had also been commissioned south of the A13. Temporary provision would be provided at Riverside Bridge from September 2015 until the new premises opened in September 2017.

Services were being constantly refreshed and developed to ensure they met the needs of children, parents / carers, and young adults. The three main objectives needed to be accomplished in a way that was affordable and provided value for money, whilst also understanding and recognising the unprecedented increase in child population and the corresponding increase in the demand for wider health and social care services.

Whilst SEND provision could continue for 18 to 24 year olds, under the Care Act legislation they were considered as adults. As a result each individual's budget would be transferred from the parents to the young adult when they turned 18.

Helen Jenner advised that the document needed to be Crystal Marked but this would be undertaken after comments had been received and requested that all comments were passed to her by next week.

Cllr Carpenter suggested that it may be worth revisiting the Adult Autism Strategy. The Chair said that it may be possible for the Sub Group(s) to review this document alongside the Adult Autism Strategy to ensure synergy between both strategies.

Having received the draft strategy document and discussed its contents,

The Board:

(i) Noted that final comments should be provided to Helen Jenner, Corporate Director of Children's Services, by next week and authorised Helen Jenner to make the necessary amendments and changes to the document;

(ii) Subject to (i) above, agreed the contents of the strategy document and its publication.

9. Children's Autism Strategic Plan

Helen Jenner, Corporate Director of Children's Services, presented the report in conjunction with the preceding agenda item.

The Board agreed the overall Children's Autism Strategy and in particular the six key priority areas.

10. Health and Wellbeing - Year End Performance Report

Matthew Cole, Director of Public Health presented the Health and Wellbeing Outcomes Framework performance report for 2014/15 and drew the Board's attention to a number of positive indicators during the year. Matthew advised that the report had been produced before the recent BHRUT Inspection and that Barts Health NHS Trust had also been put into special measures as a result.

The Board then discussed a number of issues, including:

GP Practices - The four GP practices inspected by the Care Quality Commission (CQC) had all received a 'Good' rating.

Secondary Care / BHRUT - The recent inspection at Queens Hospital had recognised the significant improvement by the Trust and it was now out of special measures and had progressed to 'Requires Improvement'. Strong clinical support and work with partners had played a part in achieving the turn around. Work was continuing with the aim of achieving 'Good' at the next inspection, which was expected around Christmas 2015.

London Ambulance Service - Concern was expressed about the performance of the LAS.

Smoking Rates and Smoking Cessation - There continued to be a high percentage of smokers in the area.

The numbers of people accessing and completing a smoking cessation courses had reduced, this could be partly due to the apparent increase in E-

cigarette consumption locally. Ante natal and Children's Centres could target 1,500 to 2,000 smokers a year as opposed to the low hundreds that were being delivered through Primary Care. There was evidence of life-long health issues for children where their mother smoked during pregnancy.

The Chair said that she felt that the resources needed to be invested to stop young people from taking up smoking in the first place, rather than on hardened smokers, some of whom had been smoking for 30+ years. Mathew Cole commented that it was becoming less socially acceptable to smoke, but the difficulty was how to get the 'changes for life' embedded into people's behaviour so that they break not just the physical addiction but the emotional aspects of smoking and do not return to smoking.

Survival Rates for cancer – The Survival rates for cancer, many of which were smoking related, were the second lowest in the country. Conor Burke suggested that this should be the focus of a future meeting.

Looked after Children Health Checks - The improvement in the percentage of looked after children with up-to-date health checks had increased at the end of March 2015. These health checks were an important part of corporate parenting and safeguarding and whilst the improvement was welcomed performance still needed to improve further.

The Board:

(i) Noted the overarching dashboard and detail provided on specific indicators, and areas where new data was available;

(ii) Noted the actions being taken to improve or sustain good performance, and the work of the sub-groups; and

(iii) Agreed that cancer treatment outcomes should be a subject for more in-depth discussion at a future meeting.

11. Systems Resilience Group - Update

Conor Burke, Accountable Officer, Barking and Dagenham CCG, presented the report and advised that BHRUT had acknowledged the significant contribution that the Joint Assessment and Discharge (JAD) service had played in operational resilience over the winter period. The discharges supported by the JAD had remained high through March to May 2015.

Connor advised that the remaining grant and time limited resources were coming to an end and the JAD service was now almost totally reliant on core funding and this raised key questions on how future capacity could be supported over the next winter period. Other forms of 'back door' joint working to replicate the benefits of the JAD service were being looked into.

Winter Planning for 2015/16 would be looked at over the summer.

The Board:

(i) Received and noted the report from the Systems Resilience Group,

including details of the briefings on 18 May and 18 June 2015; and

(ii) Noted that planning for winter pressures would be progressed over the summer months and work would start in regards to further partnership working opportunities.

12. Sub-Group Reports

The Board received and noted the reports on the work of the:

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

13. Chair's Report

The Board noted the Chair's report and comments as set out below were made:

- **£200m Public Health Cuts**
  The impact for 2016/17 would not be clear until the proposed new needs based formula and grant conditions of use were announced. The in-year £200m reduction in funding would be detailed in the 8 July emergency national budget.

- **Success in Development Funding Bid**
  £6,000 of funding had been awarded by London Councils for the Health and Wellbeing Board development.

- **Care Act Updates**
  There were now four work streams for April 2016. These were:

  - communications, information and advice;
  - cap on care costs;
  - commissioning;
  - operational consolidation and development.

  A significant area of work would be the revision of the Council's charging policy. The main risks for Phase 2 were implementation costs, pressures on the NHS and the implication of this on social care and the demand from self-funders.

- **News from Care City**
  Work had focused on those areas where partnership working was uniquely placed to accelerate progress for the benefit of the communities and in particular on healthy ageing and social regeneration.

  Existing resources would be redirected to maximise benefits, reduce duplication and to seek external funding. The activities would be clustered around four business goals:

  - Establish Care City infrastructure

- Create an innovation mechanism
- Establish research capacity
- Develop priority education programmes.

The interim premises at Maritime House, Barking, were due to open in September 2015. Care City had bid to become one of five national NHS test bed sites and the project was now being considered at second stage of the application process. Discussions were also continuing with academic partners.

- **News from NHS England**

  Five Year Forward View: Time to Deliver
  On Thursday 4 June 2015, the seven principal national health bodies published 'Five Year Forward View: Time to Deliver'. The paper was a delivery tool that looked at the progress in delivering the Five Year Forward View and the next steps to achieve the shared ambition. Work had started with a period of engagement with the NHS, patients and other partners on how they respond to the long-term challenges and closure of the health and wellbeing gaps, the care and quality gap, and the funding and efficiency gap.

  Mental Health Task Force
  Over 20,000 people had taken part in the online survey and engagement had also taken place with communities who were often marginalised. The emerging themes to date were prevention, access and integration across the system.

- **Message from Alwen Williams, Interim Chief Executive, Barts Health**
  Noted the message and five immediate action priorities to improve services.

- **Health 1000**
  Health 1000 had now been officially launched. It was an innovative new primary care practice designed to provide joined-up health and social care services for people with complex care needs. The service was based at King George Hospital and consisted of a team of healthcare professionals which provided patients with specialist, individual help so they felt more in control of their care and were able to stay out of hospital and independent for as long as possible. Feedback from patients on the service had been positive.

14. Safeguarding Nursing Provision in NELFT

Cllr Turner asked for clarification on the alleged reduction of specialist safeguarding nurses by NELFT. Gill Mills advised that there had been a change to the 'skill mix' of staff but posts had not been cut. Helen Jenner advised that she would raise the issue with, Sarah Baker, Chair of the Safeguarding Boards, in regards to requesting NELFT to report to the Safeguarding Boards to clarify the position.

15. Forward Plan

The Board noted the draft Forward Plan.

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HEALTH AND WELLBEING BOARD

8 September 2015

Title: Joint Strategic Needs Assessment 2015 – Key Recommendations	
Report of the Corporate Director of Adult & Community Services	
Open Report	**For Decision**
Wards Affected: All	**Key Decision:**
Report Author: Susan Lloyd, Consultant in Public Health Sandeep Prashar, Head of Health Intelligence	**Contact Details:** Tel: 020 8227 2799 Email: sue.lloyd@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	

Summary:

This paper highlights the key strategic recommendations arising from the refresh of the Joint Strategic Needs Assessment (JSNA) for 2015.

Background information on demographic need and more specific recommendations are available on the website: http://www.barkinganddagenhamjsna.org.uk/.

Everyone in the borough has the right to good health and Barking and Dagenham has set out a new vision **One borough; one community; London's growth borough** 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 disempowered, lonely or isolated. The new strategy provides an opportunity to work with residents to encourage civic pride, enable social responsibility and grow the borough. Improved health is a key indicator of improved economic circumstances. The recommendations of the 2015 JSNA outline the challenges and opportunities to improving health and reducing premature mortality in the borough.

Population growth and change and premature mortality remains a major challenge for the borough and is also a priority in many of the recommendations, as a result of the proposals agreed by the Board following discussion of the Longer Lives paper in July 2013.

Recommendation(s):

The Health and Wellbeing Board is recommended to:

(i) Note and discuss the content of this paper.

(ii) Support the commissioning of services by partner organisations that align with the Joint Strategic Needs Assessment findings and the Health and Wellbeing Board key themes of prevention, protection and safeguarding, improvement and integration of services and care and support

(iii) Require that, in-line with statutory requirements, the Public Health Department lead an update of the Joint Strategic Needs Assessment in 2016 to inform commissioning in 2016/17.

Reason(s):

The JSNA provides the fundamental evidence base on which the commissioning and strategic decisions of the Board are made. It directly informs the development of the Joint Health and Wellbeing Strategy. It is a statutory duty of the Health and Wellbeing Board to discharge the functions of the Council and the NHS Barking and Dagenham Clinical Commissioning Group to prepare the JSNA.

1.1 Introduction and background

1.1.1 The Board agrees the borough's Joint Health and Wellbeing Strategy. This strategy is based on local information about health and social care. This information is refreshed annual and is known as the Joint Strategic Needs Assessment (JSNA).

1.1.2 The Joint Strategic Needs Assessment is where all the information about health and social care needs of residents of Barking and Dagenham is recorded. In Barking and Dagenham this is on the JSNA website http://www.barkinganddagenhamjsna.org.uk/Pages/jsnahome.aspx.

1.1.3 Keeping all the information in one place enables Health and Wellbeing partners who are commissioning services to find the information they need so that they can commission the services that are needed to improve health and social care for the residents of Barking and Dagenham.

1.1.4 The production of the JSNA was set out in the Local Government and Public Involvement in Health Act 2007[1] and the Health and Social Care Act 2012[2] is clear that local authorities must agree the JSNA at the Health and Wellbeing Board.

1.2 Introduction

1.2.1 The Health and Wellbeing Board have agreed 9 priorities for commissioning on 28 October 2014. These priorities are:

1. Transformation of health and social care
2. Improving premature mortality
3. Tackling obesity and increasing physical activity
4. Improving sexual and reproductive health
5. Improving child health and early years
6. Improving community safety
7. Alcohol and substance misuse
8. Improving Mental Health
9. Reducing injuries and accidents

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[1] http://www.legislation.gov.uk/ukpga/2007/28/contents

[2] http://www.legislation.gov.uk/ukpga/2012/7/part/5/chapter/2/crossheading/joint-strategic-needs-assessments-and-strategies

1.2.2 The Health and Wellbeing Board agreed a refreshed Health and Wellbeing Strategy on 7 July 2015. This strategy sets out the four key themes for public health, health and social care in Barking and Dagenham. These are:

- Prevention
- Protection and safeguarding
- Improvement and integration of services
- Care and support

1.2.3 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.

1.2.4 The refresh of the JSNA identifies areas where increased work and focus can support our population to enable social responsibility.

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

- Joint Health & Wellbeing Strategy 2015 - 2018
- Joint Better Care Fund work programme
- The Business of Caring in Barking and Dagenham
- Children & Young People's Plan
- Community Strategy 2013-2016

1.3 JSNA process

Whilst led and produced by the Public Health Department, the JSNA is a joint piece of work with data, analysis and recommendations provided by a number of senior officers across the health and social care system in Barking and Dagenham.

1.4 JSNA structure

1.4.1 In Barking and Dagenham, the JSNA has evolved based on the needs of the population and changes in demographics. It is structured and indexed using the 'life course' approach used in Health and Wellbeing Strategy starting with 'Giving every child the best start in life'[3] and following through the ages and needs of the population including the health and sustainability of individuals and communities. This approach is used in the Barking and Dagenham Health and Wellbeing Strategy[4].

1.4.2 All the above support the Barking and Dagenham 2020 Vision and Growth Commission, particularly 'Ensuring Growth Improves Quality of Life'.

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[3] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report

[4] https://www.lbbd.gov.uk/wp-content/uploads/2014/11/Health-and-Wellbeing-Strategy.pdf,

1.5 Key drivers of value for money

1.5.1 Barking and Dagenham is rising to the challenge of changes to local funding of services by working in partnership to develop innovative approaches empowering individuals to take control of their own health and wellbeing.

1.5.2 There are 11 challenges to health and social care that will drive investment over the next year, these are:

1. Changes to the welfare and benefits system will negatively impact on the majority of households in the borough.
2. Demographic challenge and changing communities up to 2020.
3. Economic recession and the impact of the Government's economic policy on the public sector finances.
4. Tackling child sexual exploitation to improve the protection of vulnerable children.
5. 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.
6. Supporting the best possible educational outcomes for children and young people is central to the Council's vision and priorities.
7. Ensuring parity of esteem between mental and physical health
8. Transforming primary care and social 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.
9. Increasing the social productivity of public services and new forms of community regeneration to help individuals and communities to make positive change.
10. Evidencing quality improvement and rebuilding public confidence in Barking, Havering and Redbridge University Hospitals NHS Trust following the Care Quality Commission interventions.

2 Priorities identified in the Joint Strategic Needs Assessment

2.1 The JSNA 2015 draws out the important priorities for our residents' health and social care. The priorities for our residents 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.

2.2 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.

2.2.1 The JSNA focuses on a number of preventative areas, including NHS Health Check, smoking prevalence, immunisations, and cancer screening. This links in with the JHWS priorities of Starting Well, Living Well, and Ageing Well.

2.2.2. Early detection and optimal management of long terms conditions is one of the most important health interventions and is key factor in improving the life expectancy in borough and to close the gap between the life expectancy in Barking and Dagenham with the London average. Early diagnosis of health issues will enable peoples to deal with them effectively and manage their conditions well.

2.2.3. The NHS five year forward view commits the health services to support the public health priorities highlighting that proactive primary care is central to secondary prevention, as is the more systematic use of evidence-based intervention strategies. Lifestyle intervention programmes have shown to cut obesity and prevent diabetes and other long term conditions. Increasing participation in physical activity is one of the priorities in the boroughs Health and Wellbeing Strategy

2.2.4 One of the outcomes in Joint Health and Wellbeing Strategy of the borough is to improve health and social care outcomes through integrated services and to improve the quality and delivery of service provided by all partner agencies. The BHR health economy Five Years Strategic Plan also emphasise the need for improving health outcomes for local people through best value health care in partnership with the community and improving people's experience of integrated care which is linked to Adult Social Care Outcomes Framework (ASCOF).

3. Key Recommendations (Through the Life Course Stages)

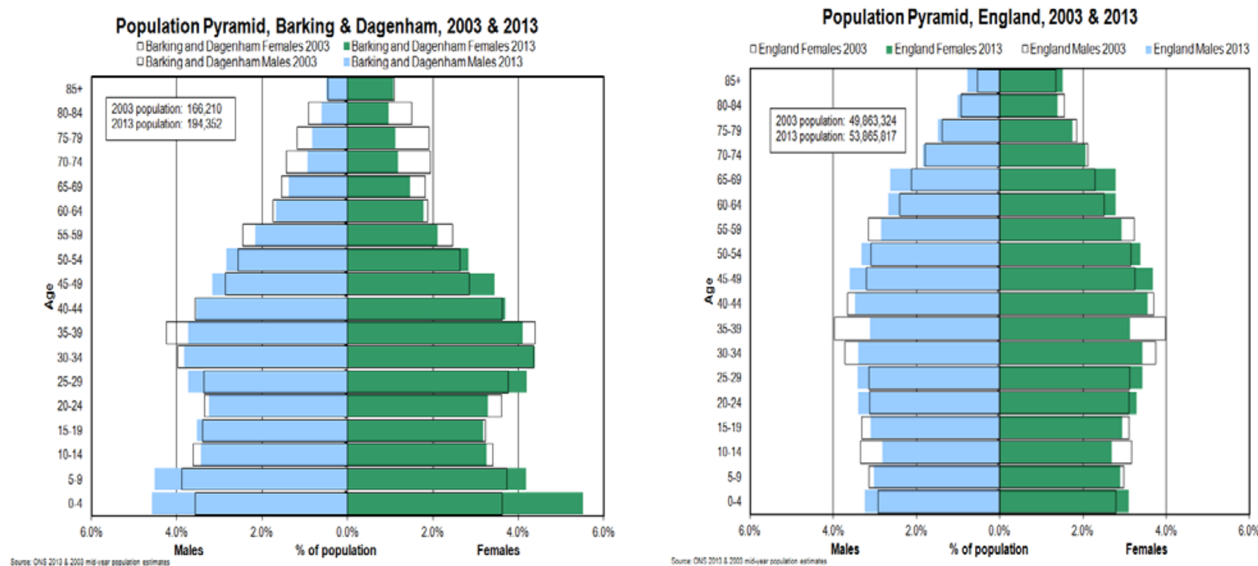
3.1 A summary of key recommendations are included as Attachment 1. The main findings are presented in the paper in sections 4 and 5.

4 The Barking and Dagenham population and it's health challenges

4.1 Population growth and changes in our local population from 2011 to 2013

- The population of the borough has increased by 8,441 between the 2011 Census and 2013 GLA mid-year estimates. This is a 4.5% increase.
- The borough has the highest population percentage of children and young people aged 0 to 19 at 32.2% in England and Wales.
- In the 2011 Census found that the population of children aged 0-4 years had grown by 49% in the previous ten years: this was the highest growth for this age group of any local authority in England and Wales.
- This changed in 2013 with the numbers of children under 5 years making up 10% of the population and between the ages of 0-19 making up 32% of the population.
- The growth in the numbers of children aged 0-5 has slowed down and the population bulge has now moved to the 5-19 age groups.
- In the year to January 2015 the school population rose by 2.5%, nationally the school population increased by 1% and across London by 2%, but in our statistical neighbours it rose 3%. Our growth in school population is lower than our statistical neighbours.
- The borough's adult population is growing at a faster pace than in London and England. The growth rate in the borough is 4.5 per cent and has gone up more than twice that of London (2%), between 2011 and 2013. Growth is also ahead of that for England.
- Between 2011 and 2013, there has been a 1.1% increase in the 65+ age group in Barking and Dagenham.
- The over 65 population account for 10% of the overall borough population which is the 13th lowest proportion out of 348 areas across England and Wales.
- The number of people aged 85 between 2011 and 2013 has remained stable with a change of -1.

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



4.2 Increased proportion of population from BME communities

- There has been a large decrease in the white population from 80.86% in 2001 to 49.46% in 2011.
- The Black African population has risen from 4.44% to 15.43%. This is the second highest proportion of this population group within a local authority across England and Wales.
- There has been a significant rise in the Bangladeshi population from 673 in 2001 to 7,701 in 2011.
- 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.

4.3 Population census – other areas

- **Religion changes.** There has been an increase in all religious groups in the borough, with the exception of Christian and Jewish groups. The number of Muslims has seen the most significant growth with the proportion rising from 4.36% to 13.37%.
- **Education and employment.** There are now significantly less people with no qualifications representing a 14.4% drop in numbers between 2001 and 2011. In 2011 49% of the working age population (16 to 65) were either employed (38%), self employed (9%) or full time students (2%).

- **Housing** Lone parent households with dependent children have seen a large increase with Barking and Dagenham now having the highest percentage of lone parent households in England and Wales at 14.3%. This is much higher than in other parts of London and England as a whole. There has been a big rise in Private Renting from 5.19% in 2001 to 16.59 in 2011.
- **Health** 6.6% of Barking and Dagenham residents aged 16-64 believe that their day to day activities are limited a lot because of a health problem or disability including problems related to old age, which is slightly higher than the London average of 5.6%.

  The residents of Barking and Dagenham are not as healthy as they could be, compared to other parts of the country with lower life expectancy. Life expectancy for both men and women living in Barking and Dagenham is amongst the lowest in London. The London average is 18.9 years for men and 21.7 years for women.
- **Deprivation** Barking and Dagenham still experiences higher than average levels of deprivation ranking 7th most deprived borough in London and 22nd most deprived area nationally.
- **Comparison with London** Changes observed in Barking and Dagenham are following the East London trend. The ethnicity profile for the borough is similar now to that of Newham and Tower Hamlets as it was in 1991. Barking and Dagenham is part of the Eastward migration from inner London and out in to Essex.

5. Key findings by life course

5.1 Pre-birth and early years priorities in 2015/16

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. One in three (30.2%) of our children live in poverty, this figure is decreasing but is still much higher than London and England. This can have a huge impact on a child's start to life, and to future educational achievement and employment prospects.

5.1.1 Priority Area: *Care and Support*

- **Our children to have regular check ups and less dental decay.** The dental health of our 3 year olds is much worse than in the rest of England. Our 5 year olds have a higher level of decay than in London and England with one in every three children having a decayed tooth. Our Asian children particularly have high rates of decay and untreated disease.

5.1.2 Priority Area: *Protection and Safeguarding*

- **Our children to be protected against diseases that we can prevent**. Uptake of immunisation in our children has improved significantly and moved substantially closer to the local target of 90% uptake, but uptake still remains below the national target of 95% across all childhood immunisations.

5.1.3 Priority Area: *Improvement and Integration of Services*

- **Our children to start well and this means having a good level of development.** We are pleased that in 2014, 60% of our children achieved a good level of development, a 13% increase on 2013 results. However there are so groups of children that need an extra focus, particularly White British children with White British girls doing slightly worse than White British boys.
- **More children with chronic and/or complex health and social care needs to be supported in an integrated way at home.** See Helen's comments.
- **An integrated early years service from conception to age 5.** The transfer of the Health Visiting service to LBBD in October 2015 is an opportunity to deliver this.

5.1.4 Priority Area: *Prevention*

- **More infants to be breastfed in the first months of life.** In recent years an increasing number of Barking and Dagenham mum's are choosing to breast feed but Barking and Dagenham are still less likely to breastfeed than mum's in London. The rate is about the same as England. We want to target our White British mums who are less likely to breastfeed than our BME residents.
- **Fewer of our parents to expose their children to cigarette smoke.** The number of our mum's who choose to be smokers when they deliver their babies has decreased but we know that one in every ten mum's still chooses to be a smoker. We want all our mums and dads who are smokers to have support to get onto the babyClear® programme.

5.2 Primary school children priorities in 2015/16

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.

5.2.1 Priority Area: *Care and Support*

- **Our children to demonstrate improved health between their Reception and Year 6 health review.** We particularly want to protect against overweight and

obesity. Provisional measurements for 2014/15 show that the number of children in reception who are obese or overweight has increased by 1%.

- The number of overweight or obese children in year 6 fell by 1.9. Both figures are still above London and England, but the results for children in year 6 may signal the reversal of the upward trend seen previously. These results are provisional and therefore should be interpreted with caution.
- **Our children to be more active and eat healthier diets.** There is more work to be done to support our children and families to do this and its very important that we get this right because obesity in childhood is known to be linked to poorer health in later life particularly heart disease and diabetes

5.2.2 Priority Area: *Protection and Safeguarding*

Safeguarding of children is covered in section 5.7.

5.2.3 Priority Area: *Improvement and Integration of Services*

- **More children and families have access to urgent care community services which meet their needs.** Our children aged 0-5 still account for a significant number of unplanned admissions to hospital in Barking and Dagenham. However over the past three years there has been less emergency admissions for children with diabetes, asthma and epilepsy and Barking and Dagenham has a lower rate of admission than London. When children are admitted the hospital stays are short and they might be avoidable. The borough has a high attendance rate of children at out-of-hours primary care services. And it's likely that this is one of the reasons that less children are being admitted. Our residents need continued to support to access urgent care services.

5.2.4 Priority Area: *Prevention*

- **More children, families and adults to take regular physical activity through school, leisure service provision, and to use the borough's green space.** In 2014/15 its unlikely that our children and young people are having 60 minutes of physical activity each day and we want to improve this situation.
- **More children to develop coping and rebound skills to manage life stresses.** At the moment we don't know enough about the mental wellbeing of our children and we want to find out more including the management of potential child exploitation situations.

5.3 Adolescent priorities in 2015/16

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.

5.3.1 Priority Area: *Care and Support*

- **More young mothers/fathers access the support provided through the Family Intervention Programme and the Family Nurse Partnership project**

and Children Centres targeted support. The borough has the highest teenage pregnancy rate in London, and we've been in this position for at least ten years. The pregnancy rate is decreasing but we need to continue to focus on helping our teenagers and young parents. More adolescents take up the opportunity for a mid-teen health review with qualified health professionals

- **Improving health outcomes for looked after children, care leavers and youth offenders** In 2013/14, significant progress was made in improving health checks of LAC and this has been sustained in 2014/15 overall. The percentage of looked after children with an up to date health check increased to 92% (provisional) compared to 76% in Q3, and 73% in Q2 2014/15. Compared to 2013/14 end of year, there has been a slight drop from 94%, but performance still remains above both national and London averages. Dental, eye and health checks for all children in care remain areas for improvement. There are currently gaps in addressing the health needs of care leavers and of youth offenders including mental health, drug and alcohol and other physical needs.

5.3.2 Priority Area: *Protection and Safeguarding*

- **Adolescents over 16 years to take up the opportunity to protect themselves through Chlamydia screening.** We are pleased that the rates of Chlamydia infection in Barking and Dagenham are reducing, bucking national and London trends. We want to continue to ensure that our over 16's have access to Chlamydia testing.

5.3.3 Priority Area: *Improvement and Integration of Services*

- **Continue to improve the educational attainment of children and young people in our borough.** Between 2001 and 2011 the number of our young people aged 16-17 in education increased substantially as did the number of young people with educational qualifications.

  In May 2014 there were 526 young people (16-18 years) not in employment, education or training (NEET) in the borough and we also did not know the situation of some young people. Less people in the borough are NEET in 2015 than in 2013 but we know that there is a strong link between young people who are NEET and those who have poorer health outcomes, as well as with teenage conceptions and new entrants to the youth justice system. It is important that we continue to support out most vulnerable children and challenge them to have positive aspirations.

5.3.4 Priority Area: *Prevention*

- **Fewer adolescents to smoke.** We do not know how many of our teenagers of our teenagers smoke but we do know if we stop our teenagers starting smoking that they are less likely to become smokers. We want to help our teenagers stop starting smoking.
- **Fewer adolescents to experience problematic use of alcohol.** We know that the number of Barking and Dagenham's young people in the tier 3 structured drug and alcohol treatment has increased year on year, and that in 2014/15 Barking and Dagenham had the highest number of young people in treatment in London. Most of these came through SubWise or youth offending, and we more likely to be male than female. This accords with information that shows that the

percentage of young people who use alcohol within Barking and Dagenham is significantly higher than the London rate; however significantly lower than the National rate. In contrast the borough has a relatively low rate of hospital admissions in young people, lower than the London and England average. Suggesting fewer adolescents make depends on hospital services as a result of alcohol.

- **More adolescents to have developed coping and rebound skills to manage life stresses.** We want to empower our adolescent residents to make informed choices about their sexual and emotional health, including issues linked to preventing child sexual exploitation. We know that about 4500 boys and girls in the borough are likely to be suffering from mental illness, and this isn't different from the England average. We know that our children with mental illness are likely to have behaviour, hyperactivity and emotional disorders and that vulnerable children are more likely to suffer ill mental health, Mental health problems in childhood and adolescence can have tragic circumstances and we want to understand how we can improve mental health services for our adolescents and children and ensure parity of esteem with physical health.

5.4 Maternity priorities in 2015/16

5.4.1 Priority Area: *Care and Support*

- **Mothers to be seen by a midwife within 12 weeks of becoming pregnant.** Our mothers who don't see a midwife are more likely to be vulnerable. Just under 8 of 10 of our mothers did see a midwife within 12 weeks of becoming pregnant and this is higher than the England average but in some parts of the borough mothers are seen much later or not at all. We particularly want to focus on mothers from black and mixed ethnic backgrounds, and teenagers under 19 who are likely to be seen by a midwife by 12th week of pregnancy.

5.5 Adulthood priorities in 2015/16

5.5.1 Priority Area: *Care and Support*

- **More adults with latent TB to be identified.** TB has been one of the diseases that has been increasing in the borough. Unlike most boroughs in London, the TB rate in Barking and Dagenham increased from 2012 to 2013, continuing an upward trend since 2002, and above the London rate for the first time. The provisional 2014 data indicates that this trend has reversed. We want to work with our neighbours and NHS England to introduce a Latent TB testing programme. This programme will find younger adults who carry TB but do not show symptoms and treat them before symptoms start and the TB becomes infectious.
- **People with mental health issues to be dealt with on an equal footing to people with physical health issues.** It is probable that not all cases of common mental illness in the borough 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. It is expected that there will be an increase in residents needing talking therapies, IAPT. These therapies need to take into account the needs of Asian communities.

- **Fewer adults with depression to require hospital admission because they will receive better community care and support.** We know that we not all our residents with common mental illness are being diagnosed, and are therefore not accessing IAPT and other services. We also know that we have a slightly higher prevalence of residents with psychosis in the borough.
- **Vulnerable residents to have access to employment opportunities.** Recent figures indicate employment rates of 32.5% in those with a mental illness compared to 67.7% for the general population. Compared to the London region and England, the borough is performing slightly better, with a narrower gap, a significant number (5,500) of people with mental illness that are not benefitting from improvements in physical and mental wellbeing associated with employment. We want to continue with our current programme of work.

5.5.2 Priority Area: *Protection and Safeguarding*

- **Fewer adults to become infected with a sexually transmitted disease or HIV.** We want people with HIV to access early testing and treatment. An increasing number of residents are being diagnosed with HIV, and the rate is above the London average and nearly three times the England average, the trend is a concern given that the LBBD rate was below the London average until 2012.
- **Protect from Gonorrhoea and Syphilis.** Our rates of Gonorrhoea rates are rising in Barking and Dagenham, with a 2013 figure of 80.8 per 100,000. However, this increase is in line with increases in the England average. Similarly rates of Syphilis in the borough were below both London and England averages until 2013, where the borough's rate increased significantly and moved above the England average. The borough's rate remains less than half of the London rate.
- **More people to be aware early when they have cancer by being aware of signs and symptoms and through taking up the offer of screening for cancers including breast, bowel and cervical.** More than seven out of ten (74.8%) of eligible women in the borough have been for their cervical smear tests, this is slightly lower than the England average. A similarly breast cancer screening uptake is lower than the England average. A positive picture is seen with bowel screening with an uptake of nearly nine out of every ten tests sent out (86.3%). We want to increase uptake and increase early diagnosis of cancer.

5.5.3 Priority Area: *Improvement and Integration of Services*

- **Focus on improving the quality of care and support for people living with diabetes and empower our residents to manage their own condition.** The outcome of diabetes in our residents can be very severe, including having amputations. Many of our residents are overweight or obese and this makes them more prone to developing diabetes, our Black African and Asian residents are more prone to diabetes than our White British residents. It is a particularly large health problem in Dagenham and in the Whalebone and Chadwell Heath wards, with higher prevalence and admission rates in these localities than in the borough as a whole. Having residents who control their own diabetes will lead to avoidable admissions.

- **Support more adults with the early signs of chronic disease identified in primary care and start treatment and care and improve services for people living with long term conditions.**
- Our residents have one of the highest morbidity and mortality rates with chronic obstructive pulmonary disease as a cause in England. We need to focus on finding cases of chronic obstructive pulmonary disease as the recorded prevalence in the borough is lower than the England average but out leading cause of death is chronic obstructive pulmonary disease.
- Hospital admissions for chronic obstructive pulmonary disease are also double the England average and Barking and Dagenham also has rate of hospital admissions for COPD of all the boroughs in outer north east London and the rate is more than double the England average.
- While the number of people aged less than 75 years who die from cancer is falling nationally, in Barking and Dagenham it is continuing to rise.

  Lung cancer is the most common cause of death in our Barking and Dagenham, residents and smoking causes 9 out of every ten lung cancer deaths. The rate of premature death from lung cancer in Barking and Dagenham is higher than London and England.
- Rates of other cancers is also high compared to England rates particularly breast, bowel and prostate cancer rates. Prevention of cancer is best achieved through a change in lifestyle particularly stopping smoking and good diet.
- One year survival rates for cancer have improved in Barking and Dagenham, with 69% of residents surviving one year in 2012. This remains the lowest survival rate in London.
- Barking and Dagenham has 1943 people on GP stroke registers, this is a lower number than in neighbouring boroughs. However residents who do have strokes in Barking and Dagenham are likely to have severe strokes and are more likely to die under 75 years of age as a result of the stroke.
- Barking has a lower than expected number of residents on stroke registers, even given that the population of the borough is young.
- **More adults to have access to community based urgent care services in ways that suit their work/life balance and to avoid unplanned hospital care.** For our residents the effective management of chronic conditions in primary care is important. There has been a reduction in the unplanned admissions of residents over 75 years. The bulk of residents now presenting as unplanned care are between 50-75 years. We want to target this age group of residents.

5.5.4 Priority Area: *Prevention*

- **Fewer adults to smoke.** Smoking is also responsible for about 17% of deaths from heart disease, and 80% of deaths from chronic lung diseases such as bronchitis and emphysema. In our borough smoking has a significant impact on life expectancy. Because smokers are more likely to develop chronic obstructive

pulmonary disease and/ or lung cancer they are more likely to die at a young age, and to have a poorer quality of life before they die. Smoking rates are higher amongst poorer residents in the borough. In 2009 smoking prevalence in Barking and Dagenham was the highest in London and 8th highest in England. By 2013 it was estimated that local prevalence had gone down and this remains the highest in London.

- **More adults have a healthy weight and more to have access to healthy affordable food produce.** After smoking, obesity is one of the most important risk factor to being healthy for our residents. Adult obesity is not measured nationally but it is estimated that over half of adults in the borough are over weigh (63.5%) and of these half are obese. Although the overall trend has been downwards since 2009/10, it remains higher than London average. This is similar to England. We want to support social prescribing with accessible referral systems.
- **Support more adults to take regular physical activity including cycling, walking and using green space.** Only 15 per cent of Barking and Dagenham's population participate 5 times per week in physical activity for at least 30 minutes and nearly 45 per cent participate once per week. Green spaces already make a significant contribution to the health and wellbeing of everyone living in the borough. We want to support social prescribing with accessible referral systems.
- **Residents to live in decent homes.** One of the greatest impacts on long term health is the type and quality of housing that people live in. LBBD is bringing council owned properties up to decent home standards. The Private Sector House Condition Survey 2009 approximately a third (37.9%) of private sector housing in the borough was non-decent, and likely to be excessively cold, damp or to have trip hazards. In 2015 A landlord licensing scheme has been introduced to encourage good private rented housing.

5.6 Older adult priorities in 2015/16

The health and wellbeing of this group is often characterised by an increasing dependency on support as individuals' age and become frailer. Health deteriorates for many of our residents in older age. For example our older residents are more likely to fall or to have poor eye health.

5.6.1 Priority Area: *Care and Support*

- **Frail elderly adults to be supported to live independently and more older adults who are eligible to use direct payments to control their own care and services.** There are significant changes to the to the number of people needing adult social care in the future an there will be an increase of the numbers of people with diabetes, stroke, heart disease and arthritis needing care and larger increase in the number of residents with dementia. It's likely that demand from residents with moderate and severe needs will double. An analysis of residents use of social care between 2008 and 2012 found that although demand for services fell in the period 2008-12, Barking and Dagenham still has more service users than its comparator boroughs;

  There was a fall (17%) in the number of older people using community based services; and use of residential and nursing care services remained stable;

Barking and Dagenham offers its services at a very competitive unit cost in comparison to its neighbouring boroughs.

- **Residents with dementia to be on a GP register and to have access to the services they need**. The recorded number of residents with dementia in Barking and Dagenham is relatively low according to the Quality Outcomes Framework. In 2013 There was variation in prevalence rates between GP practices was considerable, from 0.04% to 2.4%[5], though genuine differences exist because practices vary in responsibilities for frail populations (e.g. patients in nursing homes). It is likely that dementia prevalence is was under recorded but this situation has improved. The current dementia diagnosis rate for Barking and Dagenham is better than the national average, standing at 64% compared to 61% across England as a whole. The total of 847 patients registered compares to 1324 expected. So work still needs to be done.
- **Mental health services for older people to have parity of esteem with physical health services.** Older people (aged 65 years and over) may have additional needs and experience poor outcomes if those needs are not met. Depression is more common in older women than older men in Barking and Dagenham. The number of cases of severe depression is projected to increase among residents aged 65-69 years as the population in this age group is projected to grow over the coming years.

5.6.2 Priority Area: *Protection and Safeguarding*

- **Fewer older adults injured through accidents in the home, particularly falls.** In Barking and Dagenham every year our residents over 65 years old have around 7,000 falls. In 2013/14, 459 people over 65 years old (2,027 per 100,000) in the borough suffered injuries due to falls, which is higher than the London rate of 1,955.

  In 2013/14 our residents had a higher admission rate for hip fracture (144 incidences) by people aged 65 years old and over compared to London and England. This rate was much higher for older age residents, the number of people 80+ year old in Barking and Dagenham who had a hip fracture in 2013/14 were 115 (1801for LBBD compared with 1425 for London and 1566 for England per 100,000 population)[6].
- **More older adults and vulnerable individuals to live in high quality and more energy efficient homes, protected from weather extremes.** Barking and Dagenham has developed an integrated Affordable Warmth Strategy for 2015/20, to deliver a holistic plan to mitigate against excess winter deaths, retrofit and insulate homes, encourage reduced energy consumption and promote access to lower energy tariffs. Fuel poverty has risen slightly in the last few years but at a lesser rate than our comparator boroughs.

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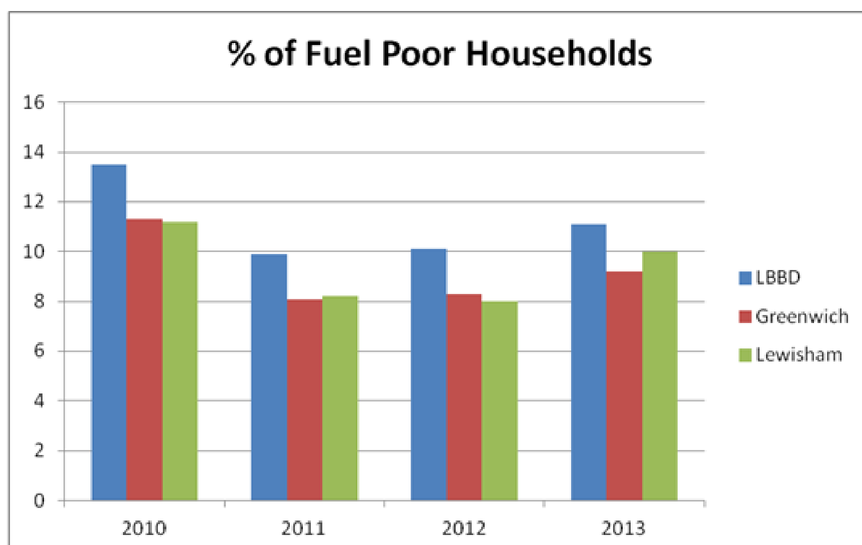
[5] http://www.hscic.gov.uk/qof
[6] Public Health England. 2015, Hip Fracture [Online] Available from: http://www.phoutcomes.info/search/hip%20fracture#gid/1/pat/6/ati/102/page/0/par/E12000007/are/E09000002 [Accessed 15 May 2015]



Source: Department of Energy & Climate Change Fuel Poverty Statistical Release 2013: https://www.gov.uk/government/statistics/2013-sub-regional-fuel-poverty-data-low-income-high-costs-indicator

- However, the Council's interventions have prevented that figure from rising still and tackling fuel poverty is to be embedded into the corporate delivery of services in Barking and Dagenham.

5.6.3 Priority Area: *Improvement and Integration of Services*

- **Adults who are terminally ill to die with dignity in a planned supported way.** This includes residents choosing to die outside hospital. Many more of our residents than die in hospital than is the case for England as a whole (60.6% for Barking and Dagenham compared with 49.3% for England). Of deaths in other places, significantly fewer people die at home (19.1% Barking and Dagenham, 22.2% England) and very significantly fewer die in a care home (13.1% Barking and Dagenham compared with 20.7% England), suggesting that our care homes are less well able to care for people who are dying and residents of care homes are more likely to go into hospital to die.

  In Barking and Dagenham around 74% of all deaths in 2011-13 were the result of cancer, circulatory diseases and respiratory diseases. With active case finding and good disease management the majority of these deaths could be anticipated and the end of life adequately planned for. While 25.2% of people with cancer and 24.3% of people with circulatory disease died at home, only 14.2% of people with respiratory disease did so, and only 15.8% of cancer deaths were in a hospice (virtually no deaths from circulatory disease or respiratory disease occur in a hospice, which primarily provide care for cancer patients).

- **Older adults to regularly access high quality optical services.** One in four of our residents 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[7]. People from BME groups are more susceptible to particular eye conditions[8] and people of African origin are 4 times more likely to develop cataracts, are and 3 times more likely to develop cataracts. They are also more likely to develop diabetes with the high associated risk of diabetic retinopathy.

Barking and Dagenham have around 9,400[9] 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.

5.6.4 Priority Area: *Prevention*

- **Older adults to be protected against catching flu.** In 2013/14, 70.5% of the 65 years and over population was vaccinated. Although these levels are below the national goal of 75%, the achievement for people aged 65 years and over is greater than that of London as a whole.

5.7 Vulnerable and Minority Groups

5.7.1 Priority Area: *Care and Support*

- **To increase the number of vulnerable adults identified by the annual Warm Homes, Healthy People programme.** Barking and Dagenham is developing its first ever integrated Affordable Warmth Strategy for 2015/20, in partnership with National Energy Action, to deliver a holistic plan to mitigate against excess winter deaths, retrofit and insulate homes, encourage reduced energy consumption and promote access to lower energy tariffs.
- **Our 3000 (approx.) children with special education needs to have their needs met and demonstrate improved educational health outcomes.** Overall the proportion of children identified with special educational need is slightly lower in Barking and Dagenham than the national picture. The numbers of children with severe disabilities is growing nationally . In barking and Dagenham this means paying particular attention to our disadvantaged residents and our Asian and Black African communities because they have a higher prevalence of young disabled children.

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

[8] 'People from Black and Minority Ethnic (BME) communities and vision services: a good practice guide', produced by the Thomas Pocklington Trust (Joule and Levenson 2008) http://www.pocklington-trust.org.uk/research/publications/gpg3.htm

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

5.7.2 Priority Area: *Protection and Safeguarding*

- **We want to protect our looked after children**. In 2013/14 there was a trend of an increasing number of looked after children in the borough, the number of looked after children has now stabilised at 457.
- **Our children's and adults domestic violence services to meet the needs of residents**. Domestic violence affects our children and adults and is the leading cause of ill health for women aged 19-44 years. Domestic abuse is a significant issue in Barking and Dagenham with the highest reported rate of domestic abuse offences across London again in 2014/15., There was an increase of 627 domestic abuse crimes reported in April 2014 to March 2015 when compared to the previous year. Domestic abuse is also a factor that features in the large majority (over 70%) of the borough's open social care cases.
- **Children to be protected against Child Sexual Exploitation**. We know that child sexual exploitation is not just an issue for Barking and Dagenham, it is a national issue. We have identified that the main model of Child Sexual Exploitation in borough is the boyfriend model and exploitation of younger girls by older men. There is little evidence of organised exploitation by groups or gangs.
- **A single standard of high quality management for private rented housing.** See section 5.4.4.

5.7.3 Priority Area: *Improvement and Integration of Services*

- More integrated support is provided to troubled families to reduce the impact on children and young people.
- **TF2 families (Troubled families 2) to have a common assessment framework (CAF) initiated if they need one.** A third of all CAFs are started between the ages of 0-5 years and we want appropriate CAFs to be initiated using the new electronic Family CAF.
- **Mental health services and pathways to explicitly consider access for individuals from minorities, including sexual orientation where there is evidence of enhanced need.** See sections 5.3.4 (children and adolescents) and 5.4.1 (adults).
- **More of vulnerable adults to have employment opportunities.** See section 5.4.1.

5.7.4 Priority Area: *Prevention*

- **Promote independence for our residents and tackle homelessness.** Barking and Dagenham is one of the less wealthy London Councils and has a significant issue with homelessness. Homelessness directly links about to health as homeless individuals and families are likely to be more unhealthy than the general population.

  The number of people in the main priority need groups to whom the LBBD Council has accepted a full homelessness duty almost 4-fold increase between 2009 and 2013.Although the numbers of applicants from BME communities have increased significantly over the last 12 months, the numbers of BME's actually meeting the criteria for statutory homelessness has remained stable.

6 Impact of Care Act 2014

The Care Act stresses the need to integrate health and social care services at all levels and is prescriptive about what it expects in terms of the JSNA and the Joint Health and Wellbeing Strategy. In response, Barking and Dagenham have recently agreed a sector wide five year strategy which will clearly inform our thinking. The importance of implementing the prevention framework is key to service transformation.

7. Mandatory Implications

7.1 Joint Strategic Needs Assessment

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

7.2 Health and Wellbeing Strategy

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

7.3 Integration

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

7.4 Financial Implications

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

The refresh of the Joint Strategic Needs assessment is intended to inform the development of the Health and Wellbeing Strategy, and future commissioning decisions relating to changes in statutory responsibilities. Given the current financial environment for both the local authority and the CCG, it is not expected that there will be new funding for investment.

7.5 Legal Implications

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

There are no legal implications.

7.6 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.

7.7 Non-mandatory Implications

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

8 Background papers used in the preparation of the report:

Barking and Dagenham Mental Health Needs Assessment

https://www.lbbd.gov.uk/residents/health-and-social-care/health-and-wellbeing/mental-health/mental-health-needs-assessment/

Barking and Dagenham Prevention Framework

https://search3.openobjects.com/mediamanager/barking/asch/files/prevention_-_a_local_framework.pdf

Adult Social Care Market Statement

http://www.npi.org.uk/files/3313/8150/0123/Final_full_report.pdf - Poverty Profiles 2014, Trust for London

Longer Lives Summary Report – LBBD (2013)

http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MID=7075#AI47136

Barking and Dagenham Director of Public Health Annual Report 2014

https://www.lbbd.gov.uk/council/priorities-and-strategies/corporate-plans-and-key-strategies/health-and-wellbeing-strategy/director-public-health-annual-report/

Care and Support Statutory Guidance – Department of Health (2014)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf

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Attachment 1

2. Key Recommendations (Through the Life Course Stages)

Stage	Recommendations
Pre – birth and early years	1. Partners to embed and develop the promotion of health and social care interventions such as breastfeeding, oral health, child nutrition, physical activity and immunisation through to 2016. (Board priority 3 & 5) 2. The Council with partners to review and develop further an integrated approach to the delivery of early year's interventions and capitalise on the opportunities presented by the transition of the 0-5 Healthy Child Programme commissioning to the Council in October 2015. (Board priority 5)
Primary School	3. Partners to ensure that commissioning takes into account the impact of the growth in the 5-19 years population and are providing adequate capacity in services to support this group in health and social care, education and community settings. (Board priority 5) 4. Partners to embed and develop the promotion of health and social care interventions such as oral health, child nutrition and physical activity through to 2016.(Board priorities 3 & 5) 5. The Council will ensure that all children and young people have the opportunity to be well-educated in order to narrow the gap in attainment and realise high aspirations for every child, including the most vulnerable. In turn this will support the development of a local, skilled workforce to match improved employment opportunities. (Board priority 5)
Adolescence	6. Partners to ensure parity of esteem between mental health services and physical health services. Public Health, working with local stakeholders, should consider undertaking a needs assessment of Child and Adolescent Mental Health (CAMH) to define the need for the services that are provided to this vulnerable population of young people, and the adults in their households. (Board priority 8) 7. Partners to further develop universal provision to support children and young people's emotional health and wellbeing. Developing resilience needs to be further considered as part of looked after children's emotional health including dealing with drugs, alcohol and sexual relationships. (Board priorities 7 & 8)

Early Adulthood	8. The Council will grow the borough offering high quality, decent homes, including private rented accommodation, and a sustainable community, in an enhanced environment and develop a local skills base, along with enhancing the borough's image to attract investment and business growth. (Board priorities 2, 8 & 9) 9. Partners to empower residents to take responsibility for their own health and social care needs including interventions that encourage behaviour change to healthier lifestyles and up take of services including sexual health, drug and alcohol harm reduction, smoking cessation, national immunisation and screening programmes through to 2016. (Board priorities 2, 3, 4 & 7)
Maternity	10. Partners to continue to work together to strengthen the maternity pathway to ensure the opportunity book mothers to see a midwife by week 12 of a pregnancy; to use the Barking and Dagenham birthing centre, and to engage with health and social care interventions such as breastfeeding, babyClear, drugs and alcohol harm reduction through to 2016. (Board priority 2)
Established Adults	11. The Council and CCG to further develop through programmes such as the Social Care Transformation, Primary Care Transformation, Better Care Fund, Care Act and Children and Families Act and Everyone Counts to ensure services promote residents' independence. Enabling them to make healthier choices in their daily lives including sexual health, drug and alcohol harm reduction, smoking cessation, NHS health checks, national immunisation and screening programmes through to 2016 (Board priorities 1, 2, 4, & 7) 12. Reduce hospital admissions and re-admissions. Partners together with residents and patient groups need to enhance and develop initiatives to increase awareness of signs and symptoms of chronic disease, particularly cancer, diabetes and COPD, to improve early diagnosis of disease and empower residents to understand how to manage chronic disease from day-to-day, which will increase life expectancy. (Board priorities 1 & 2)
Older Adults	13. We want to reduce the number of residents who suffer accidental injury. Partners together with voluntary groups need to enhance initiatives that address injury including falls prevention and appropriate and timely access to eye health services. (Board priority 9) 14. At the end of life we want our adults who are terminally ill to die with dignity in a supported and planned way. We particularly want residents to have real choice about where they die. (Board priority 1)

Vulnerable and Minority Groups	
	15. Partners to actively work towards assuring that there is appropriate specialist capacity for vulnerable groups with mental ill health, including children in households where adults have mental illness. This should have a focus on early intervention in those with psychosis, and that pathways exist at all tiers of service accessible to these populations both adults and CAMHS . (Board priority 8) 16. Children's and Adult and Community Services to monitor domestic violence services to ensure they continue to meet the needs of residents and to support projects that promote emotional wellbeing, giving opportunities to develop skills and understanding. (Board priority 6) 17. The Safeguarding Adults Board and the local Safeguarding Children's Board have a key role to ensure that multi agency capacity is sufficient to meet our safeguarding needs and that they are effectively monitored and embedded across the borough. (Board priority 6) 18. Partners to work jointly to develop and maintain a sustainable market for our residents who most need adult social care; particularly addressing services to our older residents, those with learning disabilities, autism, mental health issues, physical disability and / sensory disability, those with drug and alcohol problems and those with behaviour which challenges. (Board priority 1) 19. All partners should work towards clearly defined outcomes for employment opportunities for people who are vulnerable, including residents who have physical disabilities, learning disabilities or mental health support needs. (Board priority 1) 20. Continue to tackle homelessness and promote independence by implementing new accommodation strategies for mental health and learning disabilities (including carers). (Board priority 1)

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HEALTH AND WELLBEING BOARD

8 September 2015

Title:	Improving Post–Acute Stroke Care (Stroke Rehabilitation) – the Case for Change
Report of the Barking and Dagenham CCG	
Open Report	**For Decision**
Wards Affected: All wards	**Key Decision:** No
Report Author: Sharon Morrow, Chief Operating Officer Barking and Dagenham CCG	**Contact Details:** Tel: 0203 6442370 E-mail: Sharon.morrow@barkingdagenhamccg.nhs.uk
Sponsor: Conor Burke, Chief Officer Barking and Dagenham CCG	

Summary:

Stroke is the largest cause of complex disability and 30% of people who have had a stroke will require access to effective community stroke rehabilitation services. Improving the pathway for post-acute stroke care is one of the CCG commissioning priorities for 2015/16 and Barking and Dagenham CCG, Havering CCG and Redbridge CCG have established a BHR Stroke Pathway Transformation project to ensure that people who have had a stroke achieve the best possible outcomes. An emerging case for change has been developed following an analysis of data from acute and community providers, a service mapping exercise and stakeholder engagement.

The case for change has three main headlines:

1. There is variation in the provision of stroke rehabilitation care across the three BHR CCGs, which means that access to these services is not equitable.

2. The quality of stroke rehabilitation is not consistency meeting national quality standards, which means that people are not always given the best opportunity to achieve the best possible outcomes

3. The current level of capacity and the current level of demand for stroke rehabilitation are not aligned, which means people may wait too long for discharge home with stroke rehabilitation and delay integration back into their employment and their communities.

The CCG is engaging with stakeholder on the case of change; this will be used to inform the development of an outline business case for service improvement that will be considered at the November Governing Body meeting.

Recommendation(s) The Health and Wellbeing Board is recommended to: (i) Comment on the case for change; (ii) Agree that care and outcomes need to improve; (iii) Continue to engage with B&D CCG on improving stroke rehabilitation care.
Reason(s) The CCG is engaging on the case for change in order to better understand the impact of the current service configuration on the quality of services being delivered in Barking and Dagenham and patient outcomes. The case for change will be used to inform the development of a business case for service improvement.

1. Introduction and Background

1.1 Barking and Dagenham CCG commissioning intentions for 2015/16 were presented to the Health and Wellbeing Board in December 2014. Improving the stroke rehabilitation pathway is one of the agreed CCG commissioning priorities that are being taken forward in the commissioning plan this year in collaboration with Redbridge and Havering CCGs.

1.2 Stroke is the sudden loss of brain function when the supply of blood to the brain is either interrupted or reduced. The impact of a stroke is both instant and unpredictable. The nature and the severity of the effects depend on the amount of damage caused and the part of the brain that has been affected. It is the largest cause of complex disability; 30% of people who have had a stroke will have persisting disability, and consequently require access to effective community stroke rehabilitation services (also referred to as post-acute stroke care).

1.3 In Barking and Dagenham, Havering and Redbridge (BHR), there are 8,944 people registered on the Stroke Register with the highest prevalence in Havering due to its older population. There are 1943 people registered on the Stroke Register in Barking and Dagenham. The demand for stroke rehabilitation services will increase by around 35% over the next twenty years.

1.4 People with disability after stroke should receive rehabilitation in a dedicated stroke inpatient unit and subsequently from a specialist stroke team. Specialist co-ordinated rehabilitation, started early after stroke and provided with sufficient intensity, reduces mortality and long-term disability. A number of national guidelines and commissioning guides have articulated that early rehabilitation is effective when provided in specialist stroke units, or as part of properly organised early supported discharge service with longer term support in the community. This comprises of three types of community stroke rehabilitation:

- Early Supported Discharge (ESD): Rehabilitation at home at the same intensity of inpatient care.
- Inpatient Rehabilitation (IR): Provided in specialist community stroke rehabilitation inpatient Units

- Community Rehabilitation Services (CRS): Needs - led rehabilitation within the home environment which should include six and 12 monthly reviews to ensure on-going needs are met.

1.5 The BHR Stroke Pathway Transformation project was established in 2014 following recognition that the current community stroke rehabilitation service provision followed a disjointed pathway that was too reliant on the use of inpatient rehabilitation services, and that as a result people who have had a stroke were not achieving the best possible outcomes. The purpose of the Stroke Pathway Transformation project is to:

- Identify the best model for stroke rehabilitation locally and make sure all local people have equal access to this model of care, so that no matter where they live, stroke survivors are able to achieve the best possible outcomes.
- Make sure that everyone working to support people after a stroke are clear about what support is available
- Make sure that everyone working to support people after a stroke are clear about what support is available
- To understand how existing resources for stroke rehabilitation are currently being used to ensure they are being used in the most efficient way in the future

1.6 The Delivery Improvement Transformational Change team (DITC) within the North East London Commissioning Support Unit (NEL CSU) was commissioned by the BHR CCGs to identify what needs to change in the way community stroke rehabilitation services are currently commissioned and delivered. The outputs of this work has identified that although all three types of community stroke rehabilitation exist within BHR, there is variation in provision and quality in comparison to best practice. The number of providers with differing commissioning and delivery arrangements both within and across CCGs mean that the stroke care pathways are complex and confusing to articulate.

The key highlights are:

- The two inpatient stroke rehabilitation providers have different access criteria and different target Lengths of Stay (LoS).
- People living in Barking and Dagenham have limited access to 6/12 and 12 monthly reviews to ensure robust stroke survivorship support and on-going measurement of patient outcomes.
- Patient outcomes across the entire stroke pathway are inconsistently recorded/reported across BHR.
- Activity and financial reporting is inadequate; individual BHR CCGs are currently unable to tell how much they are spending on stroke services or how many patients are treated.
- There is no ESD service available to people living within the west of Redbridge.
- Whilst NELFT is the single provider of community stroke rehabilitation (CRS) all three borough teams have different numbers and levels of specialist staff within them.

1.7 The CCG is engaging in a period of wider stakeholder engagement and data analysis to strengthen the case for change in post-acute stroke care.

2. Proposal and Issues

2.1 The emerging case for service change for improving post-acute stroke care (stroke rehabilitation services across Barking and Dagenham, Havering and Redbridge is attached as Appendix A. The case for change has three main headlines:

1. There is variation in the provision of stroke rehabilitation care across the three BHR CCGs, which means that access to these services is not equitable.
2. The quality of stroke rehabilitation is not consistency meeting national quality standards, which means that people are not always given the best opportunity to achieve the best possible outcomes
3. The current level of capacity and the current level of demand for stroke rehabilitation are not aligned, which means people may wait too long for discharge home with stroke rehabilitation and delay integration back into their employment and their communities.

2.2 The main issues to note for Barking and Dagenham are as follows:

- In 2013/14 there were 1943 people registered as having had a stroke on GP registers; it is expected that demand for stroke rehabilitation services will increase by 35% over the next twenty years
- Emergency admissions standardised for age are higher in Barking and Dagenham than expected
- The number of deaths per 100,000 population is higher in Barking and Dagenham than expected for the age profile of the population
- The intensity at which Early Supported Discharge rehabilitation is provided is not always at the quality standards expected due to existing capacity
- The acceptance criteria for the providers of stroke Inpatient Rehabilitation are very different.
- The service at Grays Court limits the stay to a maximum of 28 days inpatient rehabilitation.
- There is no service providing the required 6 or 12 monthly stroke reviews
- 2012/13 clinical audits undertaken between 2012 and 2013 demonstrated that approximately 30 - 50% of patients in Grays Court could have been treated in the community if specialist stroke rehabilitation teams were in place to meet needs.

2.3 The Health and Wellbeing Board is asked to comment on the case for change, agree that care and outcomes need to improve, and continue to engage with Barking and Dagenham CCG on improving stroke rehabilitation care.

2.4 Potential options for service improvement will be considered by the CCG Governing Body in September and will inform the development of an outline business case for approval at the November Governing Body meeting. Any proposals for service change would be taken through a formal consultation process pending the approval of an outline business case.

3. Consultation

3.1 Further work is being undertaken with NELFT to strengthen the data analysis to ensure that the current pathway is fully captured before the case for change is finalised.

3.2 Healthwatch undertook a survey of patient and carer experience of using local stroke services in 2015, which will be taken into consideration in the case for change. The emerging case was also discussed at the Barking and Dagenham Patient Engagement Forum on 18th June 2015.

4 Mandatory Implications

4.1 Joint Strategic Needs Assessment

Cardiovascular disease is the biggest preventable cause of death in the UK, with particularly high levels of mortality in Barking and Dagenham and in particular the under 75's.

The JSNA recommends that commissioners should ensure that services and cardiac and stroke rehabilitation are in line with best practice and achieving optimal outcomes.

4.2 Health and Wellbeing Strategy

The case for change will inform future proposals for service improvement that will support delivery of the Health and Wellbeing Strategy outcomes:

- 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

It supports the priority theme of "Improvement and Integration of Services" by benchmarking services against best practice, identifying where care has failed and exploring new and different ways of providing health and social care that is more accessible and person centred.

4.3 Integration

The BHR Stroke Pathway Transformation project supports the delivery of the vision for the BHR health economy to improve health outcomes for local people through best value care in partnership with the community. The ambition is that in five years time all people will have a greater chance of living independently longer; they will spend less time in hospital but when they do they will have a better experience than now. Services will be better integrated both within and across organisational boundaries, with more streamlined access and more of them being offered 24/7, delivering high quality health and social care to patients closer to home.

4.4 Financial Implications

There will be a full financial assessment undertaken once there are proposals to consider in the next stage of the project.

4.5 Legal Implications

There are no legal considerations at this stage of the project.

4.6 Risk Management

4.7 Patient/Service User Impact

The case for change identifies that patient experience and outcomes could be improved through service redesign but does not propose any change at this stage.

5. Non-mandatory Implications

5.1 Crime and Disorder

N/A

5.2 Safeguarding

There are no identified safeguarding issues related to the case for change.

Public Background Papers Used in the Preparation of the Report:

None

List of Appendices:

Appendix A - Improving Post-acute Stroke Care (Stroke rehabilitation) services across Barking & Dagenham Havering and Redbridge: The Case for Service Change

Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

Improving Post-acute Stroke Care (Stroke Rehabilitation) services across Barking & Dagenham, Havering and Redbridge The Case for Service Change

sharonmorrow
3 Aug 2015 12:31

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1 Executive Summary

Stroke is the sudden loss of brain function when the supply of blood to the brain is either interrupted or reduced. The impact of a stroke is both instant and unpredictable. The nature and the severity of the effects depend on the amount of damage caused and the part of the brain that has been affected. It is the largest cause of complex disability; 30% of people who have had a stroke will have persisting disability, and consequently require access to effective community stroke rehabilitation services (also referred to as post-acute stroke care).

In Barking and Dagenham, Havering and Redbridge (BHR), there are 8,944 people registered on the Stroke Register with the highest prevalence in Havering due to its older population. The demand for stroke rehabilitation services will increase by around 35% over the next twenty years; equating to 335 more people per year for stroke rehabilitation.

Specialist co-ordinated rehabilitation, started early after stroke and provided with sufficient intensity, reduces mortality and long-term disability. A number of national guidelines and commissioning guides have articulated that early rehabilitation is effective when provided in specialist stroke units, or as part of properly organised early supported discharge service with longer term support in the community. This comprises of three types of community stroke rehabilitation:

- **Early Supported Discharge (ESD):** Rehabilitation at home at the same intensity of inpatient care.
- **Inpatient Rehabilitation (IR)**: Provided in specialist community stroke rehabilitation inpatient units
- **Community Rehabilitation Services (CRS)**: Needs - led rehabilitation within the home environment which should include six and 12 monthly reviews to ensure on-going needs are met.

The BHR Stroke Pathway Transformation project was established in 2014 following recognition that the current community stroke rehabilitation service provision followed a disjointed pathway that was too reliant on the use of inpatient rehabilitation services, and that as a result people who have had a stroke were not achieving the best possible outcomes. The Delivery Improvement Transformational Change team (DITC) within NEL CSU was commissioned by BHR CCGs to identify what needs to change in the way community stroke rehabilitation services are currently commissioned and delivered.

The outputs of this work has identified that although all three types of community stroke rehabilitation exist within BHR, there is variation in provision and quality in comparison to best practice. The number of providers with differing commissioning and delivery arrangements both within and across CCGs mean that the stroke care pathways are complex and confusing to articulate. The key highlights are:

- There is no ESD service available to people living within the west of Redbridge.
- Whilst NELFT is the single provider of community stroke rehabilitation (CRS) all three borough teams have different numbers and levels of specialist staff within them.
- The two inpatient stroke rehabilitation providers have different access criteria and different target Lengths of Stay (LoS).
- People living in Barking and Dagenham have limited access to 6/12 and 12 monthly reviews to ensure robust stroke survivorship support and on-going measurement of patient outcomes.
- Patient outcomes across the entire stroke pathway are not is routinely recorded or reported across BHR.
- Activity and financial reporting is inadequate; individual BHR CCGs are currently unable to tell how much they are spending on stroke services or how many patients are treated.

This document demonstrates a clear case for change in the provision of community stroke rehabilitation services. The current variation in service configuration, quality and lack of information is impacting on patient outcomes.

Therefore it is recommended that BHR CCGs undertake the following:

1. Agree that outcomes for people living with the effects of stroke will improve by changing the way that post-acute stroke care is commissioned and delivered across BHR.

2. Agree to prepare a business case to consider possible changes to the provision of post-acute stroke services.

3. Agree to engage widely with patients and the public on the case for change.

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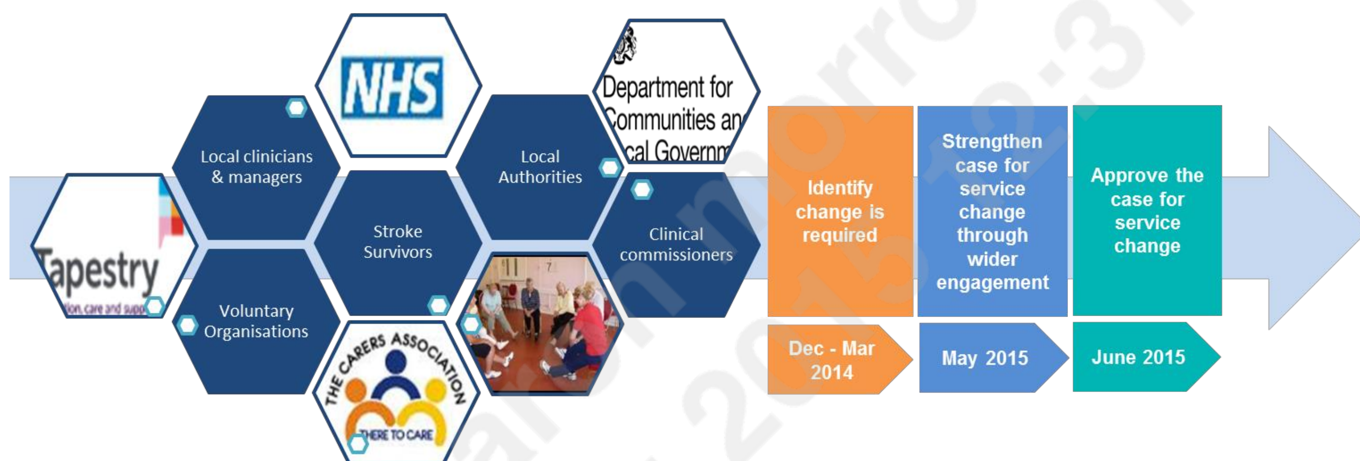
2 Introduction

2.1 Context

In November of 2014 Barking & Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Groups (CCGs) agreed to work in partnership to establish a BHR Stroke Pathway Transformation project. They believe that the current post-acute stroke care, or stroke rehabilitation service offer follows a disjointed pathway that is too reliant on the use of inpatient rehabilitation services, and that as a result people who have had a stroke are not achieving the best possible outcomes.

The vision of the BHR CCG's is to: '*identify what needs to change within the stroke rehabilitation pathway together and develop future solutions to ensure the best possible outcomes for users of stroke rehabilitation are delivered'*

Local providers of post-acute stroke care, commissioners, local authorities, voluntary organisations and stroke survivors were invited to participate in this project, providing expertise and representation on committees and clinical working groups.



The ONEL non-acute bed base review in 2012 recommended that changed needed to be made to the inpatient stroke rehabilitation bed base across BHR. Organisational change across the NHS since 2012 has meant that these changes had not yet been implemented.

Emerging evidence on the benefits of Stroke Early Supported Discharge (ESD) and the recent consultation on Intermediate Care provision in BHR has enabled the CCGs to revitalise this work. Before delivering any change to stroke inpatient rehabilitation provision in the future, commissioners and providers are keen to understand how existing Stroke ESD and Community Rehabilitation (CR) services are delivering post-acute stroke care to people living in the boroughs of BHR, to identify what needs to change in the future to improve outcomes for stroke survivors.

The Delivery Improvement and Transformational Change (DITC) team in NELCSU, in partnership with BHR CCG's, have undertaken three key activities to identify if post-acute stroke care needs to change. This includes analysis of all available data from both acute and community providers, a mapping exercise across all three BHR boroughs, and engagement with key stakeholders across the BHR landscape to validate and strengthen the findings.

The purpose of the Stroke Pathway Transformation project is to:

- Identify the best model for stroke rehabilitation locally and make sure all local people have equal access to this model of care, so that no matter where they live, stroke survivors are able to achieve the best possible outcomes.
- Make sure that everyone working to support people after a stroke are clear about what support is available
- Make sure that everyone working to support people after a stroke are clear about what support is available
- To understand how existing resources for stroke rehabilitation are currently being used to ensure they are being used in the most efficient way in the future

BHR CCGs would now like to engage in a period of wider stakeholder engagement and data analysis to strengthen their existing case for change in post-acute stroke care. They would like to understand what impact the variation in stroke services configuration has on both the quality of stroke rehabilitation being delivered, and patient outcomes. As a greater number of people are surviving their initial stroke, demand for post-acute stroke care is increasing. To ensure this demand can be met there is also a need to understand how existing stroke rehabilitation resource is being utilised. This will require a much more detailed analysis of how people move through the pathway both within and across services and organisations, as well as specific financial detail about each different phase of the pathway. This way informed decisions can be made on what is the most cost-effective way to deliver the best outcomes for people living with the effects of stroke and their carers' in the future.

2.2 Purpose of this paper

The purpose of this paper is to:

- Describe the current and future demand for stroke rehabilitation services across Barking & Dagenham, Havering and Redbridge CCGs.
- Describe what good stroke rehabilitation care should look like in relation to national best practice and understand the gaps in the existing provision of service
- Explain the emerging case for change in stroke rehabilitation care across BHR CCGS
- Describe the potential barriers to change that need to be considered
- Make recommendations for next steps to improving stroke care across BHR CCGs

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3 Demand for stroke rehabilitation care: the national and local context

3.1 What is stroke?

Stroke, also known as a ‘brain attack’ is a sudden loss of brain function when the supply of blood to the brain is either interrupted or reduced.

There are two main causes of stroke:

- **Ischaemic** – When a blood vessel in the brain is blocked by a blood clot which severally reduces blood flow. These clots can form either in the arteries connecting to the brain, or elsewhere in the body and travel through the bloodstream into narrower blood vessels in the brain – this cause of stroke accounts for 85% of all cases.
- **Haemorrhagic** – When a blood vessel in the brain breaks or ruptures. This causes blood to seep into the brain tissue, causing damage to brain cells.

There is also a related condition known as a **transient ischaemic attack (TIA),** where the supply of blood to the brain is temporarily interrupted, causing a 'mini-stroke' often lasting between 30 minutes and several hours. They are similar to ischemic strokes in that they are often caused by blood clots or other debris.

Symptoms of stroke

Strokes occur quickly, and as such their symptoms often appear suddenly without warning. Typical symptoms include[1]:

- Numbness, weakness or paralysis on one side of your body
- Slurred speech, or difficulty finding words or understanding speech
- Sudden blurred vision or loss of sight
- Confusion or unsteadiness, or
- A sudden, severe headache.

The best possible outcomes for people having a stroke have been associated with accessing urgent assessment and treatment within 30 minutes from the onset of symptoms of stroke. This is discussed further in section 2.

There are a number of risk factors that increase the likelihood of someone having a stroke. These are classified in two ways. The first group are ones that are modifiable, where changes can be made to reduce the risk of having a stroke. The second group are factors that are considered non – modifiable, or things people are unable to change to reduce their risk of having a stroke.

Modifiable Stroke Risk Factors

- Lack of physical activity
- High blood pressure
- Smoking
- Diabetes
- Unhealthy diet
- Certain medical conditions, such as sickle cell anaemia and bleeding disorders
- Alcohol and illegal drug use
- High cholesterol levels
- Obesity
- Stress and Depression

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[1] Stroke Association (2015) What are the symptoms of stroke?

Non-modifiable Stroke Risk Factors

- **Age and gender -** Risk of stroke increases with age. At younger ages, men are more likely than women to have strokes. However, women are more likely to die from strokes. Women who take birth control pills also are at slightly higher risk of stroke.
- **Race and ethnicity -** Strokes occur more often in African American, Alaska Native, and American Indian adults than in Caucasian, Hispanic, or Asian American adults.
- **Personal or family history of stroke or TIA -** TIA or a previous stroke increases the risk of having another stroke, as does having a family history of stroke.

Possible effects of stroke: Given that a stroke can occur in a variety of areas of the brain, there is a very wide range of difficulties people can experience as a result. 30% of people who have had a stroke will have persisting disability, and consequently require access to effective rehabilitation services.[2] Figure 1 describes the range and types of difficulties stroke survivors may face following their stroke and the proportion of stroke survivors who have been affected by that particular difficulty.[3]

Each individual patient will have a combination of each of these conditions with varying degrees of acuity. This variation in the needs of patients illustrates the challenges commissioners and providers of stroke services face when designing the right configuration of stroke care for their population, and ensuring robust measurement of patient outcomes being achieved.

Difficulty	% of people affected
Upper limb/arm weakness[42]	77%
Lower limb/leg weakness[42]	72%
Visual problems[43]	60%
Facial weakness[44]	54%
Slurred speech[44]	50%
Bladder control[45]	50%
Swallowing[42]	45%
Aphasia[46,47,48]	33%
Sensory loss[44]	33%
Depression[49]	33%
Bowel control[45]	33%
Inattention/neglect[44]	28%
Emotionalism within six-months[50]	20%
Reduced consciousness[44]	19%
Emotionalism post-six months[50]	10%
Identified dementia one-year post stroke[51]	7%

Figure 1: Range and types of difficulties people can have following stroke and % people affected

[2] NICE Clinical Guidelines: Stroke rehabilitation - 162
[3] Stroke Association (2015) State of the Nation – Stroke Statistics

3.2 The national picture for stroke

Improvements in stroke care since the 1960s have meant that the proportion of people who survive a stroke has been increasing steadily; 125,000 people in the United Kingdom survive a stroke each year, but often at the cost of long-term disability. The Stroke Association has reported in *'State of the nation'* that 1 in 8 strokes are fatal within the first 30 days[4], and that more than 900,000 people are currently living in the UK with the effects of stroke.

There are a number of factors that predict the incidence of stroke including age and gender.[5] These have been used to calculate the % incidence of stroke nationally and are described in Table 1 below.

Age Group	Incidence of Stroke (%)	
	Women	Men
0-44	1	1
45-64	1.5	2.1
65-74	6.2	9.2
75 and over	19.8	18.7

Table 1: Ave. incidence of stroke per age group

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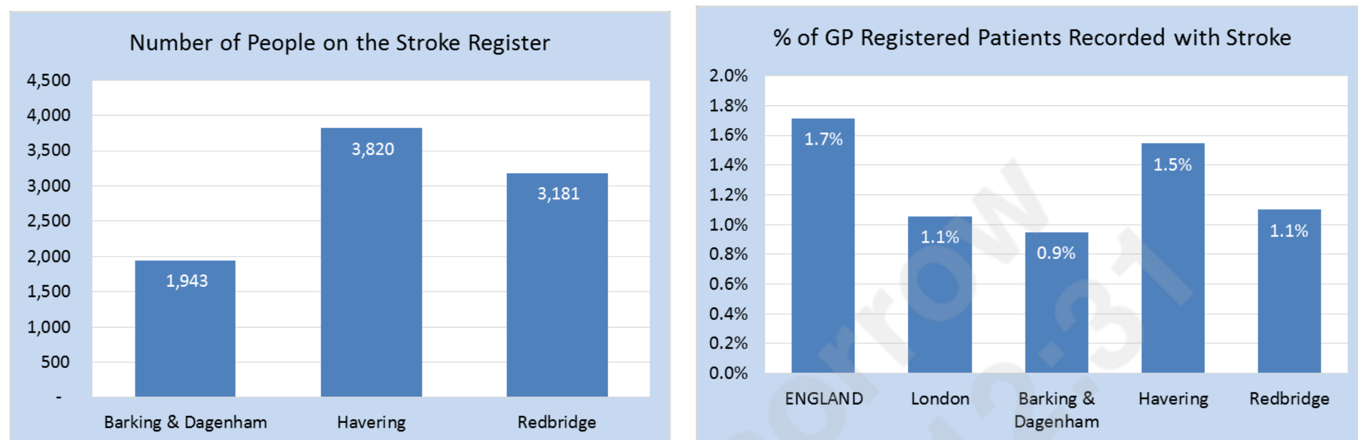
[4] D'Agostino, et al (1994) Stroke Risk Profile: The Framingham Study
[5] Majeed A; Carroll K et al. (2001) Stroke incidence and risk factors in a population- based prospective cohort study.

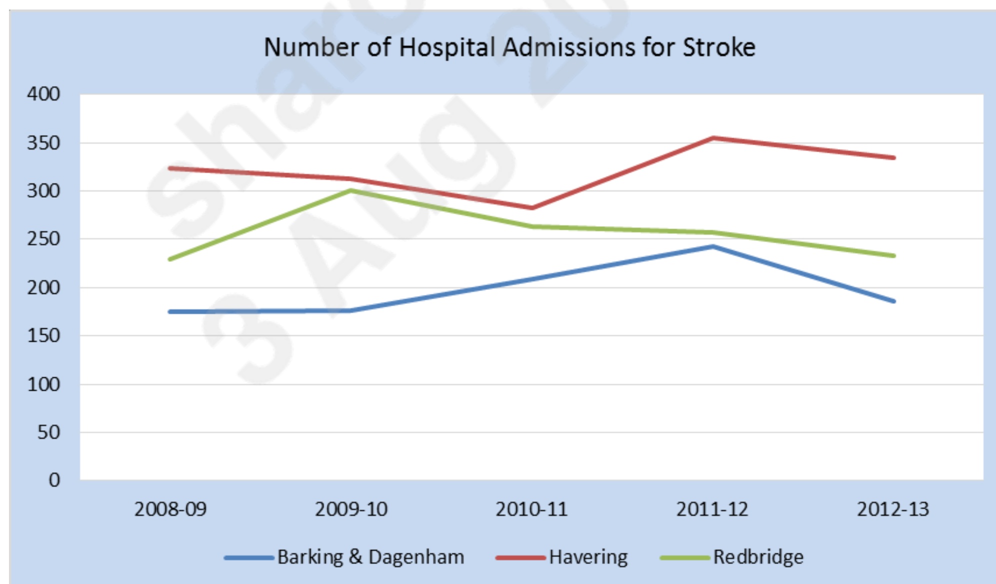
3.3 The local picture for stroke in Barking & Dagenham, Havering and Redbridge[6]

The proportion of the population over the age of 65 varies across the three boroughs with Havering having the highest at 17.9%, Redbridge 11.9%, and Barking & Dagenham the lowest at 10.3%. As a consequence the prevalence of stroke is highest in Havering and this is shown in the analysis below.

Data published by the Health and Social Care Information Centre gives a picture of the demand for stroke care in the three boroughs. GP registers show that in 2013-14 there were 8,944 peopled registered as having had a stroke. This is shown in the graph below on the left. The graph on the right shows the same number as % of all registered patients. This shows the highest number of patients in Havering which is to be expected given the age profile of the population



The graph below shows the number of hospital admissions recorded as stroke for the five years from 2008-09 to 2012-13. Again this shows Havering having more admissions (average 322) than Barking & Dagenham (average 198) and Redbridge (average 256).



[6] All data in this section from HSCIC unless otherwise stated

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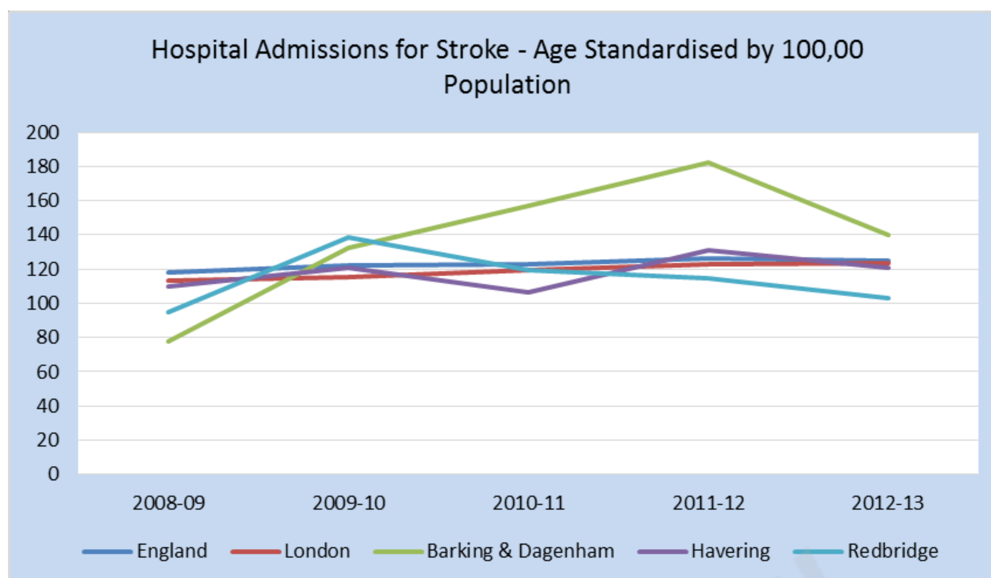
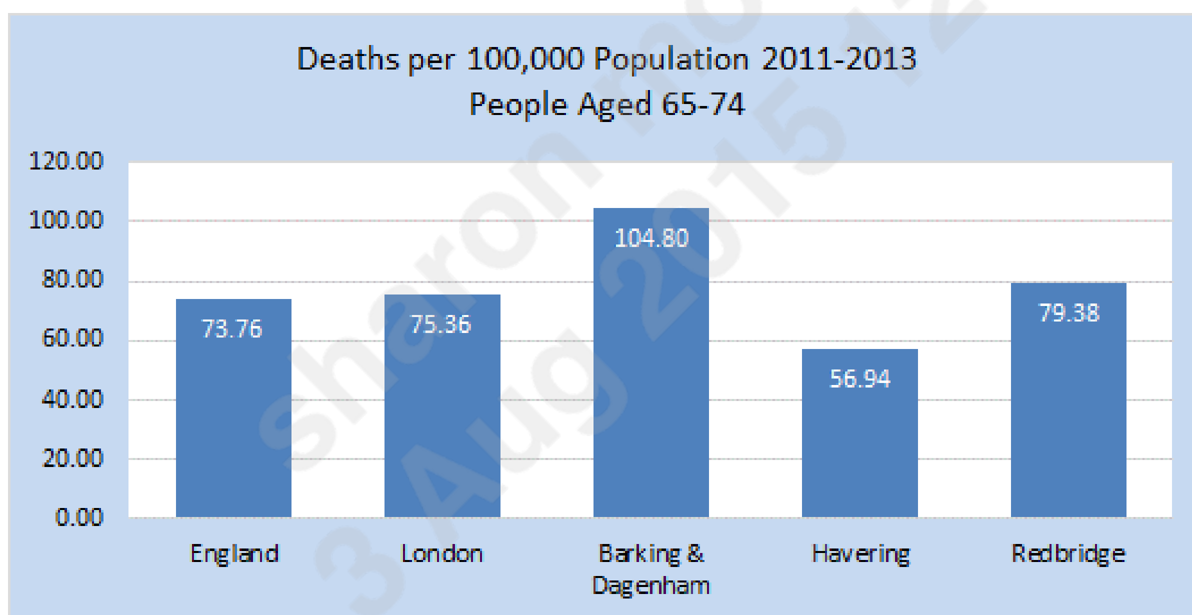
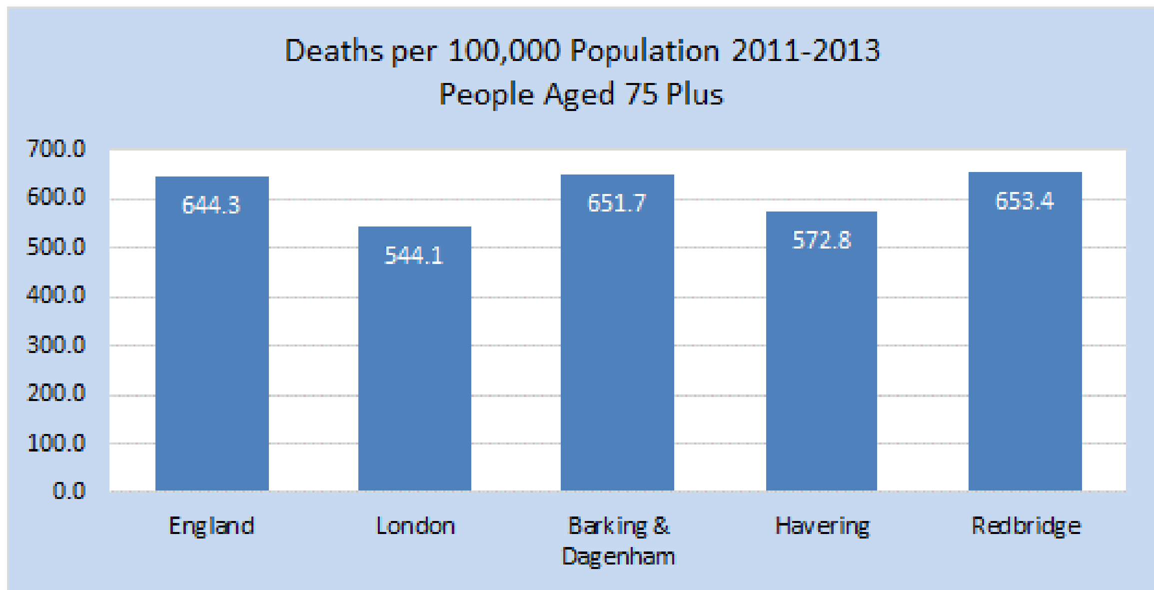
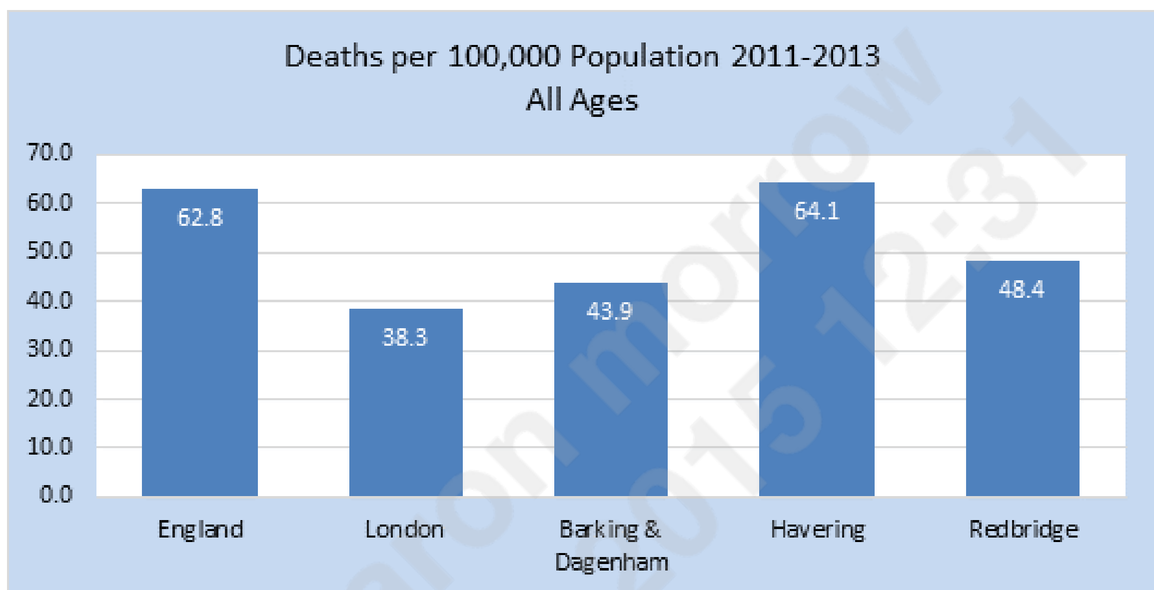
However the when the information is standardised for the age profile of the population it is Barking & Dagenham that appears to have more admissions for stroke than would be expected.



These results are replicated in the information on deaths for stroke. The graphs below show deaths per 100,000 people for 2011-2013, for all ages and for people in the age bands 75+ and 65-74. This also shows Barking & Dagenham as having more deaths than would be expected for the age profile of the population.







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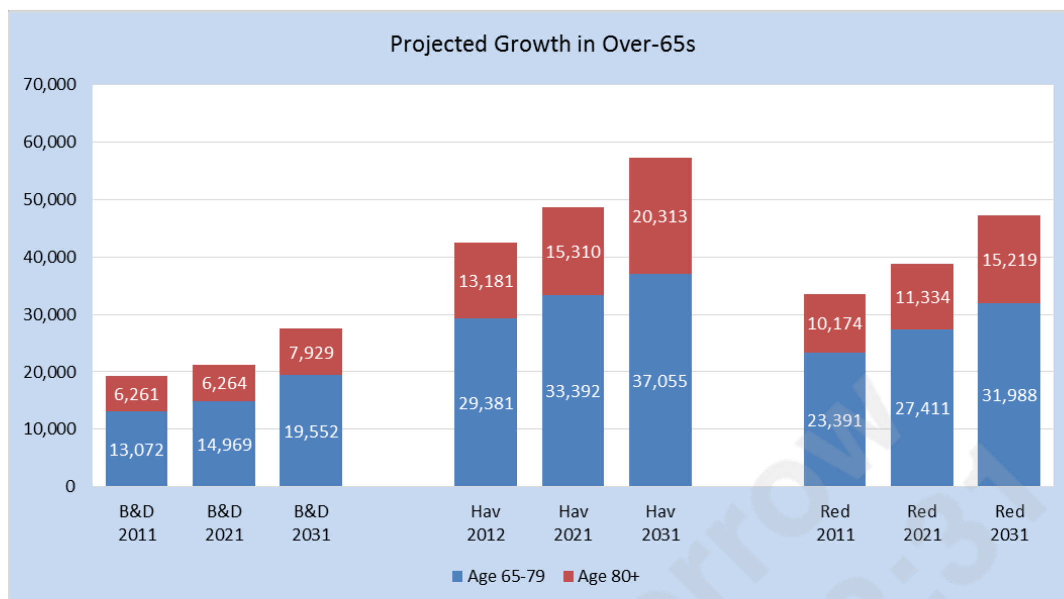
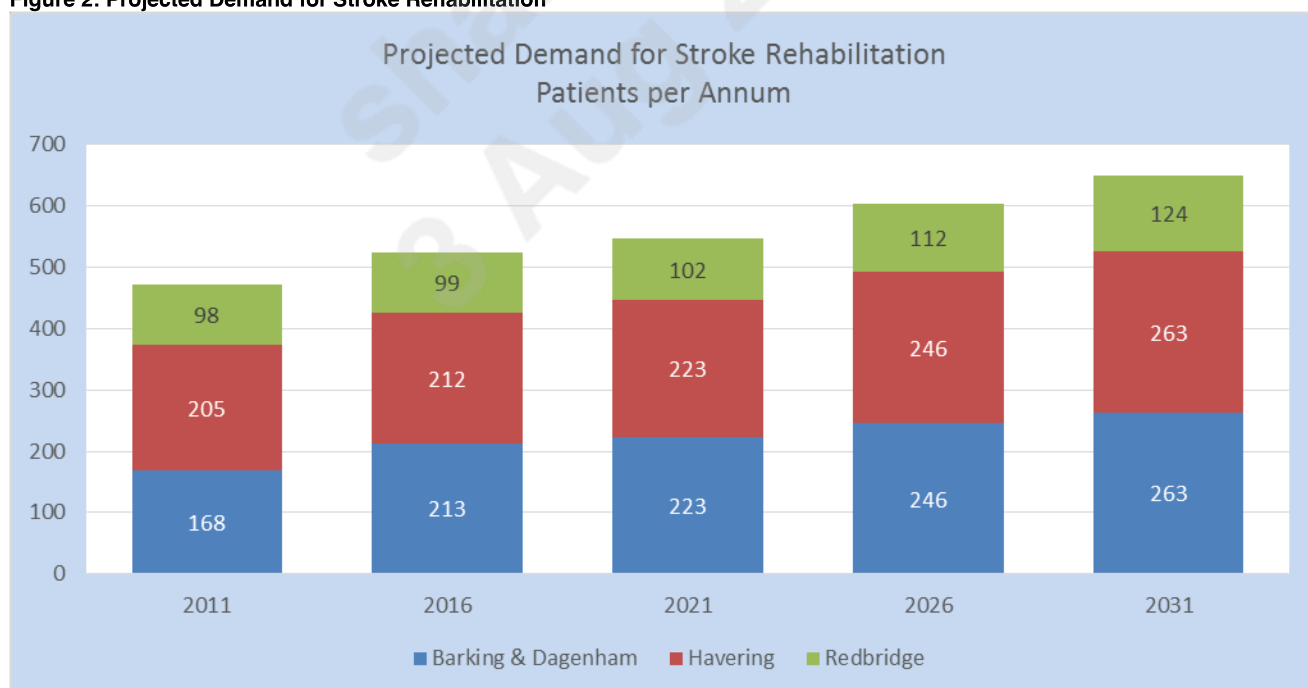
3.4 Future demand for stroke care

The numbers of people having strokes in the area will increase over the next twenty years as the population gets older. The graphs below show the expected growth in the numbers of people aged 65 plus from the census in 2011[7]. In the twenty years from 2011 to 2031 it is expected that the numbers of people aged 65 or more will increase by 38% and the number of people aged 85 or more will increase by 47%. The highest increase will be in Havering.



By taking the forecast population growth and the incidence of stroke in the population it is possible to project the future likely demand for stroke rehabilitation services. Expert opinion (Stroke CRG) suggests that 40% of inpatient stroke patients will be eligible for ESD (Figure 2); and the remainder for some form of rehabilitation (Figure 3). However it should be remembered that these estimates are based upon national levels of incidence and survival; there may be local factors that mean that demand locally will be different.

Figure 2: Projected Demand for Stroke Rehabilitation



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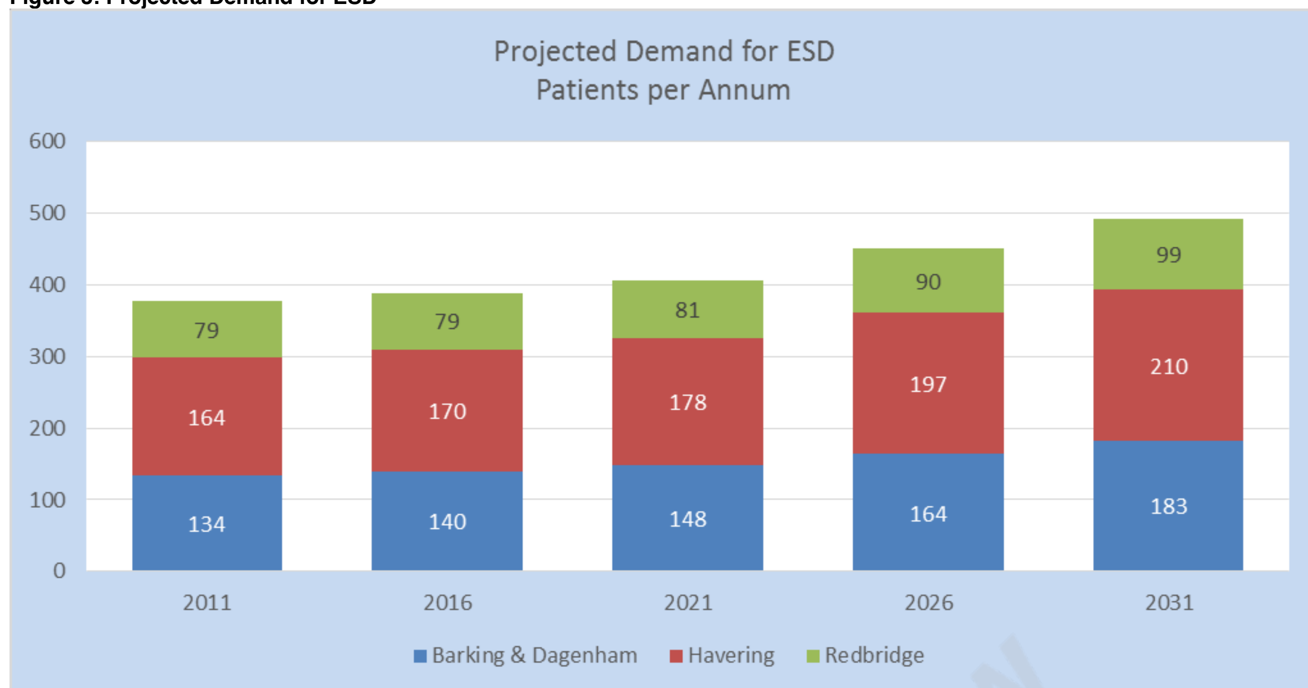
[7] Greater London Authority projection 2013 release (Capped SHLAA model)

Figure 3: Projected Demand for ESD



In total it is estimated that demand for stroke rehabilitation services will increase by around 35% over the next twenty years. By 2031 services will need to provide ESD for 115 more people per year and other types of stroke rehabilitation for 180 more people per year.

The future demand for rehabilitation including ESD will be greatest in Havering due to its older population and the increased risk of stroke in this age group.

A clear understanding of current capacity within the existing post – acute stroke services will be required to understand what impact this demand will have on existing resources and service configuration.

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4 What good stroke care looks like

National evidence and good practice clearly describes what good looks for stroke care across BHR CCGs in respect to:

- The ideal configuration of services
- The standards of good quality stroke care and,
- The outcomes people living with the effects of stroke should expect from their stroke care.

These three areas are described in more detail throughout the following section, as well as emerging evidence on commissioning for value in stroke care following the London reconfiguration in 2010.

4.1 The ideal service configuration for good stroke care

Commissioning Support for London and the Royal College of Physicians have published a number of commissioning guides in relation to both the acute and post-acute elements of good stroke care[8,9]. In 2010 the London acute stroke reconfiguration programme defined a nationally recognised stroke pathway delivered through a 'hub and spoke' model of acute stroke care that includes the care delivered through the Hyper-acute stroke unit (HASU) and the acute Stroke Unit (SU). (See Figure 4 below). Hospitals of differing capability worked together to create a centralised system where people are taken to specialist stroke units rather than the nearest hospital[10], with a maximum journey time of 30 minutes.

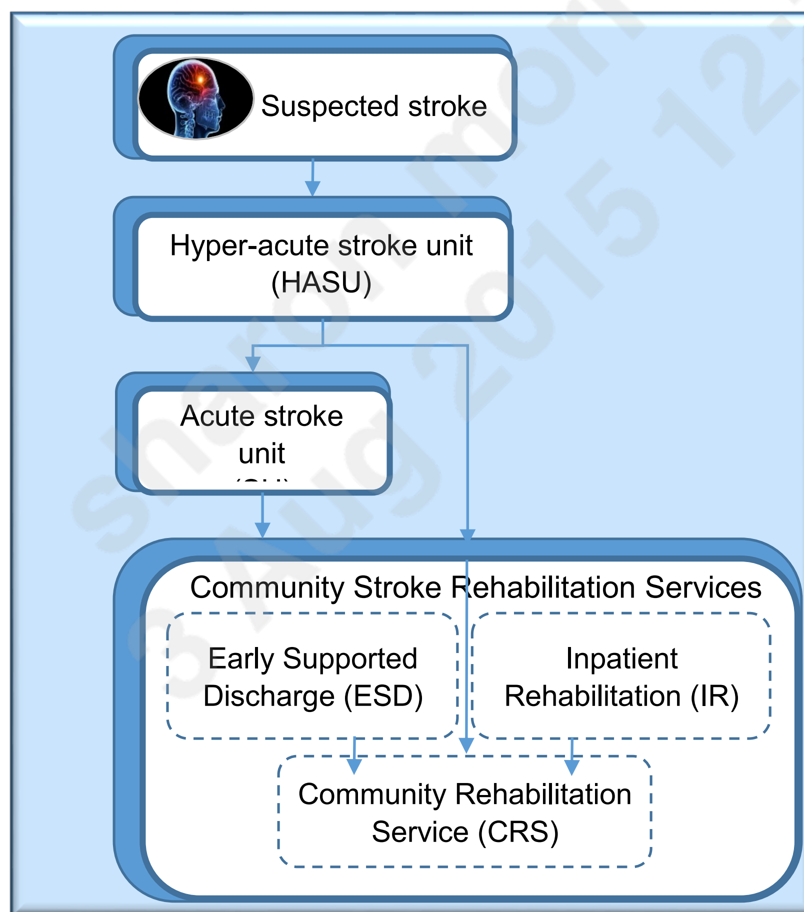
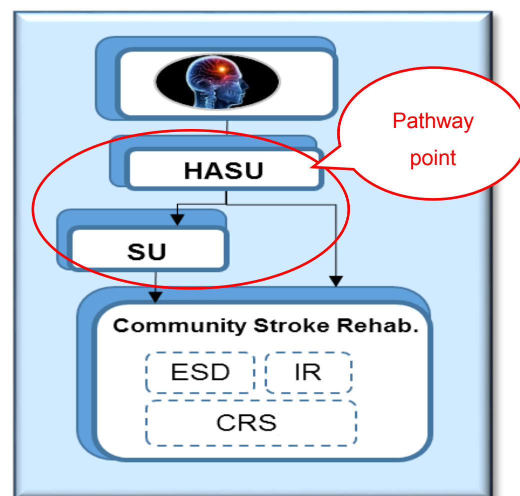


Figure 4: Summary of acute stroke pathway after London

[8] Royal College of Physicians (2012) Commissioning concise guide for stroke services.
[9] Commissioning Support for London (2010) Stroke rehabilitation guide: supporting London Commissioners to commission quality Services 2010/11.
[10] Higashida et al (2013) Interactions within stroke systems of care: a policy statement from the American Heart & Stroke Association in *Stroke*

4.1.1 The ideal configuration of acute Stroke care



The new configuration for acute stroke care is clearly articulated in a variety of commissioning guidance documents. It must be provided 24 hours a day, seven days a week, by stroke specialist staff from a wide variety of professional backgrounds. Each London provider of hyper acute and/or acute stroke care receive an enhanced tariff linked to core set of quality standards. A key enabler for ensuring adequate capacity, and therefore quality, in hyper acute and acute stroke care, has been ensuring each unit maintains the required number of beds and number of stroke specialist staff through a robust quality review process. The quality standards providers are required to meet to maintain their enhanced tariff can be found in Appendix 1.

Hyper-Acute stroke care

Hyper acute stroke units (HASU) are 24 hr centres providing high quality expertise in diagnosing, treating, and managing stroke patients. On arrival, a person is assessed by a specialist, has access to a brain scan and receives clot-busting drugs (thrombolysis) if appropriate, all within 30 minutes.[11] The capacity (numbers of beds and WTE specialist staff) of each one of the eight London HASU's has been determined by the London Strategic Clinical Network (SCN) for Stroke, and is monitored through each responsible Clinical Commissioning Group's (CCG) own governance arrangements. The ideal length of stay (LoS) within a Hyper-acute stroke unit is considered to be 24 – 72 hrs (one to three days), and no longer than five days prior to being transferred to a more appropriate care setting.

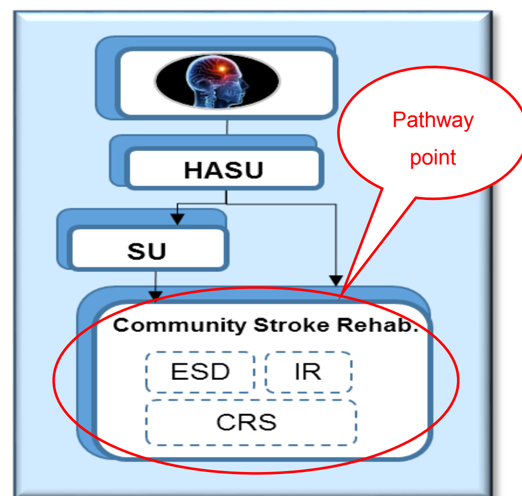
Acute stroke care

Acute stroke units, or SUs, provide multi-therapy (physiotherapy, occupational therapy, speech and language therapy) rehabilitation and ongoing medical supervision. The stroke unit people should be transferred is the one closest to their home based upon their post-code. This may be in the same hospital as the HASU, or a different one. The route people take through the stroke pathway, (E.g. whether they move from the HASU directly to CRS, or via the SU) very much depends on the level, and type of difficulty they have experienced as a result of their acute stroke.

Like the HASU, capacity within the 24 London SU's have also been determined through NHSE SCN. People who experience more profound levels of disability, or are taking longer to stabilise, are more likely to require longer periods in an SU. There is a London-wide target of 17 days for average LoS, to ensure appropriate patient flow through the pathway. National stroke guidance recommends neither an extended stay in acute units, nor referral to community Inpatient rehabilitation should be a substitute for high-quality community stroke rehabilitation (CRS) services, however as the following sections will articulate, definitions of the ideal service structure in terms of skill mix and hours of operation do not exist in the same level of detail as the acute service configuration.

[11] London Strategic Clinical Networks (2014) Stroke acute commissioning and tariff guidance.

4.1.2 The ideal configuration of post-acute stroke care



People who have survived their initial stroke and stabilised are either transferred from the HASU, or the SU to community stroke rehabilitation services based upon the findings of stroke specialist assessments. Based on national good practice, each CCG should ensure people living with the effects of stroke have adequate access to three types of post-acute stroke care, or stroke rehabilitation. These include Early Supported Discharge (ESD), Inpatient Rehabilitation (IR) and Community Rehabilitation Services (CRS). There is also a requirement for CCGs to ensure everyone living with the effects of stroke have longer-term support identified once they are discharged from their community stroke rehabilitation. This is because research has shown improvement in levels of disability can be seen up to 12 months from the initial stroke, therefore this needs to be identified at both 6/12 and 12 month intervals following a person's stroke to ensure all of their ongoing health and social care needs are met.

Figure 5 describes the ideal configuration of post-acute stroke care, both in relation to the three specific types of rehabilitation, as well as ongoing support through six and 12 monthly reviews for people living with the effects of stroke in their communities. Unlike national good practice for acute stroke care, there is less clarity about what the ideal capacity and skill mix of post-acute stroke services should be to ensure the best possible quality of care is delivered ad outcomes are achieved. NHS Commissioning Support for London have reported that when compared with general care, specialist stroke care leads to a reduction in mortality, dependence levels, and institutionalisation, therefore post-acute stroke rehabilitation must be provided by stroke specialist-trained staff to ensure the best possible outcomes for patients.

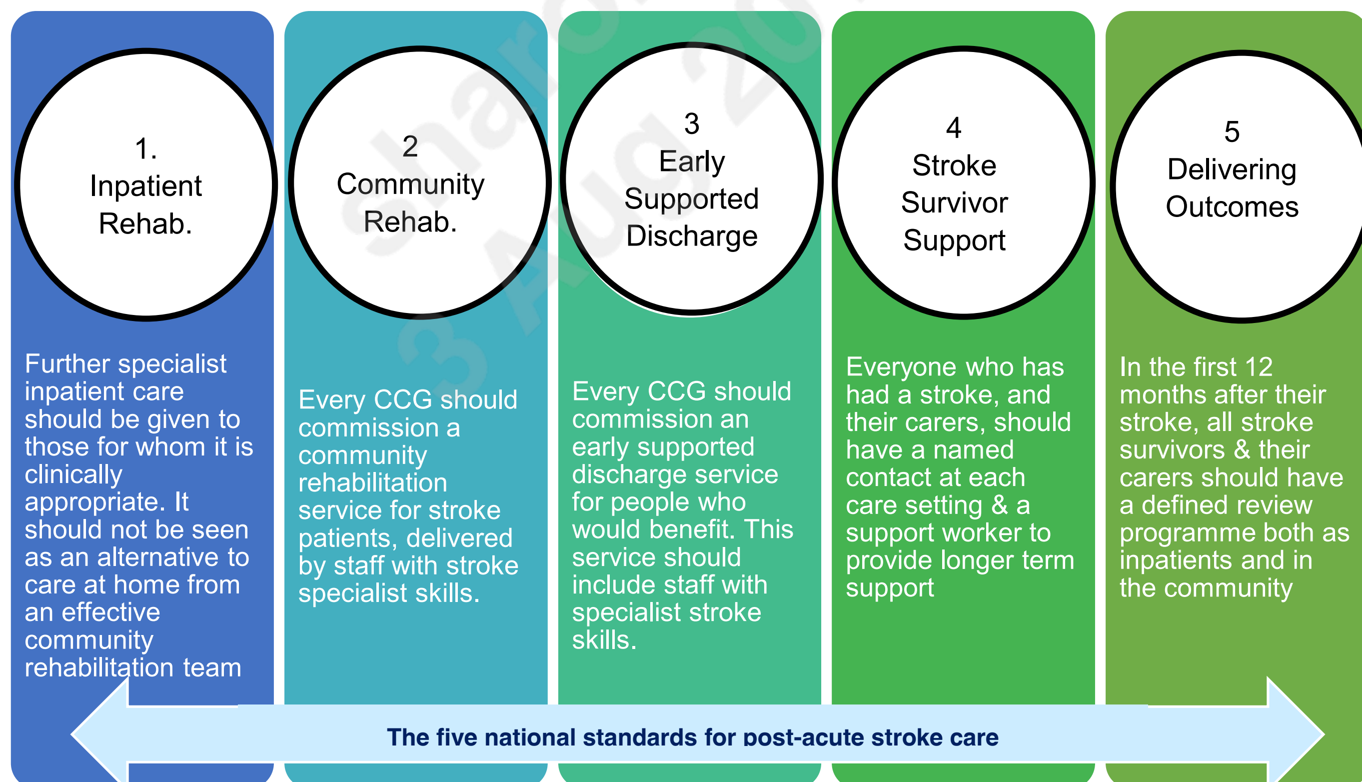
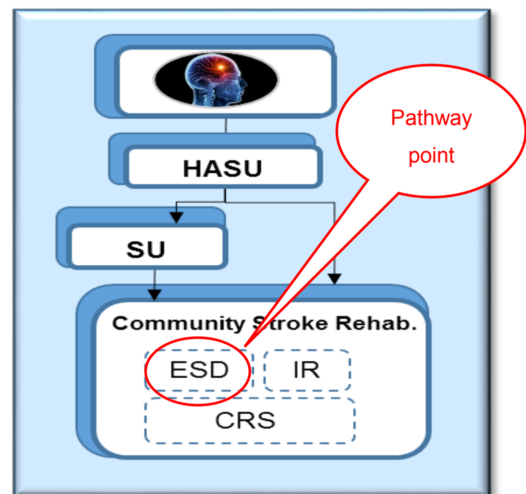


Figure 5: National stroke standards for the provision of post-acute stroke care

The following pages defines the three specific types of stroke rehabilitation.

Early Supported Discharge (ESD)

Early rehabilitation is effective when provided as part of an Early Supported Discharge (ESD) service. ESD services aim to provide patients with rehabilitation at home at the same intensity of inpatient care. It is designed to improve transfer of care arrangements, offer patient choice, deliver efficiencies in acute bed usage and deliver improved clinical and wellbeing outcomes. Evidence shows improved clinical and well-being outcomes after 6 months and 1 year as well as reduced costs through shorter hospital stays[12].



Cumulative evidence has proven that ESD services delivered by coordinated, multidisciplinary teams can significantly reduce the length of in-hospital stay and improve long-term functional outcomes for patients with mild to moderate stroke.

- ESD for up to 50 per cent of patients to a stroke specialist and multi-disciplinary team (which includes social care) in the community, but with a similar level of intensity of care as a stroke unit, can lower overall costs and reduce long-term mortality and institutionalisation rates[13].
- An individual patient data meta-analysis concluded that appropriately resourced ESD services, provided for a selected group of stroke patients can reduce long term dependency and admission to institutional care as well as reducing the length of hospital stay[14].
- A 2012 Cochrane systematic review of ESD services concluded that patients who received ESD services showed significant reductions in the length of hospital stay equivalent to approximately seven days and were more likely to remain at home in the long term and to regain independence in daily activities[15].

The case study below describes an example of how an ESD service calculated the capacity they required to deliver quality stroke ESD and demonstrated improved outcomes to their patients.[16]

Case study: Good Practice of ESD Provision
Camden stroke reach early discharge service (REDS)

Intervention

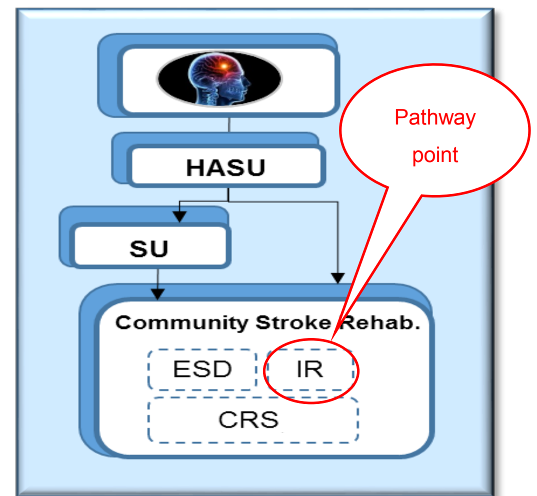
→ Stroke REDS developed from within a community stroke rehabilitation team, which is considered best practice to be able to flex with demand.
→ Operates an 'in-reach' model to assess, facilitate and complete a discharge within 24 hours of referral, including escorting the stroke survivor home using Stroke REDS transport.
→ Conducts comprehensive 6 month reviews after discharge from the service to measure outcomes and review existing stroke survivorship support.

Outcomes

✓ Improved patient independence - achieving 81% of all goals set with stroke survivors using goal attainment scaling (GAS)
✓ Reduced home care packages and dependence on social services by an average of 15 hours a week post 6 week rehabilitation with Stroke REDS.
✓ 100% of clients maintained or improved their Barthel score.
✓ 100% of clients maintained or improved their Canadian Model of Occupational Therapy (COPM) Performance score
✓ 96.6% of clients maintained or improved their COPM Satisfaction score.
✓ 87% of clients maintained or improved their Nottingham extended Activities of Daily Living score.
✓ 70% of clients maintained or improved their score on the Stroke Quality of Life 39 Questionnaire

[12] National Audit Office (2010) Progress on improving stroke care; a good practice guide
[13] DH (2007) National Stroke Strategy
[14] Langhorne (2005) Early supported discharge services for stroke patients: a meta-analysis of individual patients' data
[15] Cochrane (2012) Services for reducing duration of hospital care for acute stroke patients (Review)
[16] Skrypak et al (2012) Why early discharge in stroke care can be vital for recovery in HSJ.

Inpatient Rehabilitation



Patients who require further non-acute care after their condition has stabilised are treated in specialist stroke rehabilitation units. NICE describes these units as *"an environment in which multidisciplinary stroke teams deliver stroke care in a dedicated ward which has a bed area, dining area, gym, and access to assessment kitchens.'* People admitted to these environments have been medically stabilised in the HASU, and are either transferred via the SU or directly into the inpatient rehabilitation unit.

Stroke inpatient rehabilitation is delivered by a team of nurses, occupational therapists, physiotherapists, psychologists, social workers, speech and language therapists, medical staff and clinical neuropsychologists. Typically, stroke survivors follow an individually tailored programme based on their goals set by the survivor and their family and carers to help those for whom it is appropriate get back to work or other meaningful activity. The average length of stay in non-acute inpatient stroke rehabilitation units is 20 days but some stroke survivors stay for more than four weeks when it is clinically appropriate.

Like the ESD element of post-acute stroke care, inpatient rehabilitation units outside acute hospitals are not currently commissioned through a robust set of recognised quality standards, associated contracting and audit arrangements. That said, the London Stroke Strategic Clinical Network (SCN) have recommended that these units be contracted under the same setoff stroke standards as the acute stroke units (see Appendix 1). This decision was taken after the North East London Cardiovascular and Stroke Network reviewed the 'non-designated' stroke rehabilitation inpatient units in London.

This review highlighted the wide variation in bed capacity and length of patient stay that were difficult to explain. Two recommendations were made on the basis of this review were:

- for patients to be treated in stroke specialist units and discharged directly home, where possible, with stroke specific early supported discharge and longer term community neuro-rehabilitation as soon as is feasible.
- If stroke survivors are going to be recommended for more slow stream inpatient rehabilitation there need to be clearly identified clinical rationale such as complex therapy and equipment needs, unpredictable care needs or a completely unsuitable home environment.
- The facilities providing rehabilitation to such individuals should meet the NHS London stroke standards for SU.[17]

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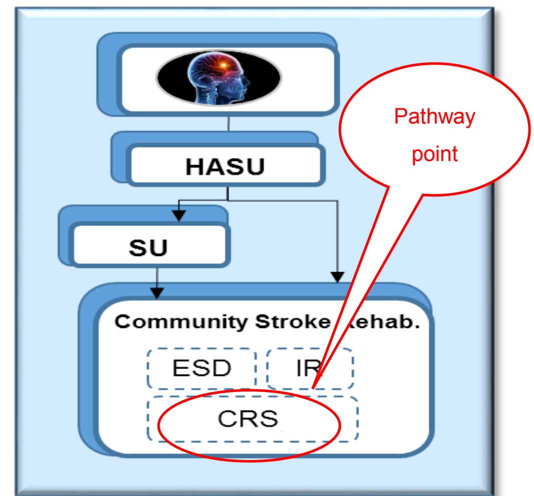
[17] North East London Cardiovascular and Stroke Network (2012) outputs from the review of 'non-designated' stroke rehabilitation inpatient units in London

Community Stroke Rehabilitation



Patients who are ready for discharge but deemed unsuitable for ESD are often referred to a Community Rehabilitation Service. It provides needs - led rehabilitation within the home environment to maximise functional ability and independence and facilitate reintegration in the community. The community rehab team is multi-disciplinary and usually consists of occupational therapists, physiotherapists, speech and language therapists and rehabilitation assistants with the option to access dietetics, psychology and nursing support if required. The team assesses the stroke survivor's needs (where possible with family and/or carers) and develops a treatment programme with the stroke survivor. The duration and intensity of the programme varied according to the needs. The programme and its goals are usually reassessed on a fortnightly basis with clear exit strategies identified from the start of the intervention.

There is value in having an ESD service structured within a community rehabilitation team, rather than being a standalone service. It provides community rehabilitation services (CRS) with flexible capacity and access to specialist advice and support. It further enables smoother patient transition into long term care and support. Camden's life after stroke services were rated top in London and third best nationally.

4.2 National Quality Standards for Stroke Care

4.2.1 Hyper-acute and Acute Stroke Care

Quality standards for the Hyper-acute and Acute phases of the patient journey were developed and have been robustly implemented and measured as part of the London Acute Stroke reconfiguration 2010-2012 through two separate processes – Clinical Audit and an annual Organisational Audit. Acute providers of stroke care are contracted to use the Sentinel Stroke National Audit Programme (SSNAP). SSNAP aims to improve the quality of stroke care by auditing stroke services against evidence based standards, and national and local benchmarks[18].

An organisational audit template for Queens Hospital HASU and SU has been provided in Appendix 1 which details all national stroke standards. London's acute stroke care providers are required to enter their data into SSNAP which is validated quarterly. It is the aim of the SCN for Stroke that the Organisational audits are undertaken annually, with the last being undertaken at Queens' hospital in June 2014. These ongoing national clinical audit processes demonstrate the level of detail providers are required to submit to demonstrate the income derived from the enhanced Stroke tariff is used to deliver high-quality acute stroke care, and ensure the improvements demonstrated in stroke mortality are maintained post reconfiguration.

Many of the standards are related to measuring the quality of the *process* of delivering good stroke care, rather than patient *outcomes.* This is not uncommon, and is partly related to the difficulty of reaching national consensus on what outcomes should be measured given the broad range of difficulties people living with the effects of stroke may experience. Whilst there is some concern about the Modified Rankin Score (mRS) used within SSNAP to record a person's improvement in disability scale and its lack of sensitivity for all levels of disability, this assessment tool is the national tool recommended for all services providing stroke care to use. There is a recommendation from the RCP that all providers of both acute and

[18] Royal College of Physicians (2014) Sentinel Stroke National Audit Programme.

post-acute stroke care be contracted to use SNNAP to improve the understanding of the quality of stroke rehabilitation being provided. Further detail on the mRS and measuring outcomes in Stroke care are discussed in section 4.3.

4.2.2 Post-acute: Stroke Rehabilitation and Longer term stroke survivorship support

An important indicator of quality in the post-acute stroke care being provided can be identified through the annual SNAPP organisational audit described above. One of the expectations of acute stroke care is to ensure that all stroke survivors have a personal health and social care plan in place on transfer between acute and non-acute stroke care. This standard is very dependent on strong multidisciplinary working both within and across organisations, and there is evidence to suggest that the greater number of 'hand-off 's' between providers and organisations within the stroke pathway, the more likely delays in care delivery are to occur. The performance of the acute trust in this indicator can suggest how able the post-acute stroke services

The National Stroke Strategy (2007) and the NICE clinical guideline for Stroke Rehabilitation (CG 162) detail several quality markers for post-acute stroke care. These include:

- After stroke, people should be offered a review of their health, social care and secondary stroke prevention needs, typically within six weeks of leaving hospital, before six months have passed and then annually. This will ensure it is possible to access further advice, information and rehabilitation where needed.
- Offer initially at least 45 minutes of each relevant rehabilitation therapy for a minimum of five days per week to people who have the ability to participate, and where functional goals that can be achieved.
    - If more rehabilitation is needed at a later stage, tailor the intensity to the person's needs at that time.
- Return-to-work issues should be identified as soon as possible after stroke, reviewed regularly and managed actively
- Carers of patients with stroke are provided with a named point of contact for stroke information, written information about the patient's diagnosis and management plan, and sufficient practical training to enable them to provide care.
- Review the health and social care needs of people after stroke and the needs of their carers at 6 months and annually thereafter. These reviews should cover participation and community roles to ensure that people's goals are addressed.

This is further reinforced by the following quality standards:

→ **Royal College of Physicians (RCP) National Clinical Guidelines for Stroke (2012):** Any patient with residual impairment after the end of initial rehabilitation should be offered a formal review at least every 6 months, to consider whether further interventions are warranted

→ **National Stroke Strategy QM14 (2007) :** People who have had strokes and their carers, either living at home or in care homes, are offered a review from primary care services of their health and social care status and secondary prevention needs, typically within six weeks of discharge home or to a care home and again six months after leaving hospital. This is followed by an annual health and social care check, which facilitates a clear pathway back to further specialist review, advice, information, support and rehabilitation where required

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→ **Care Quality Commission review on stroke care (2011):** Regular reviews after transfer home provide a key opportunity to ensure people get the support they need.

These standards have been used to define each element of a stroke rehabilitation service and the quality standards they are required to meet. Commissioners have a responsibility to ensure:

- All three different types of stroke rehabilitation are available for their populations in Figure 4 page 13 and are meeting these standards
- Stroke reviews for all stroke survivors are being delivered at 6/12 and 12 monthly points to ensure their future needs are being met and outcomes are being achieved.

4.3 National outcomes for people living with the effects of stroke

The National Outcomes Framework for 2015/16 articulate a number specific outcome measures in relation to stroke, both in relation to preventing people from dying prematurely, and helping people to recover from episodes of ill health or following injury.

Preventing people from dying prematurely

Overarching Indicator

Potential years of life lost from causes considered amenable to healthcare: adults, children and young people (NHS OF 1a i & ii) ^

Improvement Areas

Reducing premature mortality from the major causes of death:

- Under 75 mortality from cardiovascular disease (NHS OF 1.1) ^ *
- Cardiac rehabilitation completion
- Myocardial infarction, stroke & stage 5 kidney disease in people with diabetes
- Mortality within 30 days of hospital admission for stroke

Helping people to recover from episodes of ill health or following injury

Overarching Indicators

- Emergency admissions for acute conditions that should not usually require hospital admission (NHS OF 3a) ^
- Emergency readmissions within 30 days of discharge from hospital (NHS OF 3b)

Improvement Areas

Improving recovery from stroke

People who have had a stroke who:

- are admitted to an acute stroke unit within four hours of arrival to hospital
- receive thrombolysis following an acute stroke
- are discharged from hospital with a joint health and social care plan
- receive a follow-up assessment between 4-8 months after initial admission
- spend 90% of more of their stay on an acute stroke unit

There is clear evidence nationally to suggest that mortality has improved with the introduction of a hub and spoke model through the London Acute Stroke Care reconfiguration in 2010-2012. Survival at 30 days post stroke has vastly improved, from a position of 13% mortality from stroke at 90 days in 2010 in to 7% from Barking and Dagenham, Havering and Redbridge University Trust (BHRUT) in 2013/14.

Whilst this is an incredible achievement in terms of survival, there is much less clarity around what people and their carers should expect in relation to the longer term outcomes for stroke survivors. As stroke causes the greatest range of disabilities than any other condition, there is a lack of clarity about what outcome measures clinician's should use to determine the benefits, or outcomes people should achieve from post-acute stroke care, or rehabilitation.

The Modified Ranking Scale (mRS) is commonly used as an outcomes rating scale for patients post-stroke in BHR. It is used to categorise the level of functional independence with reference to pre-stroke activities rather than on observed performance of a specific task. There are a range of disability scales available (Table 2) but there is wide variability in its use and a rising debate on the appropriateness of assessing stroke outcomes with stroke impairment scales. Furthermore there is a lack of consensus on the selection of measures which best address and balance the needs and values of patients, their carers, practitioners, and commissioners.

Table 2: Classification of Outcome Measures[i]:

Body Structure (Impairments)	Activities (Limitations to Activity)	Participation (Barriers to Participation)
Beck Depression Inventory	Action Research Arm Test	Canadian Occupational Performance Measure
Behavioral Inattention Test	Barthel Index	EuroQol Quality of Life Scale
Canadian Neurological Scale	Berg Balance Scale	LIFE-H
Clock Drawing Test	Box and Block Test	London Handicap Scale
Frenchay Aphasia Screening Test	Chedoke McMaster Stroke Assessment Scale	Medical Outcomes Study Short-Form 36
Fugl-Meyer Assessment	Chedoke Arm and Hand Activity Inventory	Nottingham Health Profile
General Health Questionnaire -28	Clinical Outcome Variables Scale	Reintegration to Normal Living Index
Geriatric Depression Scale	Functional Ambulation Categories	Stroke Adapted Sickness Impact Profile
Hospital Anxiety and Depression Scale	Functional Independence Measure	Stroke Impact Scale
Line Bisection Test	Frenchay Activities Index	Stroke Specific Quality of Life
Mini Mental State Examination	Motor Assessment Scale	
Modified Ashworth Scale	Nine-hole Peg Test	
Montreal Cognitive Assessment	Rankin Handicap Scale	
Motor-free Visual Perception Test	Rivermead Mobility Scale	
National Institutes of Health Stroke Scale	Rivermead Motor Assessment	
Orpington Prognostic Scale	Six Minute Walk Test	
Stroke Rehabilitation Assessment of Movement	Timed Up and Go	
	Wolf Motor Function Test	

However as each patient should enter the rehabilitation phase of the pathway with a personal care plan, it should be possible to both assess the outcomes that each patient should expect from their rehabilitation and measure whether the extent to which these expectations were met when rehabilitation is completed.

4.4 Commissioning for Value in Stroke care

Information available in commissioning for stroke care is not available for all aspects of the stroke pathway, however there is emerging evidence where value, both in respect to patient outcomes as well as the commissioning spend.

Early Supported Discharge

ESD service has a strong evidence base that proves to reduce long-term dependency and admission to institutional care, as well as reduce the length of hospital stay. In addition, an ESD consensus[19] document states that the annual cost of an ESD team should be less, or equal to annual savings made by a reduction in length of hospital stay.

This was truly reflected in the NICE assessment of the Camden REDS case study for quality improvement and cost savings. There were savings in excess of £277,800 through a reduced need for non-elective bed days and ongoing social services packages of care – equating to £118,069 per 100,000 population. This was achieved entirely through a joint commissioning approach, funding a well-resourced ESD team, including therapy service provision integrated with an enabling care approach to provide intensive stroke rehabilitation within the patient's home. This reduced acute and inpatient bed days and reduced dependence on ongoing social services packages of care.

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[19] Fisher et al (2011) A consensus on stroke: early supported discharge

In 2009, the service reduced the average length of stay for 32% of all Camden strokes in 2009 by 10 days on average, leading to a potential £307,161 saving in acute bed-day costs. In 2011/2012 the service reduced the average length of stay for 41.3% (74/179) of all strokes in Camden by 10 days on average, leading to a potential £277,800 saving in acute bed-day costs.

5 The emerging case for change in Stroke Rehabilitation across BHR

5.1 What's working well across BHR stroke services?

HASU/SU

BHRUT Acute

- ✓ Mortality from Stroke at 30 days - 7% during 2013/14, an improvement from 13% in 2010.

ESD

BHRUT ESD service

- ✓ July – Dec 2014 SSNAP reporting; for 67 pts seen pathway processes show team is meeting required standards set; seen within 1 day of discharge (1) and 2 days between being first seen by team and date rehab. goals agreed (0-4)
- ✓ mRS scores for same period showed 20% of people having some improvement in mRS.

Stroke Survivorship

Havering: Carers Trust Supporting Independence Programme

- ✓ April 2014 demonstrated that 93% of people had benefited from the programme, particularly in the areas of Health and Emotional well-being and Choice and Control.
- ✓ Positive feedback from both NELFT and BHRUT stakeholders

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5.2 How are we doing in respect to stroke care configuration and provision across the pathway?

5.2.1 Hyper-acute and Acute stroke care

Through the SSNAP organisational audit of the acute service at BHRUT in June 2014, it is understood that both the HASU and SU are providing the right numbers of stroke unit beds and WTE staff to deliver the quality of stroke care required.

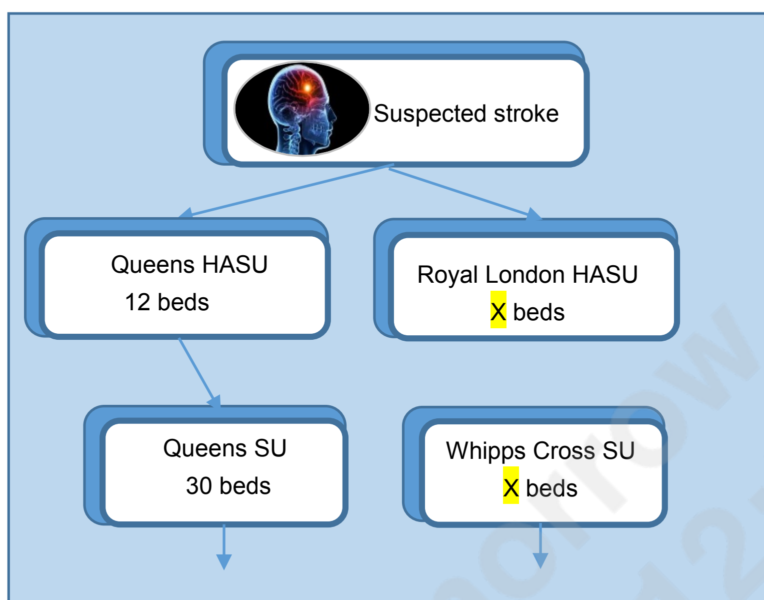

Figure 6: Summary of acute stroke provision supported through enhanced stroke tariff

5.2.2 Post-acute stroke care

The way in which the three types of post-acute stroke services are commissioned and delivered across BHR is very complex. Whilst there is one main provider for community stroke rehabilitation (NELFT), service configuration within each borough is very different. The table below is an overview of current service provision by provider, and the geographical population they provide post-acute stroke care to.

Service Type	Provider	Site	CCG population
IP	BHRUT	Beech Ward – King Georges Hospital site (15 beds)	Barking & Dagenham Redbridge Havering
	NELFT	Grays Court (17 beds)	Barking and Dagenham Havering
ESD	BHRUT	Therapy team based at Queens Hospital site (X WTE stroke specialists)	Barking & Dagenham Redbridge (except Wanstead strip) Havering
	NELFT	Barking & Dagenham and Havering CRS (X WTE stroke specialists) Redbridge ICC(X WTE stroke specialists)	B&D Havering Redbridge
CRS	NELFT	Barking & Dagenham and Havering CRS (X WTE stroke specialists) Redbridge ICC(X WTE stroke specialists)	B&D Havering Redbridge

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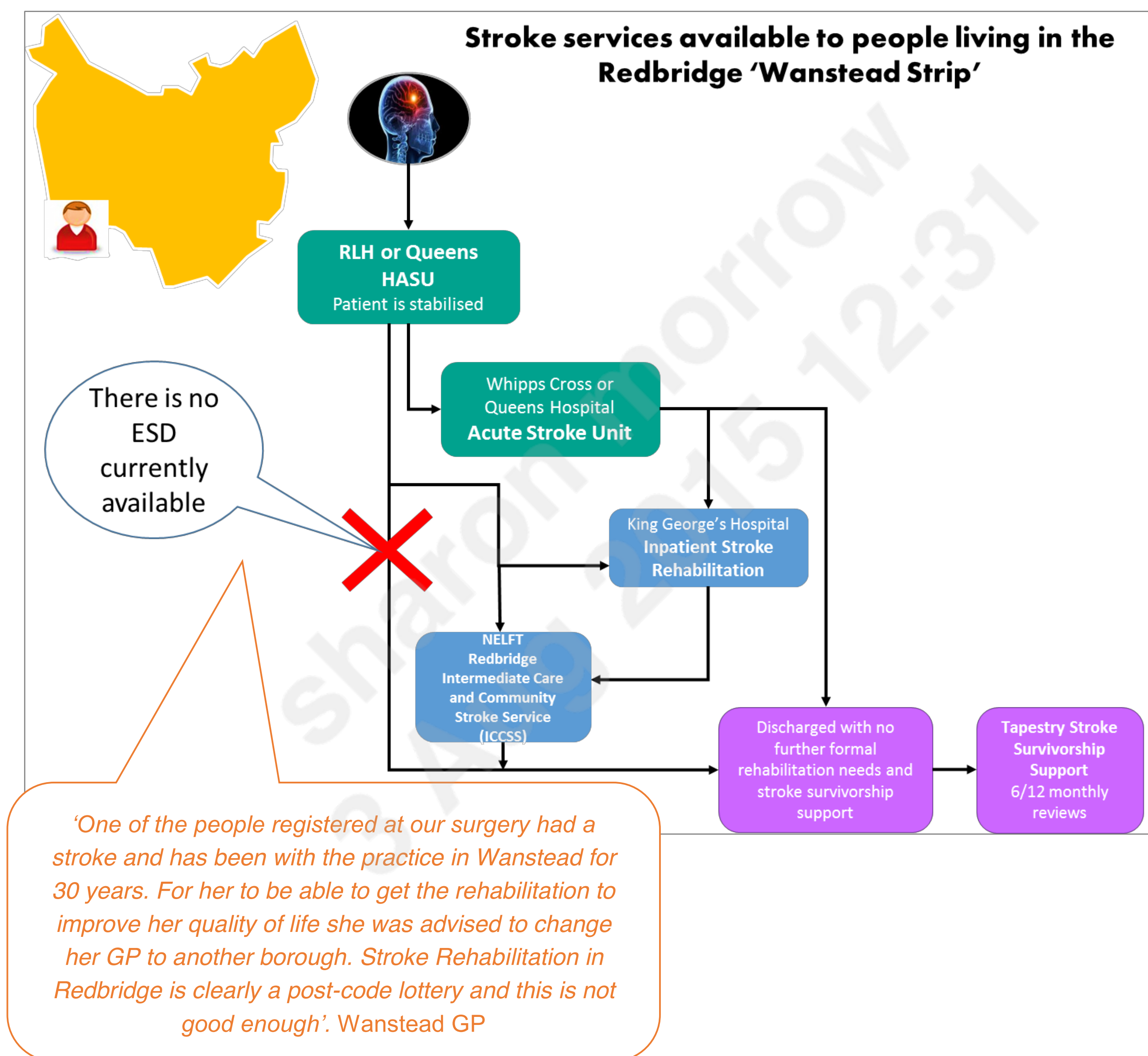
Given the complexities in describing current service configuration, this section describes the current provision of stroke care across the three BHR CCGs, and highlights areas of variation in service provision. The four diagrams below describe the different patient journeys through the stroke pathway, in relation to where they live and the impact this has on the services available to them.

5.2.3 Redbridge Stroke Service Provision

There are two different service offers to people who survive their stroke living in Redbridge. This document has already described the benefits of Early Supported Discharge in relation to outcomes and patient experience. If you live in the Wanstead strip of Redbridge there is currently no ESD services commissioned. This is based on historical boundary arrangements in relation to acute providers; currently BHRUT is the provider of the stroke ESD service but they are not required to provide this service to people living in Wanstead.



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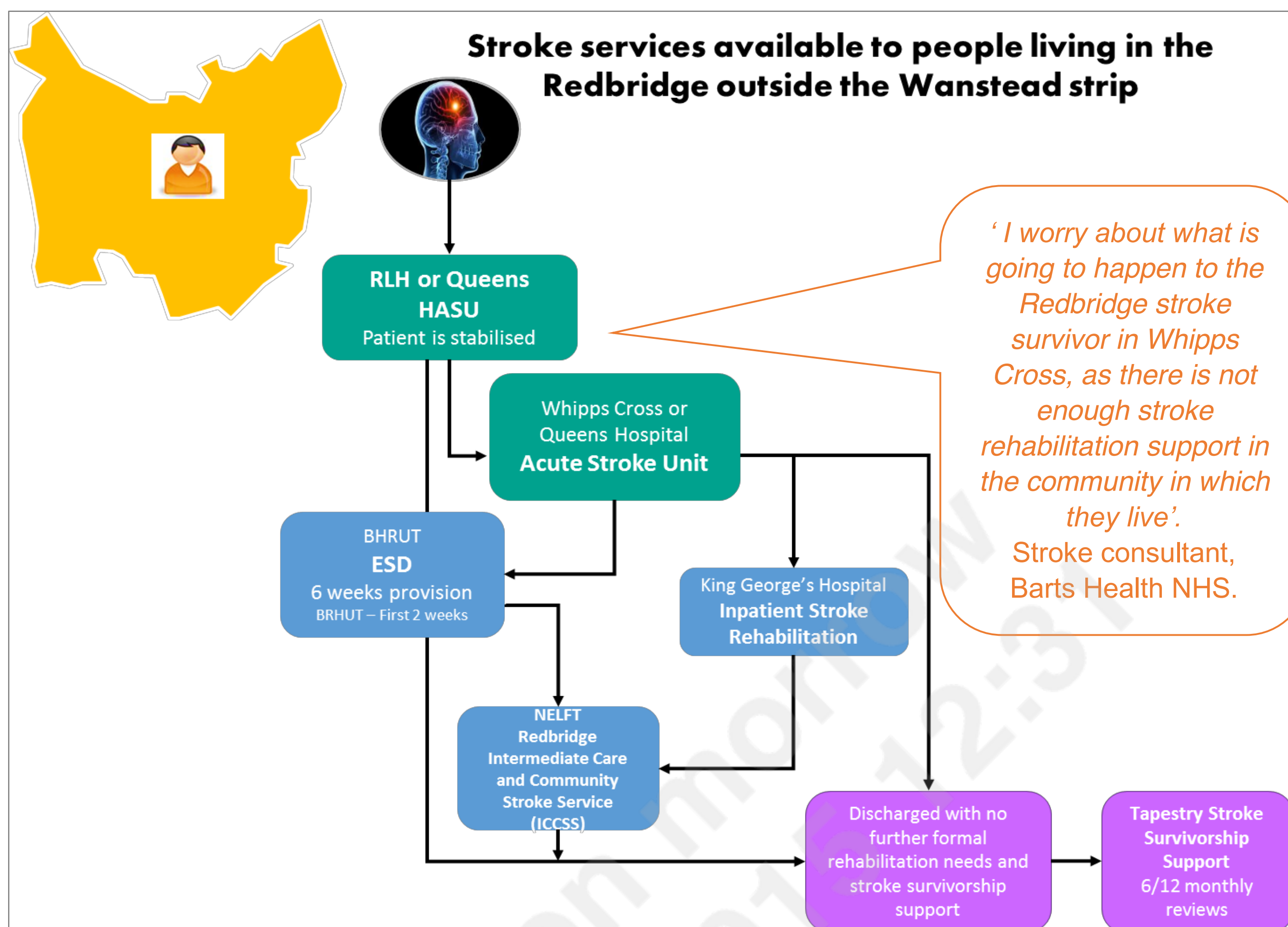
For people living in the rest of Redbridge the service offer in post-acute stroke care is very different. The BHRUT ESD therapists accept referrals from both Queens and Whipps Cross acute stroke units, with priority currently given to referrals from Queens to ensure patient flow through their acute stroke service.

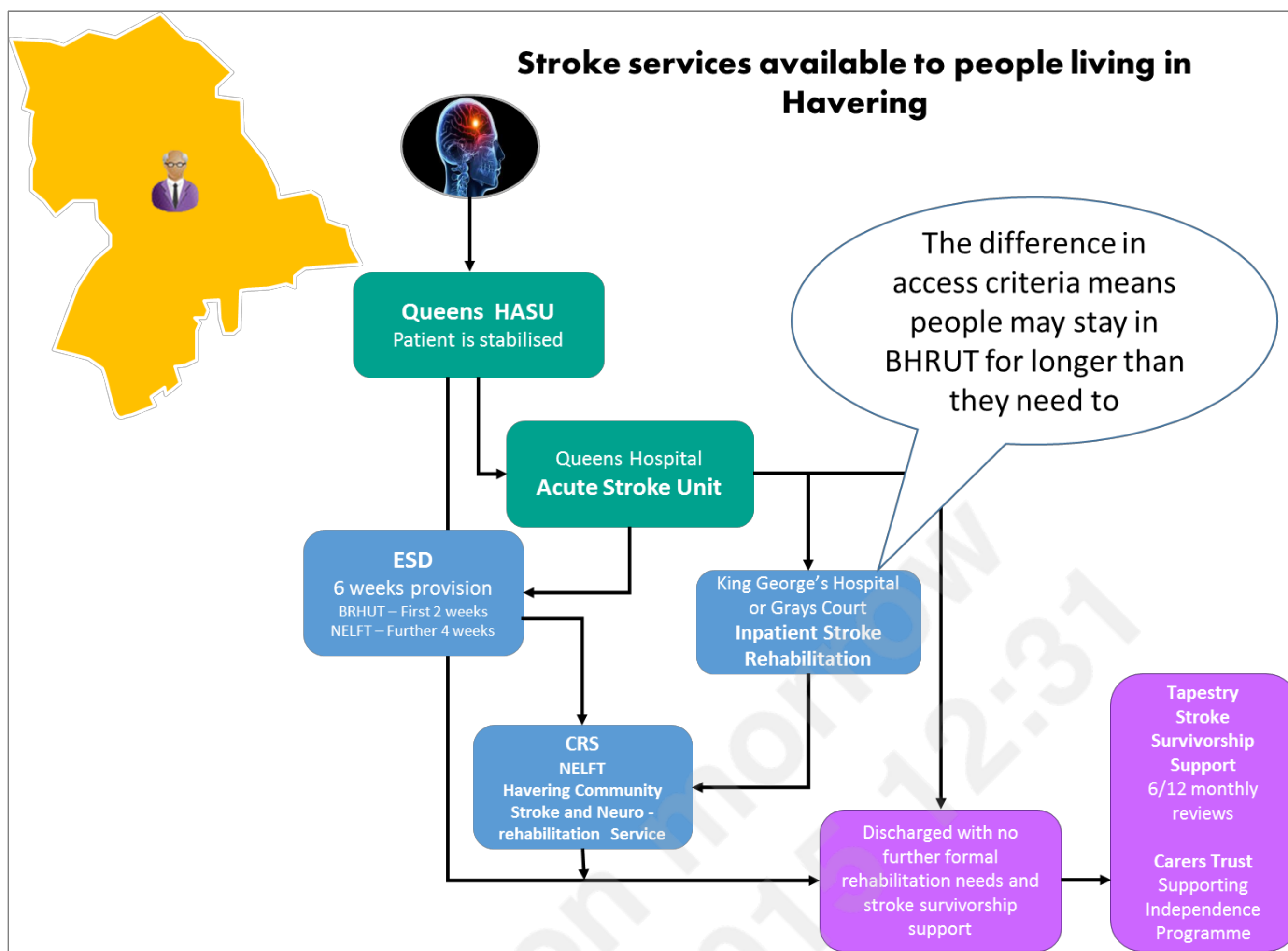


There is clearly inequity in access against national best practice standards for the provision of ESD stroke services for people in Redbridge. Other issues relating to the post-acute service offer for Redbridge patients identified through the pathway mapping workshop held on the 14th December 2014 include;

- Once discharged from the BHRUT ESD service, the Redbridge ICCSS provides a further 28 days of ESD support to people who require the support of one therapist to mobilise/participate in their rehabilitation. Stroke survivors needing the support of two people to deliver rehabilitation in their home receive no further ESD support.
- There is concern about the % of stroke specialists providing the stroke rehabilitation within the Redbridge ICCSS in comparison to that available in Havering and Barking & Dagenham.
- There is currently no provision of ESD or CRS for stroke survivors living in a nursing home.
- Existing capacity of both the BHRUT and ICCRS ESD services means that the intensity at which ESD rehabilitation is provided is not always at the quality standards expected e.g. 5 days per week for 45 minutes for two weeks per therapy required.
- Given the reduced post-acute service offer in Redbridge, GPs have reported that they are unsure as to where to refer stroke survivors to for the support they need.

5.2.4 Havering Stroke Service Provision

All residents living in Havering have the access to the same level of post-acute stroke care provision.

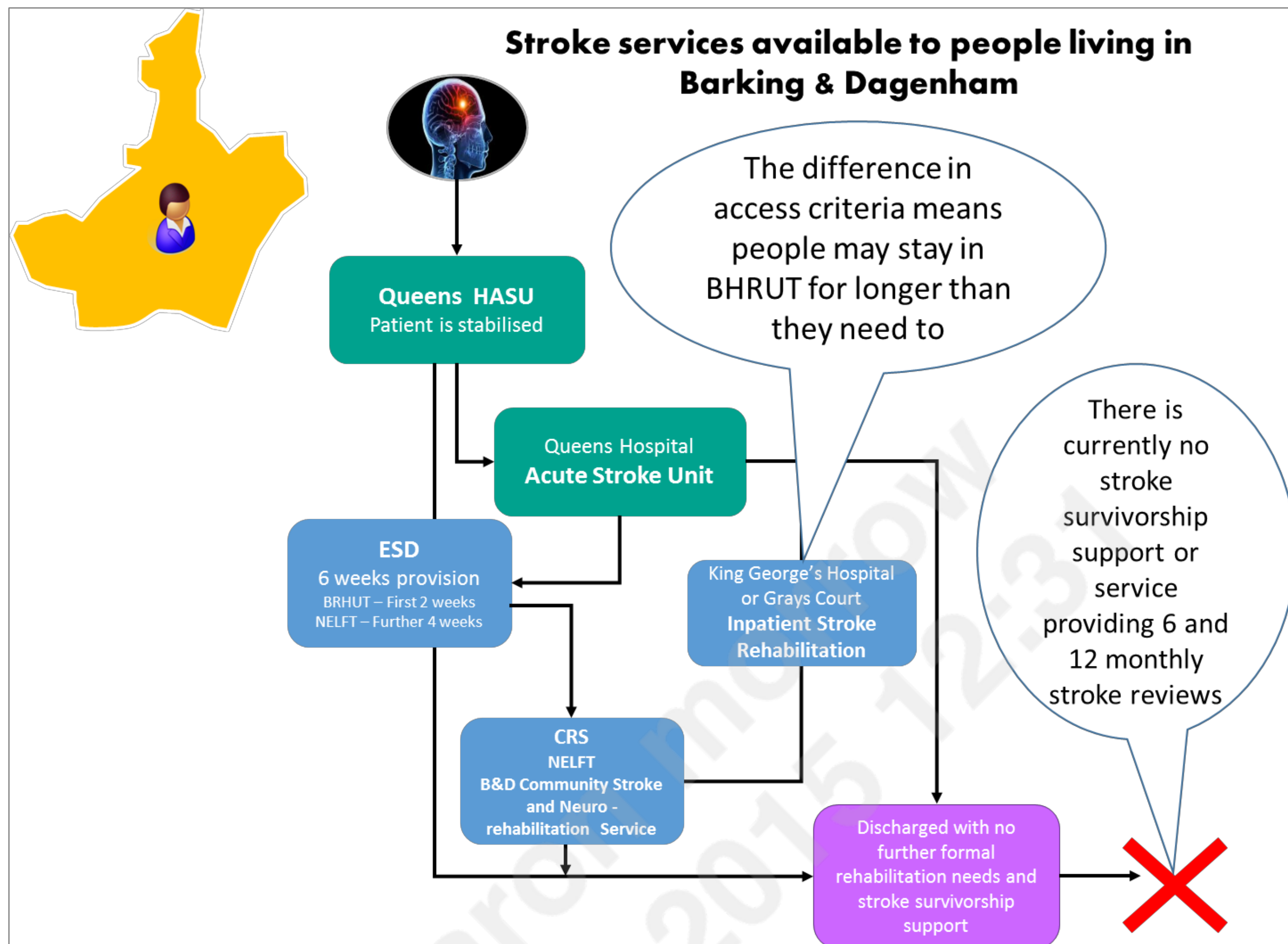


There are, however, several concerns in relation to the quality of stroke rehabilitation being provided.

- Once discharged from the BHRUT ESD service, the NELFT Havering Community Stroke and Neuro-rehabilitation service provides a further 28 days of ESD support to people regardless of whether need one or two therapists to support them in their rehabilitation sessions.
- Existing capacity of both the BHRUT and Havering NELFT ESD services means that the intensity at which ESD rehabilitation is provided is not always at the quality standards expected e.g. clinicians have reported 5 days per week for 45 minutes for two weeks per therapy is a challenge for existing capacity, and are more likely to provide this 3 days per week.
- The acceptance criteria for the providers of stroke Inpatient Rehabilitation are very different;
    - BHRUT (15 beds in King Georges Hospital, Beech ward) accepts people who are less medically stable given the cross-cover arrangements of medical and stroke specialist therapy staff across BHRUT. This ensures throughput through the HASU and ASU elements of the pathway, freeing up these units for less stable stroke survivors.
    - NELFT (17 beds at Grays Court). The acceptance criteria at Grays Court requires people to be more medically stable, meaning some patients may wait longer in acute stroke units to receive their rehabilitation in Havering and Barking & Dagenham.
- The service at Grays Court also limits the stay to a maximum of 28 days inpatient rehabilitation, therefore if stroke survivors are likely to require longer inpatient rehabilitation to achieve their goals prior to being discharged home, they will remain in an ASU inpatient bed at BHRUT.

5.2.5 Barking and Dagenham Stroke Service Provision

Like Havering, residents living in Barking & Dagenham have the same access to the same level of post-acute stroke care provision regardless of where they live in the borough. There are, however, several concerns in relation to some stroke rehabilitation provided.



Whilst Havering and Barking and Dagenham appear to have better post-acute stroke care provision in line with national standards, other issues relating to the post-acute service offer for Barking & Dagenham patients identified through the pathway mapping workshop held on the 14th December 2014 include;

- Like Havering, once discharged from the BHRUT ESD service, the NELFT Havering Community Stroke and Neuro-rehabilitation service provides a further 28 days of ESD support to people regardless of whether need one or two therapists to support them in their rehabilitation sessions.
- Existing capacity of both the BHRUT and Barking and Dagenham NELFT ESD services means that the intensity at which ESD rehabilitation is provided is not always at the quality standards expected e.g. 5 days per week for 45 minutes for two weeks per therapy required.
- The acceptance criteria for the providers of stroke Inpatient Rehabilitation are very different. BHRUT (King Georges Hospital, Beech ward) accepts people who are less medically stable given the cross-cover arrangements of medical and stroke specialist therapy staff across BHRUT. This ensures throughput through the HASU and ASU elements of the pathway, freeing up these units for less stable stroke survivors. The acceptance criteria at Grays Court requires people to be more medically stable, meaning some patients may wait longer in acute stroke units to receive their rehabilitation in Havering and Barking & Dagenham.

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- The service at Grays Court also limits the stay to a maximum of 28 days inpatient rehabilitation, therefore if stroke survivors are likely to require longer inpatient rehabilitation to achieve their goals, they will remain in an ASU inpatient bed at BHRUT.
- There is currently no service providing the required 6 or 12 monthly stroke reviews as recommended in post-acute stroke care best practice.
- Clinical audits undertaken between 2012 and 2013 demonstrated that approximately 30 - 50% of patients in Grays Court could have been treated in the community if specialist stroke rehabilitation teams were in place to meet needs.[20]

Whilst all three boroughs have access to Community Rehabilitation Service which is provided by NELFT, there are variations in the service provision within boroughs and across them.

The skill mix of the community rehabilitation teams in all three Boroughs do not include all of the specialists recommended to be included in a multidisciplinary team; in particularly, teams do not include speech and language therapists and have limited access to psychologists. As a consequence patient discharges from the acute setting are often delayed whilst the patient receives speech & language therapy. There is also a lack of specialist nursing input in the Redbridge community rehabilitation team. Further detail is required to understand the difference between the skill mix and resource available within each team.

5.3 How are we doing in respect to commissioning for quality?

With the London reconfiguration of acute stroke services in 2010-2012, a concise set of quality standards was developed to ensure the providers of these services delivered the standard of care expected and were commissioned through a London stroke tariff to do so. Acute stroke care providers are also commissioned to ensure they record all of their data in relation to these quality standards within the SSNAP data base, which allows quarterly reports to be generated across the provider landscape.

Because of this level of infrastructure and quality assurance through the annual quality stroke review process, BHR CCGs are able to benchmark acute provider performance in a robust manner. Whilst they are starting to use SSNAP to understand the quality of care provided by some post-acute stroke services, other standards from clinical guidelines have been used to understand the current quality of post-acute stroke care being provided by NELFT and BHRUT.

5.3.1 Hyper-acute and acute stroke care (HASU and SU)

The results of the SSNAP Organisational Audit that was undertaken in June 2014 are presented below. Overall the three acute organisations providing stroke care to residents living within BHR scored the same band in respect to the quality of stroke care they deliver. A full description of each of the six domains can be found in Appendix 2.

Acute Organisational Audit 2014 Performance Table	Total no. stroke beds	Overall band	D1*	D2	D3	D4	D5	D6
Barking, Havering and Redbridge University Hospitals NHS Trust *HASU + SU*	57	B	A	A	D	B	D	A
Barts Health NHS Trust (Royal London Hospital) *HASU + SU*	26	B	B	C	A	A	A	A
Barts Health NHS Trust (Whipps Cross Hospital) *SU only*	19	B	B	B	D	A	B	A

[20] ONEL Non-acute bed review (2013)

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An analysis of the individual domains highlights concerns in two particular areas for BHRUT, and one for Whipps cross, which may indicate why discharge into community stroke services is not as clear or as smooth for people as it should be. Both hospitals scored D in domain D3 due to having reduced ratios of nurses and therapists to numbers of stroke beds and found delivery of 7 day therapy services difficult to deliver. This raises two key concerns; that communication between the acute and community rehabilitation providers, and therefore the next step in the journey for people on the stroke pathway, is not as good as it should be, and that patients are unable to be discharged when they are ready on weekends. BHRUT also scored D on D5, as the existing governance arrangements for the delivery of monthly service improvement meetings using SSNAP data to drive service improvement are not as robust as they are expected to be.

One area of improvement required at the Royal London site was in access to specialist roles (D2). It is understood that access to clinical psychologists specialised in stroke care at the Royal London is reduced and patients are often not receiving the required assessments or interventions before discharge from the acute unit.

5.3.2 Post- acute stroke care

Given the differences in service configuration and provision of post-acute stroke care across the BHR CCGs, it is currently a challenge to streamline reporting arrangement for stroke across the pathway. Although SSNAP has recently launched a post-acute clinical audit for stroke, community providers are not all contracted to use the SSNAP system, and therefore data input is variable across the country.

To understand if there is a case for service change in relation to post-acute stroke care, a variety of sources of information from clinicians and national best practice have been used. The table below provides a benchmark of the post-acute stroke services against the Royal College of Physicians guideline for Stroke which includes the best practice standards referred to in section two of this document. [21]

Quality Standard/s	Is there a known gap?			Comment/Gaps
	H	R	B&D	
6.2.1 Pts with stroke offered a minimum of 45 mins. of each active therapy required for a minimum of 5 days per week within their tolerance levels.	Y	Y	Y	The rehabilitation provided by the NELFT ESD service after handover from BHRUT is not always at the acuity recommended, often 3/7 days rather than 5.
6.3.1. Every patient should have their progress measured against goals set at regular intervals determined by their rate of change	 Y	Y Y Y	 Y	• Redbridge ICCRS provides time-limited interventions for a period of 4 weeks. • GC inpatient rehab provides maximum treatment period of four weeks • Quality reporting on goals achieved not currently routinely reported
6.21.1 Patients with continuing problems with swallowing food or liquid safely should: have regular reassessment and management **6.38.1** Care should be taken when assessing people with communication impairments.		Y	Y	• Referral back to SALT services for further input post the initial acute assessment is difficult • There are delays in accessing SALT reviews for residents in Redbridge and B&D due to a variation in service operational delivery by NELFT in these two boroughs. Havering CRS has SALT integrated with their CRS team.
6.29.1B patients who wish to return to work should be referred to a disability employment advisor or vocational rehabilitation team if advisor not available	Y	Y	Y	• Vocational rehab. not available to residents of BHR boroughs
6.30.1 A Any patient whose social interaction after stroke is causing stress or distress to others should be assessed by a clinical psychologist	Y	Y	Y	• IAPT service across all boroughs does not currently see patients who are unable to attend the clinic setting.

[21] Royal College of Physicians (2012) Clinical Guideline for Stroke

6.35.1 Brief, structured psychological therapy should be considered for patients with depression.				• There is inadequate resource for clinical psychology provision within existing stroke CRS teams
7.1.1 A Any patient whose situation changes should be offered further assessment by the specialist stroke rehabilitation service **B** Any patient with residual impairment should be offered a formal review every 6 months **E** Patients should have their stroke risk factors and prevention plan reviewed every year **7.4.1** Pts and their carers should have their individual practical and emotional support needs identified annually		Y	Y Y	• Community rehab team in Redbridge is integrated with both generic and specialist stroke therapists within it. Pts may be treated by non-stroke specialist therapists • Both Havering and Redbridge CCG commission stroke association to deliver the 6/12 stroke review • Havering and Redbridge commission stroke association to deliver annual stroke reviews
7.3.1 Local commissioners should ensure that community integration and participation for disabled people is facilitated through making sure appropriate stroke specialist services and generic voluntary services and peer support are available and that information and signposting to them are given.			Y	Both Havering and Redbridge have formally commissioned a variety of stroke support services in the community e.g. swimming club, support groups.
7.5.1 All people with stroke in care homes should receive assessment and treatment from stroke rehabilitation services in the same way as patients living in their own homes		Y		Redbridge ICCSS don't currently provide community rehabilitation to nursing home residents

There are quite clearly gaps in the quality of care being provided in relation to national quality standards for stroke rehabilitation. It is understood that these gaps are likely to be a result of the variation in current configuration and provision across a multitude of providers, or a lack of service capacity in a particular area or team.

5.3.3 Quality in relation to Early Supported Discharge (ESD) in BHR

The NHSE Strategic Clinical Network for Stroke have recently published a report identifying that London Stroke care needs to be improved[22]. It uses SSNAP data received from providers of acute and post-acute stroke care from Q3 2013/14 and 2014/15 and highlights there is low uptake of life-after stroke services such as ESD, community rehabilitation and six monthly stroke reviews for people discharged from BHRUT.

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[22] NHSE Strategic Clinical Network for Stroke (2015) National Stroke Audit indicates London needs improvement

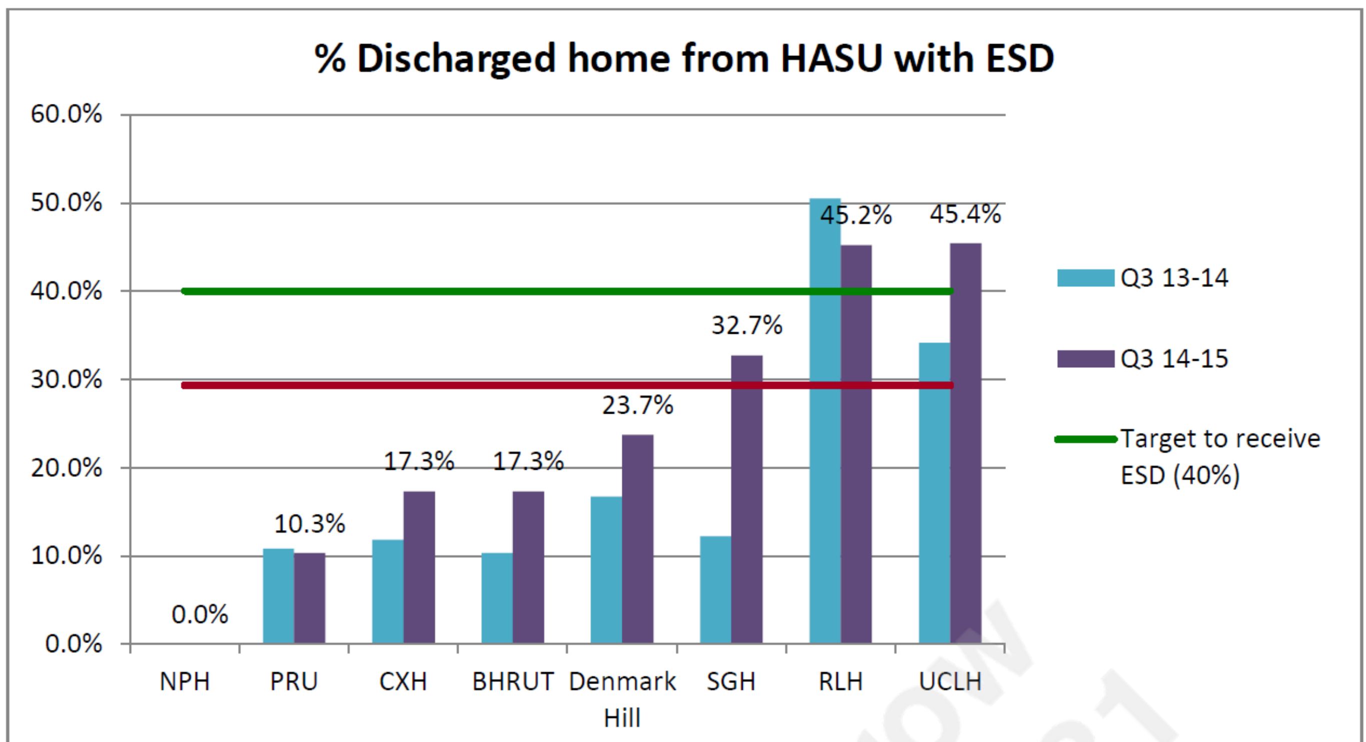

Figure 7: % of patients discharged home from HASU to stroke/neuro-specific Early Supported Discharge between Q3 2013/14 and 2014/15

The information presented in the graph above (Figure 7) highlights that fewer than the targeted 40% of people who have had a stroke are being discharged with ESD from the BHRUT HASU or SU. Although BHRUT has demonstrated an improvement between from Q3 2013/2014 and Q3 2014/15, there are less than half the amount of people being taken home with ESD support, indicating people are not being offered the best possible outcomes in relation to stroke care.

The graph in the following page (Figure 8) does not show a comparison between 2013/2014 and 2014/15, however it too demonstrates that BHRUT are not able to discharge as many people with ESD from the SU as national best practice advises. Clearly, people living in the BHR geography are not getting the same level of access to ESD, and therefore the type of post-acute stroke care that has demonstrated the best quality outcomes for patients. Something needs to change.

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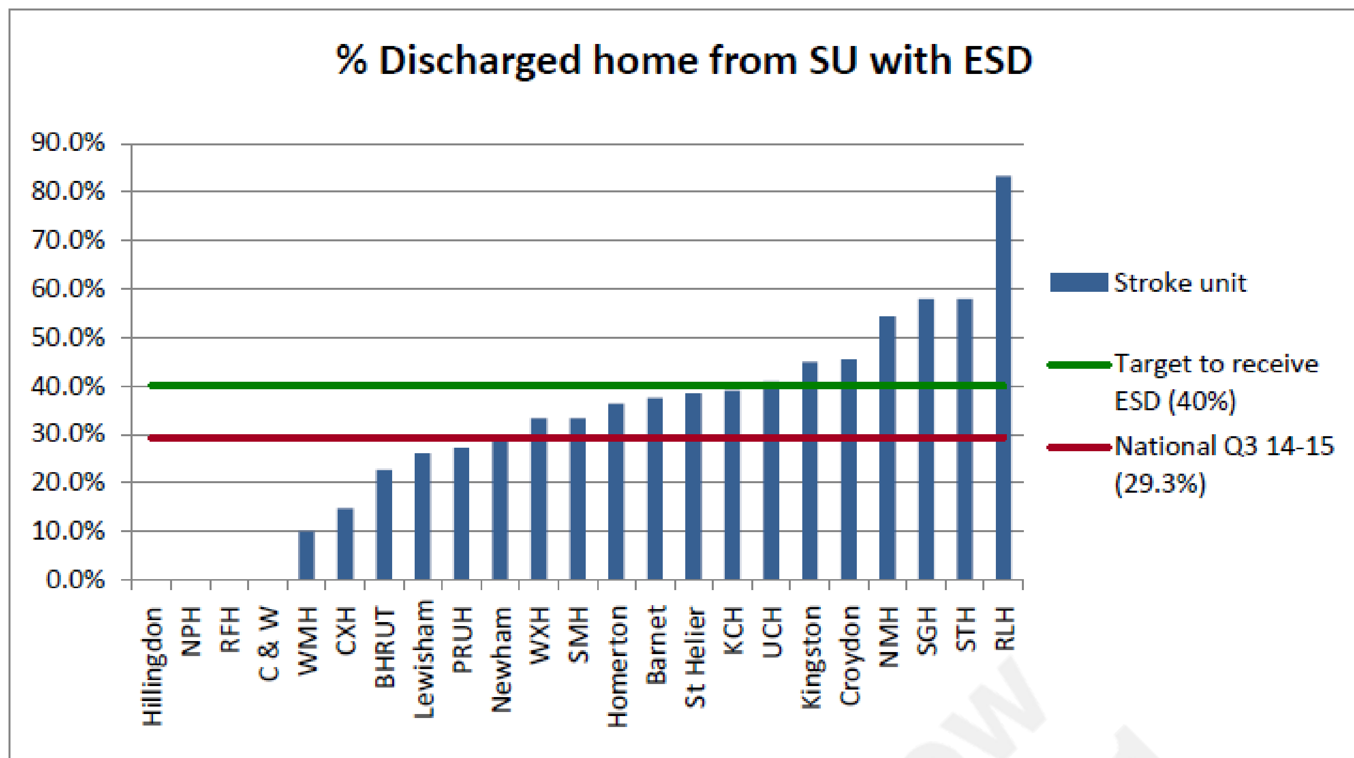
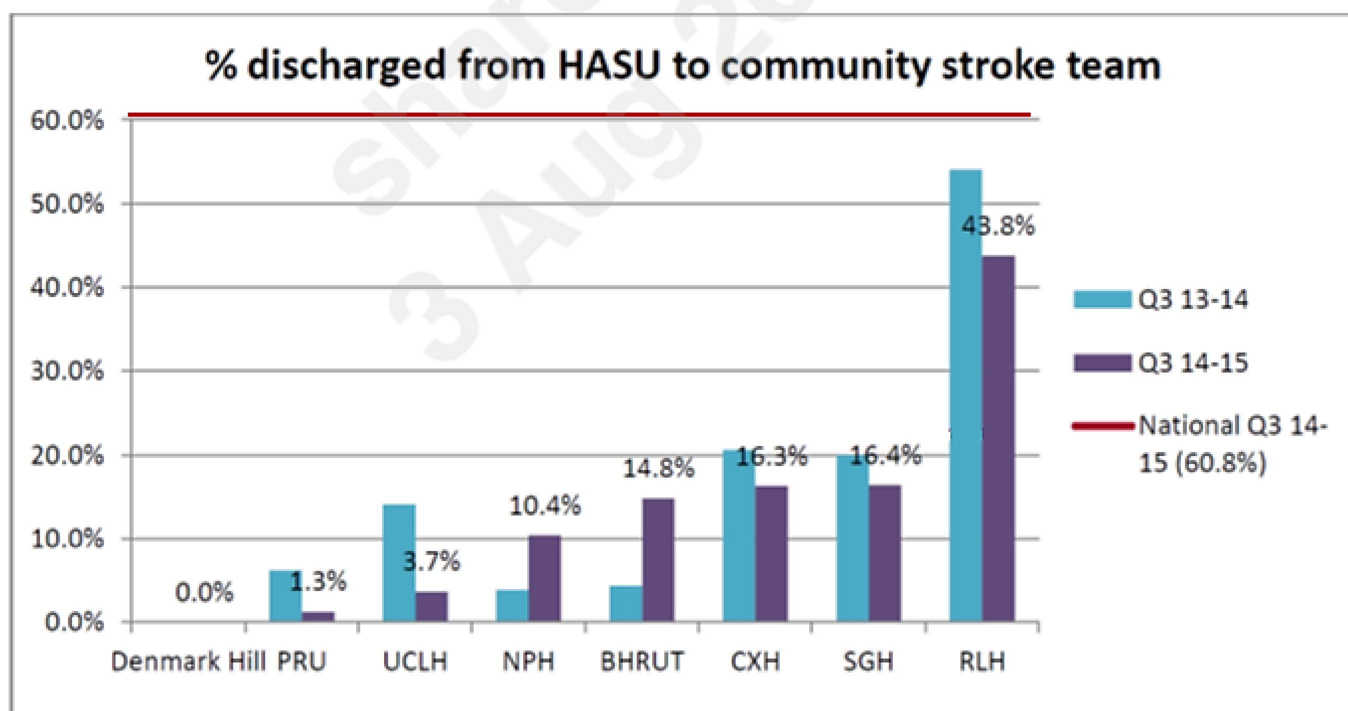


Figure 8: % of patients discharged home from SU to stroke/neuro-specific Early Supported Discharge between Q3 2013/14 and 2014/15.

5.3.4 Quality in relation to Community Stroke Rehabilitation Service

The two graphs below also demonstrate that stroke survivors are not necessarily getting the best possible access, and therefore quality of post-acute stroke care. Whilst the London standard is that 20% of people should be discharged from HASU or SU to community stroke team, 14.8% of people in BHRUT with stroke are being discharged from HASU, and approximately 16% from acute stroke unit.



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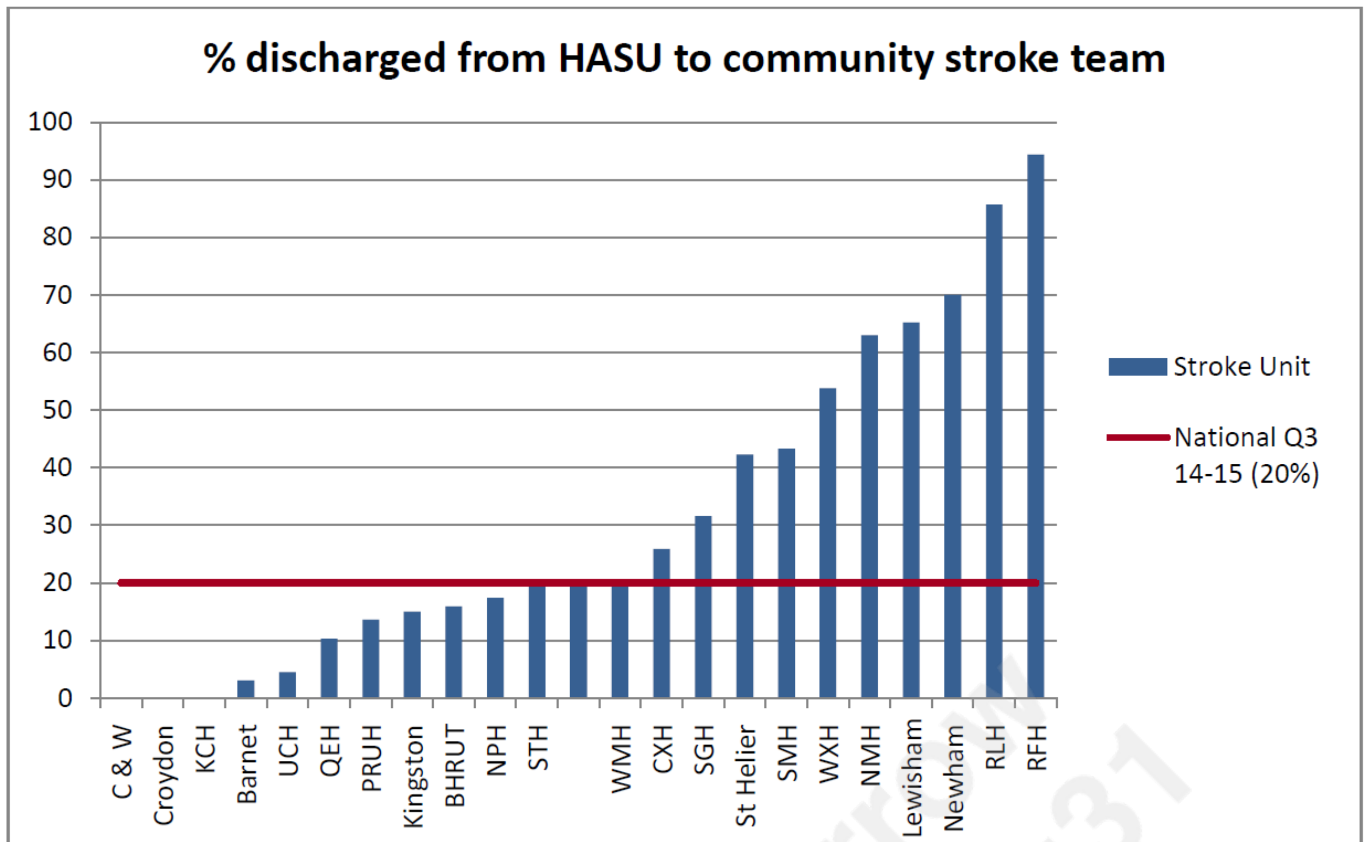

Considering that discharges from BHRUT to either stroke ESD or CRS services are way below the London quality standards being set, there is a need for BHR CCGs to change the way the existing post-acute stroke services are commissioned. More needs to be understood in relation to the quality standards in relation to Inpatient rehabilitation, as this information was not included in the benchmarking provided in this report.

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5.4 How are we doing in respect to commissioning for outcomes?

Whilst acute stroke providers are systematically using SNNAP to record nationally recognised outcomes for stroke, as this document has articulated in the section 2 there is currently very little information routinely recorded or reported across providers and organisations in respect to any outcomes from post-acute stroke care. This is largely due to the lack of consistency in commissioning services to use the nationally recognised SSNAP database for recording information on post-acute stroke care.

RCP Finding/Recommendation	Commentary	B&D	H	R
Participation in the SSNAP inaugural organisational audit of post-acute stroke care commissioning has been excellent with 99.6% of responsible bodies providing data	*All three BHR CCGs participated in the audit of post-acute stroke care*			
There is widespread variation, both by region and country, in the types of post-acute stroke care currently being provided.	*Variation does exist both within and across BHR CCGs, and the type of care available does depend on where people live. Patients living in the "Wanstead strip" receive a different service to the rest of Redbridge*			
There is concern that care home residents may be being denied access to stroke rehabilitation services in some areas.	*Some community rehabilitation services do not currently provide stroke rehabilitation to people living in care homes*			
All commissioners are recommended to draw up consistent service specifications with their provider organisations and include participation in SSNAP clinical audit as a requirement	*Of the four service specifications available for post-acute stroke care across the BHR CCGs none mention regular reporting through the SSNAP data base and all varied in content in relation to interventions, outcomes and performance measurement requirements.*			
All commissioners are recommended to support a 6 month post-stroke assessment for all patients as recommended in the National Stroke Strategy and required by the CCG Outcome Indication Set (CCG OIS)	*2/3 BHR CCGs are currently commissioning 6 month post-stroke assessments for their population.* *This creates a challenge in assessing the outcomes patients are achieving post-discharge from health and/or social services.*			
All commissioners should be commissioning stroke-specific Early Supported Discharge (ESD)	*2/3 BHR CCGs are commissioning ESD for their population. Service offer also varies across the patch*			
All commissioners are recommended to consider joint health and social care collaboration to address major shortfalls in provision of emotional and psychological support after stroke and vocational rehabilitation	*There is great variation in the provision of survivorship support across BHR landscape, with some being commissioned by either health or social care.*			
Commissioners are recommended to participate with providers in using SSNAP data as part of a programme of managed quality service improvement	*There is variation across BHR CCGs in how the information provided by the SSNAP data base is used to inform routine performance management and/or delivery improvement*			

Given the lack of readily available outcome data, the contracts and service specifications of those providers commissioned to provide both acute and post-acute stroke care were reviewed. Discussions with clinicians providing the services were also held in order to understand a) whether they used nationally recommended outcome measure such as mRS or b) what they were currently recording to enable them to understand the outcomes they were helping people to achieve.

The table below illustrates the outputs of this analysis.

Pathway Phase	Type	Provider	Are Outcomes for Stroke Measured and Reported?
Hyper-acute / Acute		BHRUT Barts Health	✓ Morality Rates ✓ mRS
Stroke Rehabilitation	In-Patient	Grays Court (NELFT)	✗
		BHRUT	✓ mRS
	Early Supported Discharge	BHRUT	✓ mRS
		NELFT	✗
	Community Rehabilitation Service	NELFT	✗
Stroke Survivorship Support	6 / 12 monthly reviews	Stroke Association	✗
		Carers Trust	✗

The DITC have found the availability of data on stroke-specific key performance indicators (KPI's) both within services and across the stroke pathway is sparse, and generally focus on measuring process measures e.g. the numbers of patient's seen, access, amount of time spent on stroke rehabilitation and level of intensity, rather than the outcomes stroke survivors are currently achieving.

I would love to know what the 6/12 and 12 monthly reviews are telling us about the patients we saw in HASU and what outcomes they have achieved. Currently, I have no way of doing that across so many different stroke rehabilitation and support services'.

Whilst some individual stroke service providers, such as BHRUT and Barts health, meet monthly to discuss their stroke service improvement plans, there is currently no formal meeting or forum where outcomes being achieved can be presented across the entire pathway, something that local stroke physicians have expressed frustration about.

Given the lack of outcome data available specific to the stroke pathway through existing commissioning and contracting arrangements, there is clearly a case for change in relation to developing and agreeing a number key patient outcomes the BHR CCGs may wish to measure in the future. This will need to be informed by discussions with expert clinicians to define a clear set of outcomes to be measured throughout the stroke pathway, and how this will routinely measure and reported on in the future to identify the outcomes people living with the effects of stroke are achieving.

5.5 How are we doing in respect to commissioning for Value?

The different contracting and reporting arrangements across the number of different types of providers mean that the BHR CCGs are currently unable to tell how much they are spending on stroke services. Consequently it is difficult to assess whether the existing resources going into stroke care represents the best way to achieve the best outcomes for patients. The first step in understanding the case for service change in relation to cost and value for money is try to understand the resources that are currently being spent on each element of the stroke pathway.

Unlike the previous sections in this document, it is important to understand existing spend across the entire stroke pathway to ensure any future redistribution shifts resources to the best place to serve stroke survivors. As there are a number of providers for each phase of the existing pathway, this has this far proved challenging, and further work is required to fully understand how current resource is being spent.

Figure 9 on the following page articulates the existing contracting information understood by the BHR CCGs in relation to spend, and why the current contracting and reporting requirements do not enable the BHR CCGs to understand if they are spending the right amount of available resource in the best element of the pathway.

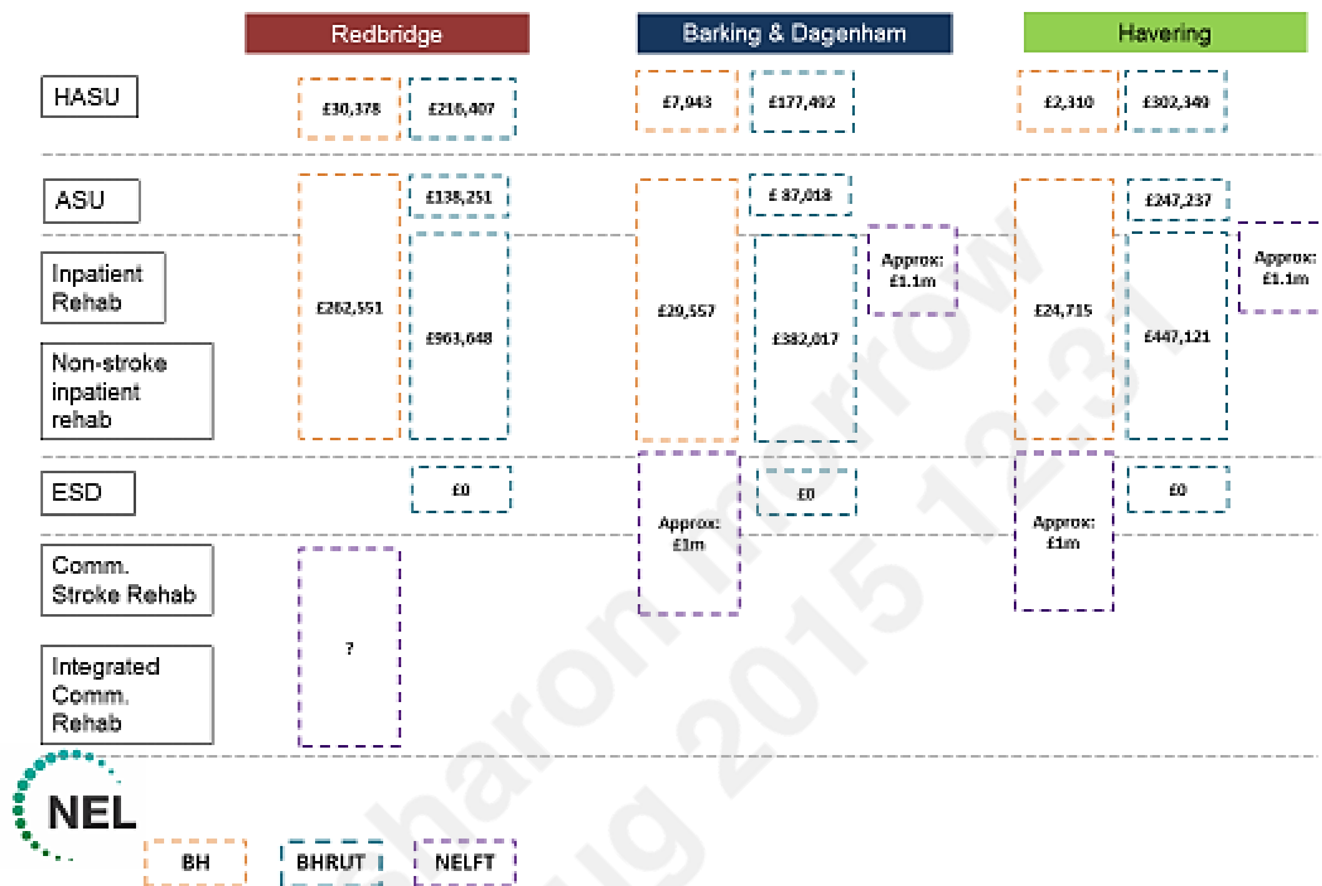

Figure 9: Existing contracting information understood by the BHR CCGs in relation to spend

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The amounts shown on the diagram above are taken from a combination of the contract values and the Trusts' service line reporting (SLR). The problems that this has highlighted are:

- Barts Health, that provide an inpatient service to some Redbridge patients from Whipps Cross Hospital, do not differentiate in their charges between ASU and inpatient rehabilitation
- BHRUT do not differentiate between inpatient stroke rehabilitation and rehabilitation for other conditions. The basis of the charge is by individual patient tariff. Also no specific charge is made for ESD, so the assumption is that this is also included in the price for inpatient rehabilitation.
- The community services provided by NELFT are on a single block contract with no differentiated prices. From the Trusts SLR a cost of stroke rehabilitation can be estimated. However the SLR does not show the cost to each commissioners, nor does it differentiate between the cost of ESD and the rest of the community stroke rehabilitation team.

5.6 Recommendations on next steps for the BHR CCGs

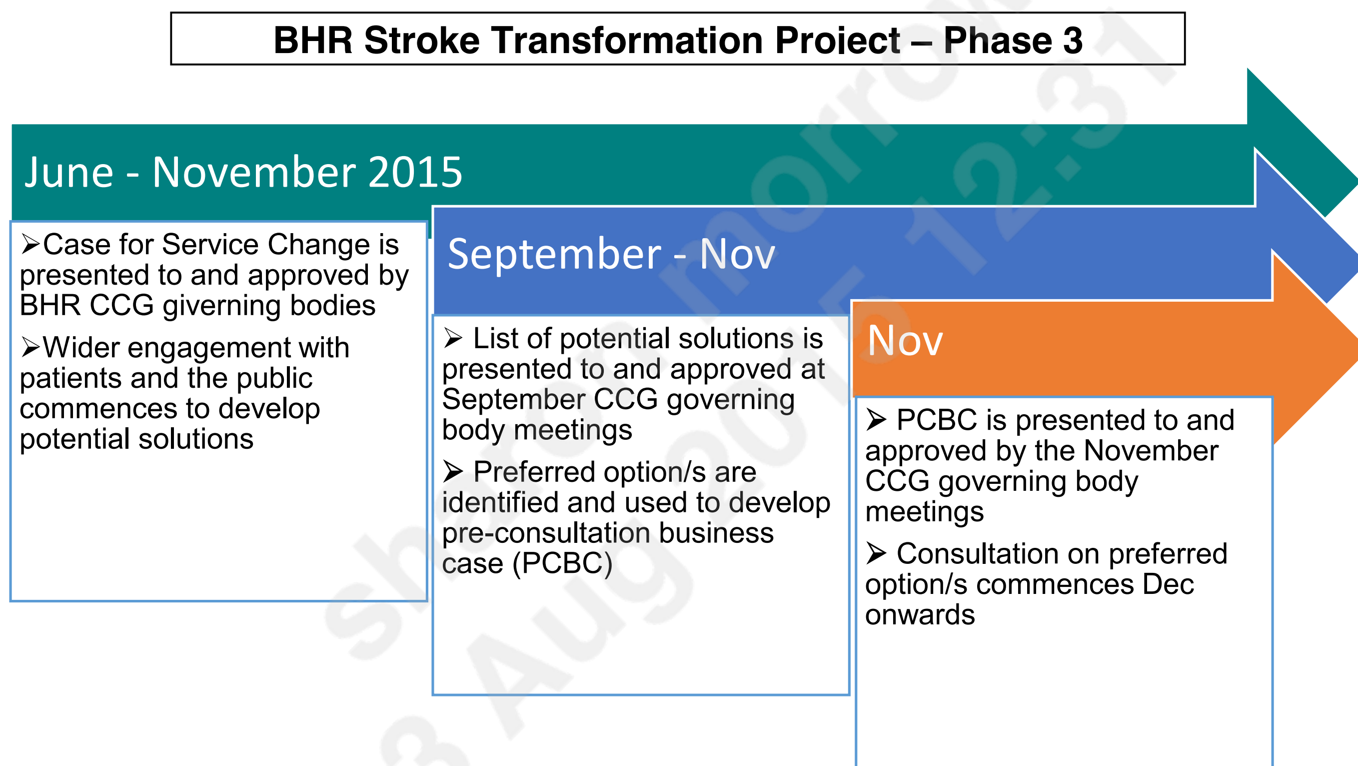
At their governing body meeting in June 2015 the three BHR CCGs are asked to take the findings of the case for service change in post-acute stroke care and agree the following three recommendations.

1. **Agree that outcomes for people living with the effects of stroke will improve by changing the way that post-acute stroke care is commissioned and delivered across BHR.**

2. **Agree to prepare a business case to consider possible changes to the provision of post-acute stroke services.**

3. **Agree to engage widely with patients and the public on the case for change.**

Once the governing bodies have approved the case for service change, wider public and patient engagement on the BHR Stroke Transformation project will commence. This will include engaging on the case for service change, as well as a list of future solutions to the issues raised in this document. The proposed timescales for Phase 3 of the project is described in Figure 10 below.



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Appendix 1: SSNAP Organisational Audit template for BHRUT HASU and SU

HASU Annual review template 2013/14
Unit: Queen's Hospital, Romford
Number of beds: 12

HASU Criteria	A1 STANDARDS	Measurement	RAG rating	Additional notes
STAFF				
16	Provision of **0.73 WTE** Physiotherapist/5 beds **Required: 1.75** **Combined HASU & SU staffing: 7.44**	Calculation provided by Trust. Should include appropriate evidence (budget statements, staff lists, staff roster etc) to demonstrate that the staff genuinely work on the SU. When retrospectively assessing, the scoring is as follows: hitting or exceeding the ratio – Green, Red - outside 11%		Staff rotas
17	Provision of **0.68 WTE** Occupational Therapist/5 beds **Required: 1.6** **Combined HASU & SU staffing: 6.38**			Staff rotas
18	Provision of **0.68 WTE** SALT/10 beds **Required: 0.8** **Combined HASU & SU staffing: 3.2**			Staff rotas
24	Provision of 24/7 nursing workforce to provide: **2.9 WTE** nurses / bed **80:20** trained to untrained skill mix **Required: trained 27.8** **Untrained 7**	Calculation provided by Trust. Should include appropriate evidence (budget statements, staff lists, staff roster etc) to demonstrate that the staff genuinely work on the SU. When retrospectively assessing, the scoring is as follows: hitting or exceeding the ratio – Green; Red outside 20%		Staff rotas
INFRASTRUCTURE (exception reported only)				
1	A robust operational pathway for receiving suspected stroke patients, alerting HASU team of suspected stroke patient admission and transferring to HASU from A&E	Review the arrangements	Discussion & written evidence	
2	A radiology service responsible for provision of the following (24/7): • CT scanning for suspected stroke patients • CT reporting by radiology or stroke consultant	Do these exist?	Discussion	

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	• A contingency plan to ensure continuity of provision of CT scans		
3	Established high-level thrombolysis treatment pathway	Provide evidence of pathway	Discussion & written evidence of pathway
4	**24/7** availability of appropriately trained staff in eligibility assessment and administering thrombolysis treatment	Provide evidence, e.g. staff rotas	Rota
9	**24/7** availability of appropriately trained staff in assessment of suspected stroke patients who are ineligible for thrombolysis treatment	Provide evidence, e.g. staff rotas	Rota
20	Arrangements for timely repatriation to appropriate local or co-located SU	Review the arrangements	Written evidence of policies and protocols
22	Consultant led HASU team	Provide management structure and name of lead consultant	Rota
23	Provision of 24/7 consultant cover provided by at least 6 BASP thrombolysis trained consultants on a rota able to make thrombolysis and hyper acute treatment decisions	Provide evidence, e.g. job plans	Rota
28	Evidence of management plan for access to neurosurgery, interventional neuroradiology and vascular surgery for appropriate patients	Review the arrangements	SSNAP & discussion

HASU Criteria	A2 STANDARDS	Measurement	RAG rating	Additional notes
5	**100 %** of appropriate stroke patients, identified as potentially eligible for thrombolysis treatment, to be scanned within next available CT slot (this must support a door to needle time of 60 mins)	(Ischaemic patients only) Green >=90%, below 60% Red		SSNAP
7	**100 %** of appropriate stroke patients to receive thrombolysis within 3 hrs or as soon as possible of symptom onset	Green 100%, <75%=Red		SSNAP
8	**100%** of appropriate patients scanned within 24 hrs of admission to A&E	Green 100%, <90%=Red		SSNAP

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10	**95 %** of all appropriate stroke patients to be admitted to HASU directly from A+E	Green 95%, <75%=Red		SSNAP
11	**70 %** of all stroke patients to receive swallow test within 24 hrs of admission	Green 70%; <50%=Red		SSNAP
13	**75 %** of all patients to receive physiotherapist assessment within 72 hours of admission (performance standard)	Green 75%, <50%=Red		SSNAP
14	**100%** of appropriate patients to receive continuous physiological monitoring (ECG, oximetry, blood pressure) by appropriately trained staff	Green >=95% , below 80% Red		SSNAP

HASU Criteria	B STANDARDS	Measurement	RAG rating	Additional notes
6	90% of stroke patients eligible for thrombolysis (to be thrombolysed), to receive thrombolysis treatment within 45 mins of entry to A&E (door to needle time)	Green 90%, <80%=Red		SSNAP
12	100 % of appropriate stroke patients to be weighed during admission	Green 100%, <75%=Red		Local audit results
15	Daily consultant level ward rounds	Check patient notes and job plans		Trust to provide written evidence
27	100 % appropriate patients and carers to receive contemporary patient information provided in a variety of formats	Provide evidence that this is happening. Up to date leaflets and patient information (not photocopies), evidence that different font size, languages and different colours are available		Trust to provide written evidence

HASU Criteria	C STANDARDS	Measurement	RAG rating	Additional notes
6	50% of stroke patients eligible for thrombolysis (to be thrombolysed), to receive thrombolysis treatment within 30 mins of entry to A&E (door to needle time)	Green 50%, <30%=Red		SSNAP

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31	Patient and carer involvement in development of stroke services	Provide evidence that this is happening, e.g. focus groups, patient satisfaction surveys, discovery interviews		Trust to provide written evidence
33	Evidence of timely implementation of service delivery improvements e.g. new guidance, compliance improvements	Provide evidence that this is happening		Trust to provide written evidence
35	Demonstration of participation in stroke related research, as a key part of HASU services	Provide evidence that this is happening e.g. lists of trials / research projects		Trust to provide written evidence
25	Recruitment plan for vacant positions and success in filling vacant positions	Evidence of a recruitment strategy. Discuss vacancy rate		Discussion and rotas

HASU Criteria	D STANDARDS	Measurement	RAG rating	Additional notes
26	Plan for rotation of posts across the professional groups along the patient pathway	Provide evidence that this is happening. This should cover junior doctors, therapists and nurses		Discussion and rotas
34	Completion of leadership training by key members of the stroke team to support stroke service improvement	Provide evidence that this is happening		SSNAP

Additional comments:

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SU annual review 2013/14

Unit: Queen's Hospital, Romford
Unit size: 30 beds

Criteria	A1 Standards	Measurement	RAG rating	Data source
	STAFF			
11	Provision of **0.84 WTE** physiotherapist/5 beds **Required: 5.04** **Combined HASU & SU staffing: 7.44**	Calculation provided by Trust. Should include appropriate evidence (budget statements, staff lists, staff roster etc) to demonstrate that the staff genuinely work on the SU. When retrospectively assessing, the scoring is as follows: hitting or exceeding the ratio – Green; outside 11% - Red. • Named staff roster provided • Head count • Rotas • WTEs can be made up using no more than 15% agency. Bank is an acceptable substitution for substantive staff. • If Bank Staff, need to see recruitment plan including permanent posts. • Performance in a subsequent period should show agency as a % no more than 10%.		Discussion – trust to provide data
12	Provision of **0.81 WTE** OT/5 beds **Required: 4.86** **Combined HASU & SU staffing: 6.38**			Discussion – trust to provide data
13	Provision of **0.81 SALT WTE** /10 beds **Required: 2.43** **Combined HASU & SU staffing: 3.2**			Discussion – trust to provide data
23	Provision of 24/7 nursing workforce to provide: **1.35 WTE** nurses/bed, **65:35** trained to untrained skill mix **Required: Trained 26.3** **Untrained 14.2**			Discussion – trust to provide data
	INFRASTRUCTURE			
8	Evidence of a protocol to initiate suitable secondary prevention measures in all appropriate patients			Discussion & written protocol

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9	A radiology service responsible for provision of the following: CT scanning and reporting, MRI scanning, ultrasonic angiology			Discussion
16	Availability of rehab facilities i.e. access to physiotherapy gym, OT kitchen, SALT equipment			Discussion & walk round
17	Demonstration of maintenance of all 5 characteristics of a good stroke unit: MDMs at least weekly to plan care; provision of information to patients; continuing education programs for staff; consultant physician with responsibility for stroke; formal links with patient & carer organisations			SSNAP
18	Demonstration of agreed referral pathways from SU to community rehab providers			SSNAP
21	Sharing of information between SU and GP and rehab provider (if applicable)			Discussion & presentation of template letters
22	Consultant led SU team; minimum of 5 consultant or equivalent ward rounds per week; dedicated junior medical team trained in stroke management			SSNAP

Criteria	A2 Standards	Measurement	RAG	Additional evidence/Comments
1	Timely admission of patients from HASU: 90% of patients repatriated within 24 hours	Timely is defined as within 24 hrs of confirmation that a patient has a discharge date and time, patient should be admitted to an SU (within 24 hrs of confirmed discharge date and time) Green ≥90%, below 65% Red		SSNAP
2	95% of all stroke patients to be admitted directly to SU on HASU transfer	Green 95%, <75% Red		SSNAP
3	95% of stroke patients to spend all of their in-hospital time in SU	Green: 80% or above, Red below 75%		SSNAP

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4	75% of all patients to receive a physiotherapist assessment within 72 hours of admission to SU	Green 75%, <50% Red		SSNAP
5	60% of all patient to receive an occupational therapy assessment within 7 days of admission to SU	Green >=60%, below 50% Red		SSNAP
6	75% of all patients to be weighed within 72 hours of admission to SU	Green100%, <75% Red		Local audit
10	70% of all patients to have their mood assessed by time of discharge	Green 70%, <60% Red		SSNAP
14	Patient access to a social worker	Provide evidence that this is happening e.g. systems are in place, referral forms		SSNAP
35	Provision of, and attendance at, MDT stroke training programs.	Provide evidence that they are taking place and numbers of attendees, e.g. agendas, feedback sheets from MDT training attendance records etc. Reflected and monitored in PDPs.		Trust to provide written evidence

Criteria	A2 Standards	Measurement	RAG	Additional evidence/Comments
7	100% of appropriate patients to receive weekly nutritional screening	Green 100%, <80%=Red		SSNAP
15	Availability of supporting services e.g. orthotics, podiatry, orthoptics, dietetics	Demonstrate that these exist e.g. evidence of referral pathway and paperwork and patient notes		Trust to provide written evidence
19	Arrangements for discharge of patient from SU with appropriate support	Evidence of protocol and provision of discharge plan for 100% of patients JCP: Green 85%, <75%=Red		Trust to provide written evidence
20	Plan for management of average length of stay (LoS)	Evidence of active monitoring of LoS, investigation into long LoS, active reduction of LoS plans, evidence that discharge plans are created early on in a patients stay		Discussion
24	Recruitment plan for vacant positions and success in filling vacant positions	Evidence of stroke recruitment strategy and vacancy rates		Discussion and evidence from rotas of numbers of staff in post
26	100% of appropriate patients and carers to receive contemporary patient information	Provide evidence that this is happening. Up to date leaflets and		Trust to provide written evidence

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	and care plans provided in a variety of formats	patient information in different font sizes, languages and colours		
27	Provision of a named contact on discharge for each patient	Provide evidence that this is happening		Trust to provide written evidence
30	Demonstration of a stroke management group to oversee service delivery and improvement e.g. review of performance standards, impact of new guidance and methods for improvement of service	Provide evidence that this is happening – agenda/minutes, reasonable frequency		Trust to provide written evidence
34	Provision of structured training plan for new and rotational staff to ensure a competent understanding of the stroke pathway and compliance to standards	Provide evidence of a stroke specific induction program		Written evidence
37	Active involvement in local stroke networks	Network to assess evidence of meeting attendance lists and rapid and reliable provision of data		Trust to provide written evidence

Criteria	C and D Standards	Measurement	RAG	Additional notes
28	Process for obtaining and incorporating patient feedback into SU service development	Provide evidence that this is happening, e.g. focus groups, patient satisfaction surveys, interviews		Trust to provide written evidence
29	Patient and carer involvement in development of stroke services	Provide evidence that this is happening, e.g. stroke forum regularly attended by clinical management		Trust to provide written evidence
31	Evidence of timely implementation of service delivery improvements e.g. new guidance, performance standard compliance improvements	Provide evidence that this is happening		Trust to provide written evidence
33	Demonstration of participation in stroke related research, as a key part of SU services	Provide evidence that this is happening, e.g. lists of trials / research projects		Trust to provide written evidence
25	Plan for rotation of posts across the professional groups along the patient pathway	Provide evidence that this is happening		Discussion & where possible evidence of rotas

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32	Completion of leadership training by key members of the stroke team to support stroke service improvement	Copies of PDPs provided, list of courses attended		Trust to provide written evidence

Criteria	Standards	Measurement	RAG	Additional notes
5	90% of high risk TIA patients to receive a specialist assessment and treatment within 24 hours of first presentation to a healthcare professional	TIA pathway to cover both high and low risk treatment arms Evidence of compliance against performance standard e.g. local audit Green <90%, red less than 60%		Trust to provide written evidence
7	90% of low risk TIA patients to receive a specialist assessment and treatment within 7 days of first presentation to a healthcare professional			Trust to provide written evidence
11	90% of appropriate TIA patients with symptomatic carotid stenosis to undergo CEA within 14 days of first presentation to a healthcare professional	Evidence of compliance with agreed network pathway e.g. local audit		Trust to provide written evidence

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Appendix 2: 6 domains of stroke service organisation within the Sentinel Stroke National Audit Programme (SSNAP)

D1-Acute care: Presence of up to 7 features representing quality of care of stroke units treating patients within the first 72 hours of stroke; level of thrombolysis provision; nurse staffing levels at 10am weekends per ten beds

D2-Specialist roles: Frequency of consultant ward rounds; presence of senior nurses and/or therapists; access within 5 days to all of: social work expertise, orthotics, orthoptics, podiatry; palliative care patients treated on Stroke unit; access to clinical psychologists and aspects of care provided; provision of services which supports stroke patients to remain in, return to or withdraw from work and/or education or vocational training; patients staying in bed until assessed by physiotherapist

D3-Interdisciplinary services: Ratio of nurses and therapists to beds on the stroke unit(s); 6 or 7 days working for therapists; frequency and membership of formal team meetings

D4-TIA/Neurovascular clinic: Time TIA service can see, investigate and initiate treatment for all high- and low-risk patients; waiting time for carotid imaging (high- and low-risk patients)

D5-Quality improvement, training & research: Report on stroke services produced for trust board; presence of a strategic group responsible for stroke and membership; funding for external courses and number of days funded for nurses and therapists; clinical research studies; formal links with patients and carer's organisations; patient/carer views sought on stroke services; report produced in past 12 months which analysed views of patients

D6-Planning and access to specialist support: Patient information on: social services, benefits agency, secondary prevention advice and patient version of stroke guidelines/reports; personalised rehabilitation discharge plan given to patients; access to stroke/neurology specialist early supported discharge and community team for longer term management

sharon marlow
3 Aug 2015

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HEALTH AND WELLBEING BOARD

8 September 2015

Title: Urgent and emergency care and Vanguard application	
Report of the Barking and Dagenham Clinical Commissioning Group	
Open Report	**For Decision**
Wards Affected: All wards	**Key Decision: No**
Report Author: Carla Morgan, Strategic Delivery Project Manager	**Contact Details:** Tel: 0208 926 5197
Sponsor: Conor Burke, Chief Officer Barking and Dagenham Clinical Commissioning Group	
Summary: Our local System Resilience Group (SRG) - a partnership of CCGs, providers, local authorities, GP Federations, out of hours provider (PELC), London Ambulance Service, Healthwatch and the Local Pharmaceutical Committee (LPC), has been successful in an application to become a national urgent and emergency care (UEC) Vanguard. Vanguard status gives us a platform from which to implement some of the findings from the recent BHR urgent care conference and look to streamline and simplify the urgent care system and access for our patients.	
Recommendation(s) The Health and Wellbeing Board is recommended to note the content of this report.	
Reason(s) The proposal supports the Council's vision to enable social responsibility – supporting residents to take responsibility for themselves, their homes and their community and ensuring that everyone can access good quality healthcare when they need it. http://moderngov.barking-dagenham.gov.uk/documents/s82613/Vision%20and%20Priorities%20Report.pdf	

1. Introduction and Background

1.1 Urgent and emergency care has been a key challenge for our health economy for many years with a background which includes:

- A complex urgent care system with duplication and fragmentation across services
- Challenged health economies and challenged acute trusts

- Key performance targets, particularly in accident and emergency, not being met

1.2 A BHR urgent care conference was held on 1 July 2015. The purpose was to gather views on how we can transform urgent care services over the next 2-5 years.

1.3 Closely following the BHR urgent care conference an opportunity to bid to become an urgent and emergency care Vanguard was announced.

1.4 The BHR System Resilience Group (SRG) - a partnership of CCGs, providers, local authorities, GP Federations, out-of-hours provider PELC, London Ambulance Service, Healthwatch and Local Pharmaceutical Committee(LPC), was successful in an application to become a national urgent and emergency care (UEC) Vanguard.

1.5 Vanguard status gives us a platform from which to implement some of the findings from the recent BHR urgent care conference and look to streamline and simply the urgent care system and access for our patients.

2. Proposal and Issues

2.1 At the BHR urgent care conference on 1 July 2015 we asked attendees to really challenge themselves to think about what the future should hold for urgent care across our three boroughs.

2.2 Attendance at this event included the wider NHS (e.g. NHS England) and non-NHS stakeholders including Health and Wellbeing Board chairs, Healthwatch, patient representatives, clinicians, external and local providers and CCG members.

2.3 The key themes from the day are:

- **Simplify the pathway** through a **co-design** approach
- Maximise the **digital and technology opportunity**
- Excellent **self-care** support is essential to support urgent care
- Align **contracts** to support integrated delivery
- **Develop the Workforce** to meet future needs

2.4 During the day we asked attendees to describe ‘urgent care’ in two words - the word clouds show the words used by attendees to describe urgent care now and how they would want urgent care to be in the future - the bigger words were used by many attendees when describing urgent care.

Urgent Care is…

Urgent Care will be…

2.5 'Vanguards' for the new care models programme are one of the first steps towards delivering the *Five Year Forward View* and being part of the Vanguard programme will support us to improve and integrate services.

2.6 The Vanguard programme has four core principles

- Clinical engagement
- Patient involvement
- Local ownership
- National support

2.7 Vanguard sites are given access to a national support package and are encouraged to deliver innovation at pace, with learning shared nationally throughout the programme. Vanguards are encouraged to exploit opportunities for radical care redesign and to remove artificial barriers to change. This means that as a Vanguard we will be given freedoms and flexibilities which we would otherwise not have – examples of this could be freedom to change national reporting, procurement or information sharing requirements.

2.8 As a Vanguard site, in addition to the practical support offered by the national teams, we will have access to a £200m Transformation Fund. To access this fund, bids called value propositions, must be submitted which show how we will close three gaps - health and wellbeing, care and quality and the funding gap.

2.9 At the UEC Vanguard launch day on 27 August 2015 we will start to discuss with the national team what our support package will look like.

2.10 Vanguard status gives us a platform from which to implement some of the findings from the BHR urgent care conference and look to streamline and simplify the urgent care system and access for our patients.

2.11 Our Vanguard application sets out our aim to create a simplified, streamlined urgent care system delivering intelligent, responsive urgent care for the 750,000 residents across the BHR health economy - the most challenged health economy in the country.

2.12 Using the outputs from the BHR urgent care conference, the SRG believes there is a need to do things differently and that patients are confused by the many and various urgent and emergency care services available to them - A&E, walk-in centre, urgent care centre, GPs, pharmacists, out of hours services etc.

2.13 Becoming a UEC Vanguard will support the SRG in its ambition to streamline these points of access to just three - supported by a smart digital platform that will recognise patients and personalise the help they get as soon as they get in contact. This involves:

1. 'Click' - online support and information - will help people to self-care and book urgent appointments when needed
2. 'Call' - telephone for those who need more advice, reassurance or to book an appointment
3. 'Come in' – where patients really need emergency care - the front door of the hospital will become our new ambulatory care centres

2.14 The detail of this ambitious plan will be developed throughout September and will build on existing successful partnership working between NHS and social care organisations across the three boroughs.

2.15 Workstreams will include:

- Development of the operational model to include all aspects of urgent care provision including self-care support
- Communication and engagement
- Technology
- Contracts, finance and organisation development
- Workforce
- Governance and project management

3 Consultation

3.1 The BHR urgent care conference was held on the 1st July, and the outcomes from this event were used to shape the Vanguard application.

3.2 We are developing a communication and engagement strategy which will be supported by a detailed plan. Two of the four core Vanguard principles are patient

and clinical engagement and so the plan will have a high level of communications and engagement activities included to ensure the Health and Wellbeing Board, Health and Adult Services Select Committee and other stakeholders are regularly updated on progress.

3.3 The new operational model will be developed with patients and staff through a co-design process and will be completed by March 2016.

4 Mandatory Implications

4.1 Joint Strategic Needs Assessment

This programme will further the findings of the JSNA with regards to reducing ill health.

4.2 Health and Wellbeing Strategy

This programme will further and support the following priorities in the H&WB Strategy:

- To improve the quality and delivery of services provided by all partner agencies
- More children and families have access to urgent care community services which meet their needs
- More adults have access to community based urgent care services in ways that suit their work/life balance.
- More older adults have access to community based urgent care services

http://www.lbbd.gov.uk/AboutBarkingandDagenham/PlansandStrategies/Documents/HealthandWellbeingStrategy.pdf

4.3 Integration

This programme is sponsored by BHR System Resilience Group (SRG) - is a partnership of CCGs, providers, local authorities, GP Federations, PELC, LAS, Healthwatch and LPC.

One of the underpinning aims of the Vanguard programme is for our already well established partnership working to evolve into a more formal contractual arrangement. This will be a whole system approach to deliver a new care model.

4.4 Financial Implications

None identified at this point

As a Vanguard site, in addition to practical support offered by the national teams, vanguards also have access to a £200m Transformation Fund.

As part of the Vanguard programme we are required to adopt and test a new contracting / pathway payment mechanism as supported by Monitor.

4.5 Legal Implications

None identified at this point

4.6 Risk Management

None identified at this point

4.7 Patient/Service User Impact

None identified at this point

5. Non-mandatory Implications

None identified at this point

5.1 Crime and Disorder

None identified at this point

5.2 Safeguarding

None identified at this point

5.3 Property/Assets

None identified at this point

5.4 Customer Impact

None identified at this point

5.5 Contractual Issues

None identified at this point

5.6 Staffing issues

None identified at this point

Public Background Papers Used in the Preparation of the Report:

None

List of Appendices:

Appendix A - BHR urgent care conference

BHR Urgent Care Conference

Summary of outputs

#bhrurgentcare

1 July 2015

The aim of the day

To gather views on how we can transform urgent care services over the next 5-10 years. We know that urgent care is an issue nationally and locally with too many people confused about where to go and waiting far too long.

A key aim is to really challenge ourselves about what the future should hold for urgent care across our three boroughs.

The outcome of the day formed a basis for our urgent care strategy and roadmap for the upcoming years

Who was there?

Local providers

Kings Park surgery GP

Urgent Care Practitioners

Age UK Redbridge, Barking and Havering

Greenbrook

SELDOC Ltd

Commissioners

NELCSU

Optum

Local Pharmaceutical Committee

Barking and Dagenham, Havering and Redbridge CCGs

BHR Local Medical Committee

Kalsi / PCP Community Anticoagulation Clinic

KPMG

BHR GP Federations

BMI

NELFT

London Borough of Havering

Public Health

London Borough of Barking and Dagenham

Care UK

London Ambulance Service

BARTS Health

GPs

Patient reps

Capita

Adult social Care

National Providers

Partnership of East London Cooperatives (PELC)

NHS England

Healthwatch Barking and Dagenham

Healthwatch Havering

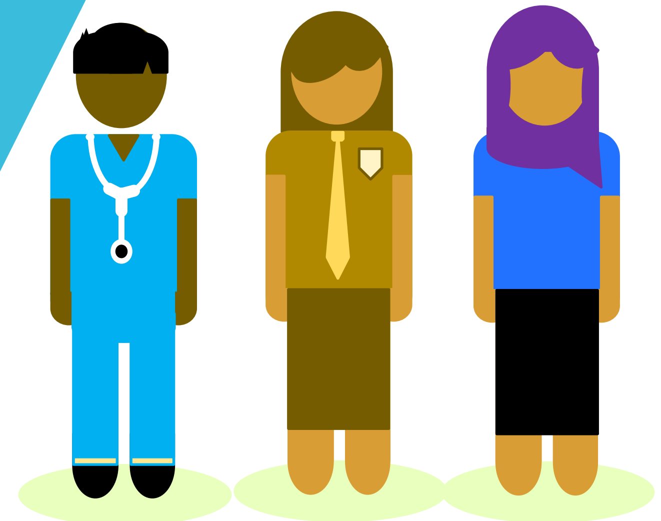
Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)

Patient Engagement Forum chair

Hurley Group

London Borough of Redbridge

Invitations were sent to the wider NHS and non NHS stakeholders; patient reps, clinicians, external and local providers and CCG members.

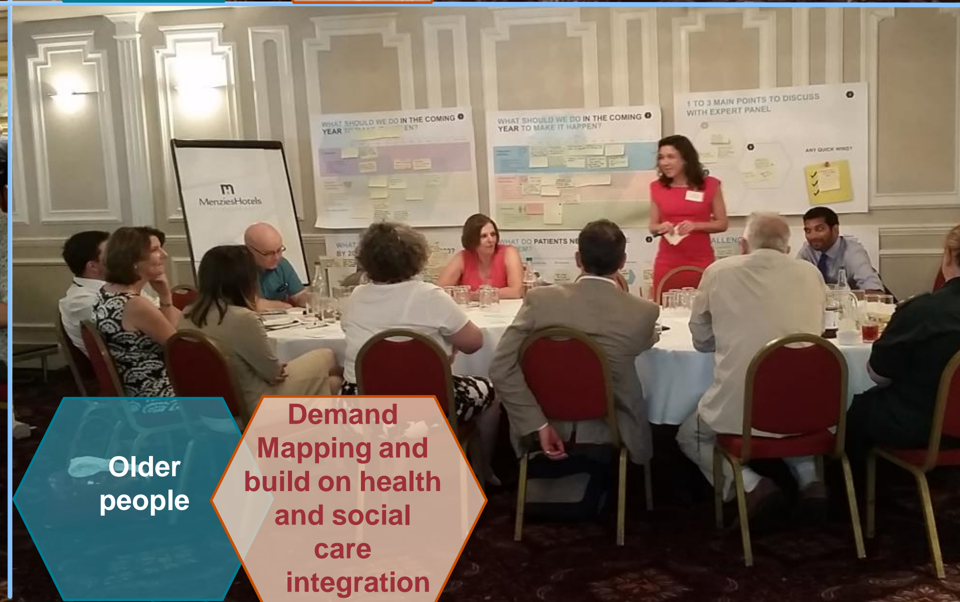


Currently Urgent Care is…

On arrival at the conference, delegates were asked to complete this sentence:

Please complete the following sentence with two words:
Currently urgent care is ______ _______

Vision from the workshop groups – key themes



Vision from the workshop groups

CHILDREN

Main Themes

There is a need for greater integration and to reduce the current level of fragmentation

Vision for 2017-2020:

Changing the skill mix of workforce:

- upskilling professionals, including pharmacists, health visitors, nurses as well as those in the third sector
- integrated education approach across all of these people, including the voluntary/third sector
- coordinated education of staff on how to educate patients and carers about managing their own health care and how to navigate the system.

Digital access to information:

- "Click & Call' model: create a web site endorsed by both professionals and patients as a first port of call
- A telephone triage centre as the next step which could signpost to appropriate services.

OLDER PEOPLE

Main Themes

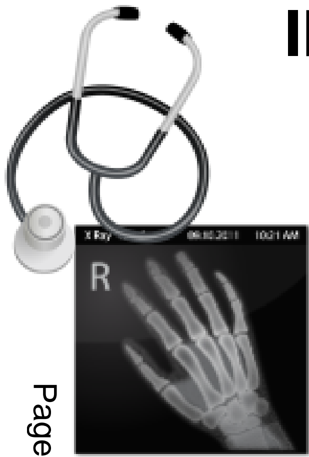
Bringing in the patient perspective (through patient reps). Being more transformational, rather than transactional.

Vision for 2017-2020:

- There was consensus that each provider brings in different cultures which creates organisational boundaries and hurdles
- Agreed that the pathway would benefit from having one single (lead) provider
- Idea to commission the pathway for frail elderly as a whole, not each separate organisation, was supported
- Keen to involve nursing homes and ambulance services much more
- End of Life care was left untouched, but it was recognised as a key next step.

Vision from the workshop groups

MINOR ILLNESSES / INJURIES



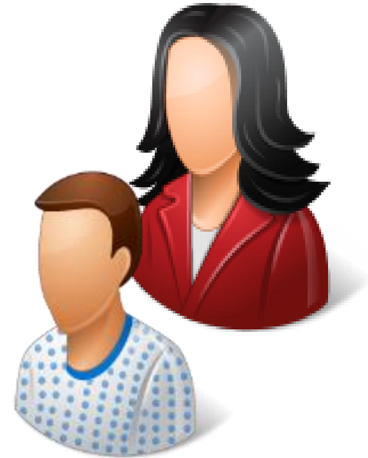
Main Themes

Recognition that urgent care can't be looked at in isolation, and any changes need to be considered in the broader context.

Vision for 2017-2020:

- Removing some of the duplication in the system
- There was general agreement that at the moment, there are multiple options for people with minor injuries and that this is causing both confusion (what to access, when) and duplication of roles
- Need for better communication – both with the public and with NHS staff
- Upskill staff to know the most appropriate place to send people.

MENTAL HEALTH



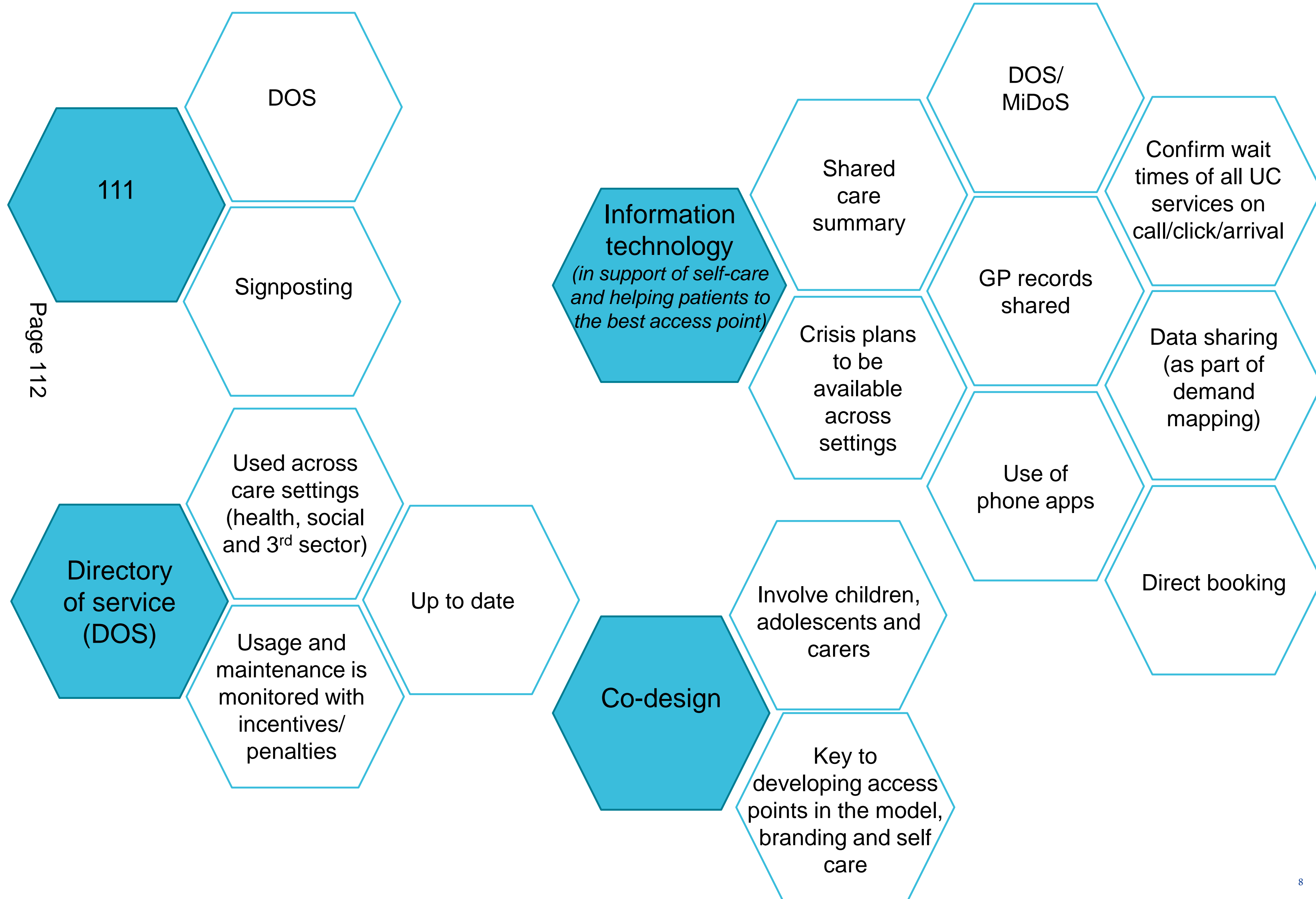
Main Themes

Being clear on the specifics of what services are available, where they are and when a person can access services. Discussions took place on how providers should respond to that.

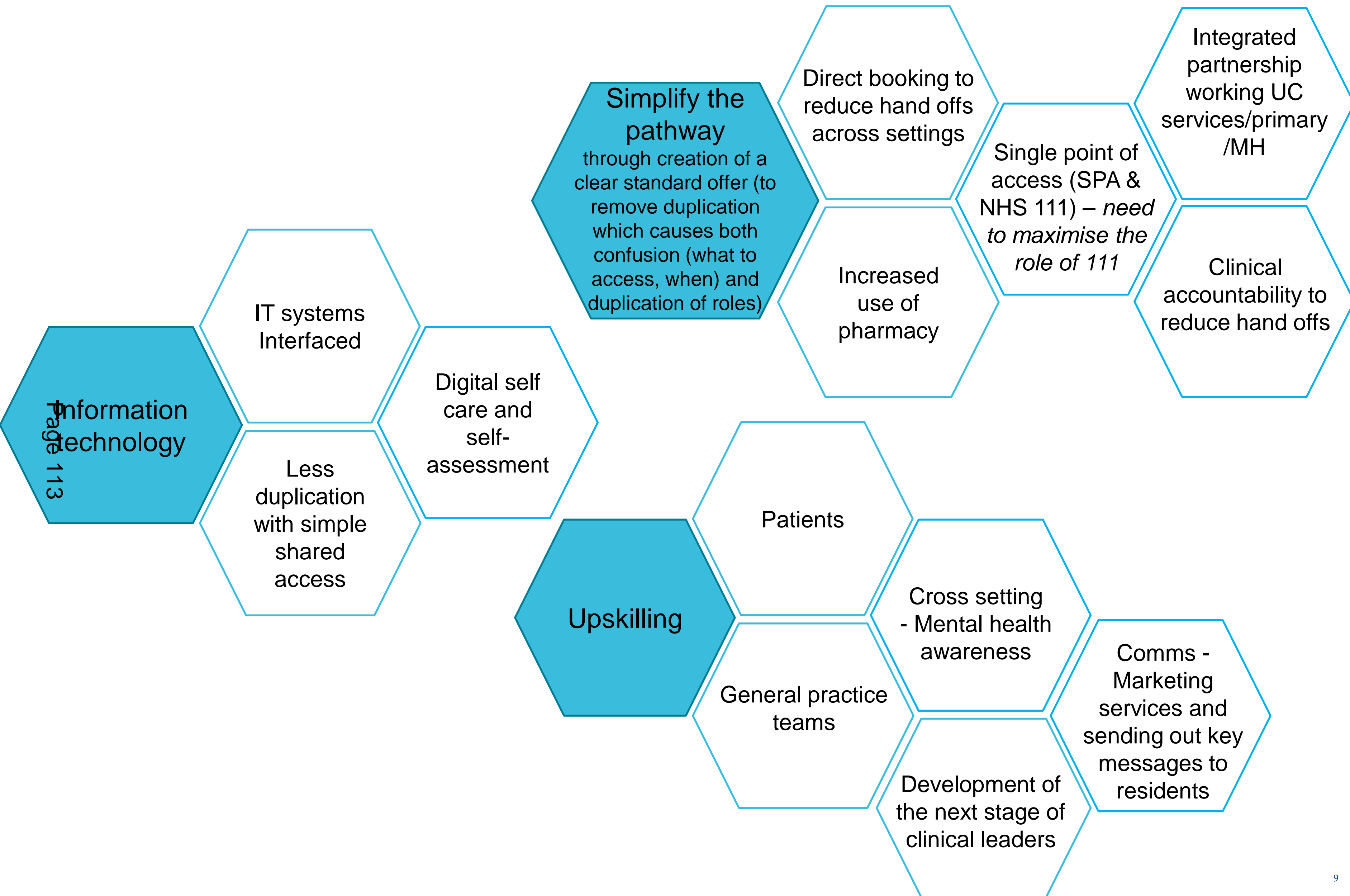
Vision for 2017-2020:

- Access, education
- Understanding how MH patients should interact with the urgent care system differently (but in parallel) to other patients
- Developing a clear understanding of what the MH UC pathway actually is. It was clear that this is really lacking.

Vision - common themes



Vision– common themes



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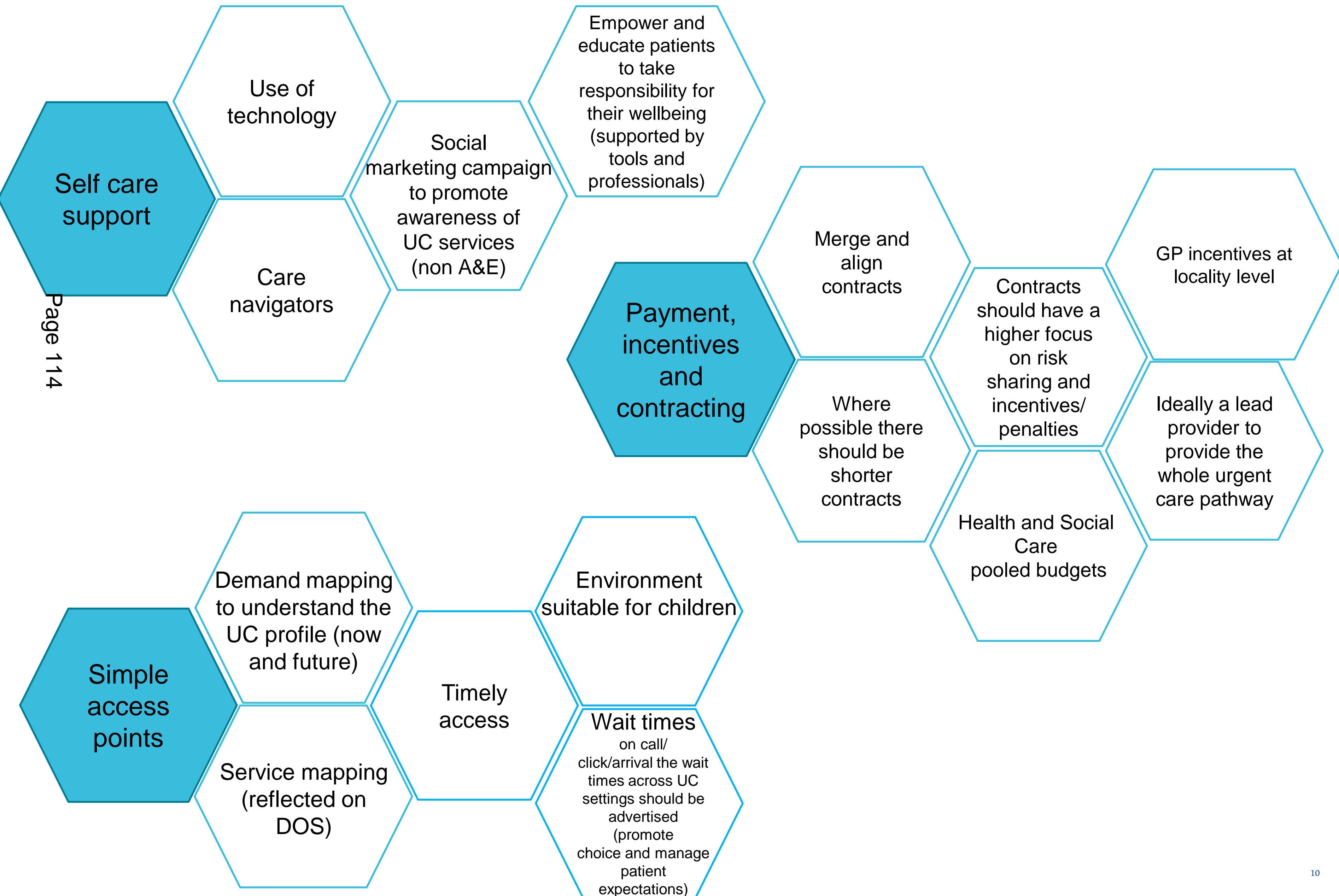
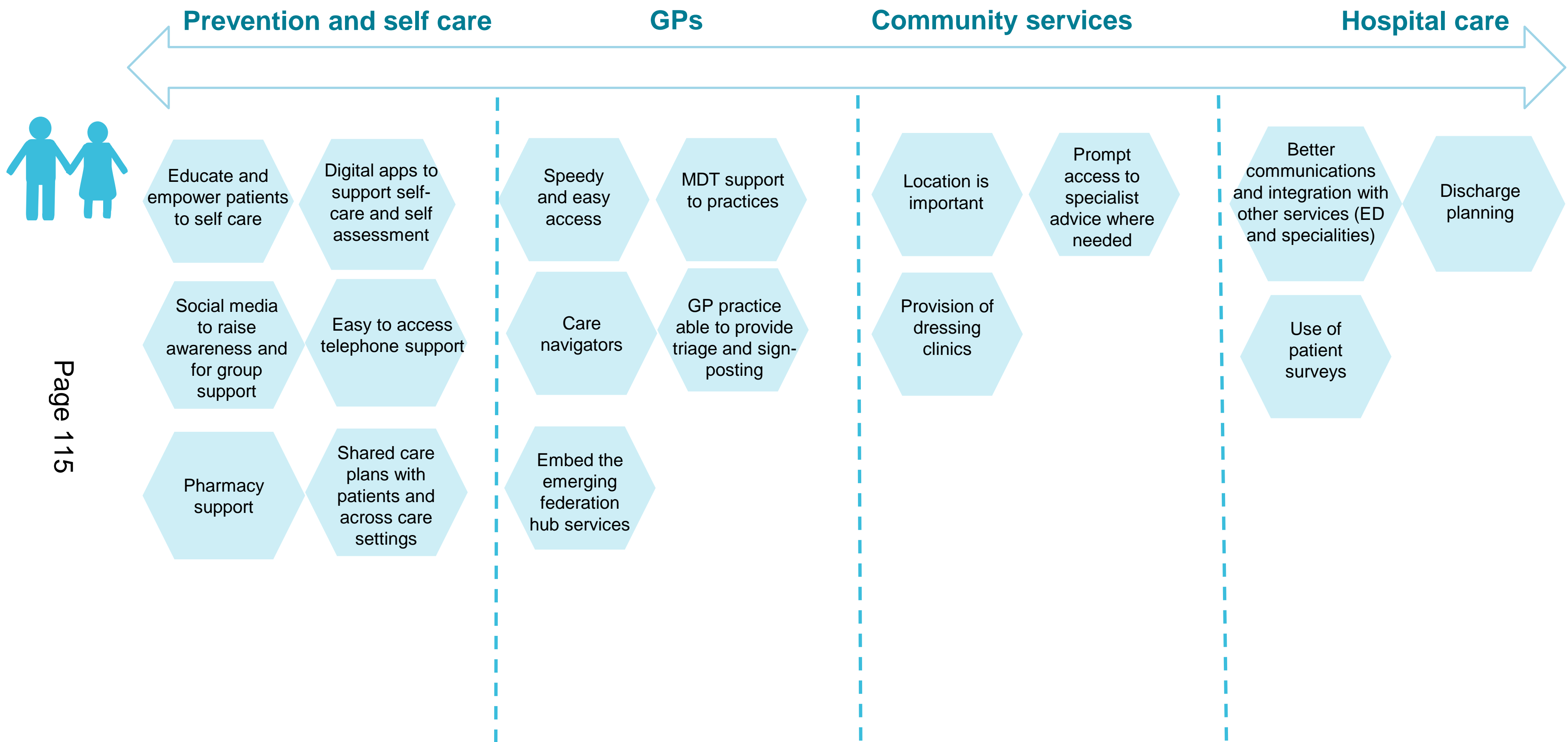
Vision – common themes



What do patients need? – common themes



Access
- Urgent care appointments via IT – call or click
- MiDoS
- SPA
- Creating a standard service offering simplified access
- Fast access and easy to know or find out where to go

IT
- Patient held records (iphone app)
- Use of MiDoS to support an easy way of finding out the most appropriate services.

Multi-Disciplinary teams
- for integration and knowledge transfer

Personal budgets

Next steps

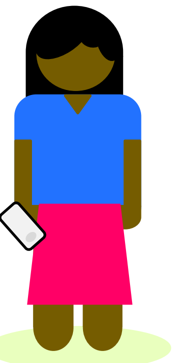
MINOR ILLNESS AND INJURY

- Future demand analysis
- Map current service provision
- Robust planning

MENTAL HEALTH

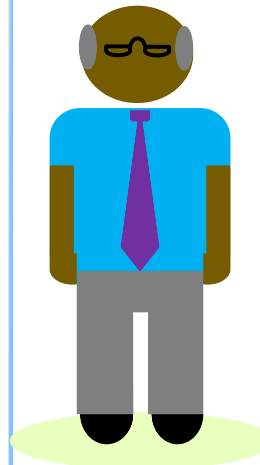
- Current demand and spend analysis
- Map current service provision
- Develop integrated UC delivery plan

CHILDREN



- Develop a paediatric DoS
- Complete a needs analysis
- Co-design services with patients
- Health care apps/records for patients to carry themselves

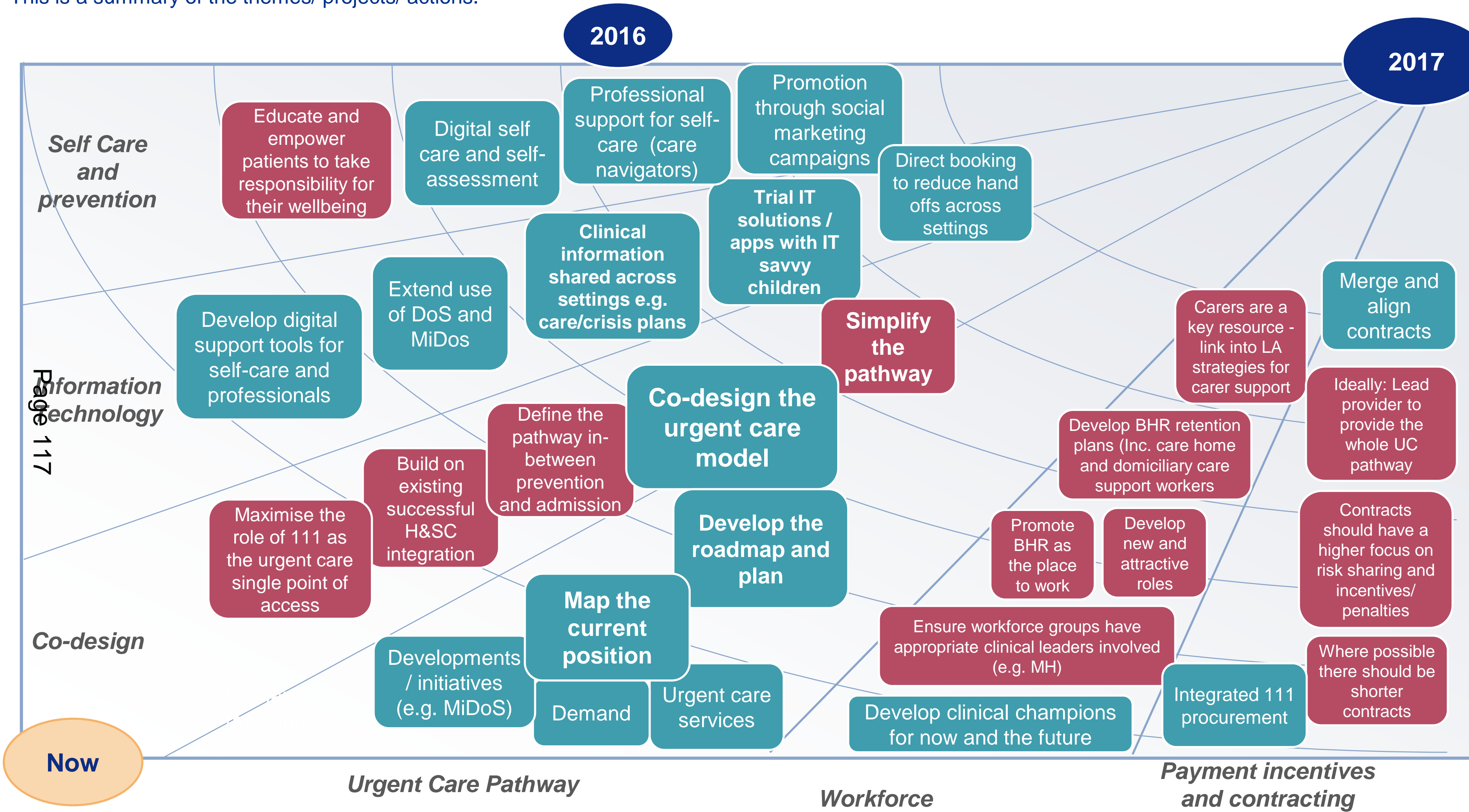
OLDER PEOPLE



- Collaborative working
- Define pathway inbetween prevention and admission
- Key to Involve nursing homes and ambulance services
- Consider prime provider model

Roadmap

Based on output of the breakout sessions, pitches and posters, completed with overall views of participants during the conference
This is a summary of the themes/ projects/ actions.



Key: Action Workshop statement

In 2020, Urgent Care is…

Final thoughts and next steps…

How confident are you that we can deliver the vision?

This poster indicates confidence levels at the end of the BHR urgent care conference

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Next steps after the conference

- **Develop the Urgent Care strategy**
- **CCG Governing Body paper to September's meeting**
- **Map the current position**
- **Develop the Urgent Care delivery plan**
- **Consider submitting an urgent and emergency vanguard application based on the conference outputs.**

BHR was successful with bid to become an Urgent and Emergency Care Vanguard!!! One of only eight in the country and the only Vanguard in London!

Urgent Care is…

Now

Urgent Care will be…

2020

HEALTH AND WELLBEING BOARD

8 SEPTEMBER 2015

Title:	Review of the Joint Assessment and Discharge Service
Report of the Corporate Director of Adult and Community Services	
Open Report	For Decision
Wards Affected: All	Key Decision: No
Report Author: Bruce Morris Divisional Director, Adult Social Care	Contact Details: Tel: 020 8227 2749 E-mail: bruce.morris@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director, Adult and Community Services	

Summary:

The Board has received previous reports regarding the establishment and progress of the Joint Assessment and Discharge Service (JAD), intended to provide an integrated approach to supporting the discharge of patients from BHRUT**.**

The contributing partners are, BHRUT, NELFT, London Boroughs of Barking and Dagenham and Havering, and the three CCGs covering the local health and social care economy. The JAD does not currently include the London Borough of Redbridge**.** The London Borough of Barking and Dagenham was the initial host for the service and has led the implementation programme.

The service has been operational since June 2014. A Section 75 agreement formalising partnership arrangements between the contributing partners was agreed by the Health and Wellbeing Board in February 2015.

Over recent months a review has been undertaken, led by LBBD, to consider the effectiveness of the arrangements during the winter period, the capacity required by the service, and to determine the longer term hosting arrangements. Partner organisations agree that:

- The JAD is achieving its aims and are committed to it continuing as a model.
- The JAD continues in the format and capacity that was originally envisaged
- The longer-term hosting arrangements transfer to London Borough of Havering.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) agree the transfer of hosting arrangements to London Borough of Havering and delegate authority to the Corporate Director of Adult and Community Services to finalise the transfer, including the staffing arrangements detailed elsewhere in this report;

(ii) delegate authority to the Corporate Director of Adult and Community Services to sign a deed of variation to the Section 75 arrangement to formalise this transfer;

Reason(s)

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

1. Background to the Service

1.1 The Joint Assessment and Discharge Service (JAD) Service went live on 9 June 2014 and consists of 50 FTE health and social care staff.

1.2 The contributing partners to the service are, BHRUT, NELFT, London Boroughs of Barking and Dagenham and Havering, and the three CCGs covering the local health and social care economy. The JAD does not currently include the London Borough of Redbridge**.** The London Borough of Barking and Dagenham is the current host for the service and has led the implementation programme.

1.3 The service is arranged into Ward Groups covering Queen’s and King George Hospital. The JAD is the single point of contact for all referrals of people who may require health and/or social care support on discharge with a named worker allocated to each ward. In addition the service covers the intermediate care beds and provides a service for patients placed in hospitals out of the area.

1.4 The service has formed a key element of the Operational Resilience plans across health and social care, supporting both improved flow through the hospital and providing a service in Accident and Emergency departments to support both admission avoidance and diversion to other more appropriate services. This has involved Social Work support working across the 7 days and at peak periods of demand.

Governance

1.5 A Section 75 agreement formalising partnership arrangements between the contributing partners was agreed by the Health and Wellbeing Board in February 2015. At the same time, the relevant Clinical Commissioning Group Governing Bodies and London Borough of Havering progressed the Section 75 through their own formal processes and agreed the arrangement.

1.6 Whilst the development and implementation of the JAD has been overseen by the Integrated Care Coalition and the Urgent Care Board, regular Executive Steering Group meetings have been held. The Steering Group has representation from each participating organisation and has been chaired by LBBD as the host organisation for the JAD. The Steering Group has played a crucial role in reviewing progress against the milestones that were established within the individual work streams of the original project plan, providing oversight of performance and acting as a point of resolution for key issues. This group was formally mandated by the Section 75 arrangement as the executive function in governing the service.

2. Review of the service

2.1 London Borough of Barking and Dagenham signalled its intention to begin a review of the operation of the JAD in Spring 2015.

2.2 The review took place between March and June and covered the following elements:

1. **The functions of the JAD -** Additional time-limited funding had been allocated to the service within three months of the service going live in June 2014. This provided additional capacity to the JAD to take on more functions outside the original scope of the service as part of the Operational Resilience programme. Although the additional funding came to an end on 31 March 2015, there were continued expectations that the service would continue to operate at this enhanced level.

   Partners were asked to consider whether they wished for the service to continue to provide these additional functions or whether the service returned to "business as usual". Given the service had been operating at enhanced capacity since implementation, the notion of "business as usual" was difficult to define in terms of baseline activity. If this was to be the case, partners were asked to consider how an enhanced service model would be funded.

2. **Longer-term hosting arrangements** – Since the outset of the JAD, partners agreed that consideration would need to be given to the longer-term hosting arrangements for the service once it had been established. Whilst there had been a consensus that LBBD would initially act as host because the Borough had led on planning, developing the model, and securing agreement to proceed, it was recognised that this would not necessarily be the best longer term arrangement.

   Partners were asked to review the proposal that hosting arrangements would transfer to London Borough of Havering. This was proposed for two reasons: Firstly, Queen's Hospital (the largest element of the JAD service) is located in Havering and secondly, work with Havering residents has so far accounted for more than 60% of JAD activity. It was noted that any changes to hosting arrangements would need to be in place before the next 'winter pressures' period to avoid any distractions for the staff as they dealt with anticipated increased service demands.

2.3 Alongside these two elements, individual contributing partners were also asked to provide feedback on the progress and operation of the JAD. A workshop was held on 3 June at Queen's Hospital to give partners an opportunity to reflect together on the JAD in light of performance information provided by GE Health (who supported the health and social care organisations during the winter period) and, importantly, to hear the service perspective to ensure this was fed into the process.

3. Review Outcomes

3.1 The review of the JAD resulted in the following outcomes:

3.2 **There was a broad consensus that the JAD was achieving its aims and all partners were committed to it continuing as a model.** It was acknowledged that the benefits have been felt by some agencies more than others, with the acute Trust having found the service to have the greatest beneficial impact compared to previous arrangements. The intention of the JAD model was to provide a concrete way for BHR partners to come together to support a challenged acute Trust, and to this end it appears to have been successful.

However, it is clear that the service requires senior level commitment and ownership from **all** partners if it is to continue to deliver, and is wholly dependent on this continuing.

3.3 **It was agreed that the service should run as it was originally envisaged.** Local authorities have no additional funding available for additional staffing and NHS organisations would need to see any permanent changes as part of wider contract negotiations. It was agreed that if an enhanced service was required in the future, for example to deal with "pressures", then this would be provided through time-limited additional funding, using the funded establishment as the foundation.

3.4 **There were no objections to a transfer of hosting to London Borough of Havering**, provided this could be accomplished without any service disruption.

3.5 **There was a continued aspiration from the contributing Clinical Commissioning Groups for better "metrics" to quantify the benefits or otherwise of the service**. It is clear that the data which would be required is held in NHS (primarily BHRUT) systems, and while the service is hosted by a local authority there is no capacity to produce the reports requested even if the data were freely available.

4. Recommendations

4.1 The Health and Wellbeing Board is recommended to agree the following recommendations as a result of the review of the JAD service:

- To agree the transfer of hosting arrangements to London Borough of Havering and delegate authority to the Corporate Director of Adult and Community Services to finalise the transfer, including staffing arrangements detailed elsewhere in the report;
- To delegate authority to the Corporate Director of Adult and Community Services to sign a deed of variation to the Section 75 arrangement to formalise this transfer;

5. Next steps

5.1 On agreement of the recommendations above, the following steps will be taken:

Staffing

5.2 LBBD and LBH will work closely together to oversee consistent processes and a smooth transfer of hosting arrangements.

5.3 Staff in the JAD are currently employed by either NELFT, BHRUT, LBH or LBBD, according to the original funding envelopes partners committed. Apart from LBBD staff, they are formally “seconded” for line management purposes to LBBD.

5.4 Under the new arrangements, staff will be seconded for line management purposes to Havering. Each of the organisations is consulting their own employees regarding the change in secondment arrangements and a meeting has been held with all staff affected and letters have been sent confirming the proposals.

5.5 In addition, in order to consolidate the new arrangements it has been agreed to transfer the post of service manager to L.B. Havering. This will ensure clear lines of accountability for the performance and management of the service, and align employment and supervisory roles for this key post in the delivery of the service. There are no material changes to terms and conditions for the postholder and they are fully in agreement with the proposed transfer.

Authorisation

5.6 All of the contributing organisations to the JAD have specific governance arrangements in which the transfer of the hosting arrangements will need to be discussed and agreed. Each of the partner organisations are taking responsibility for managing their own governance arrangements to ensure that any changes have the necessary formal authorisation.

Variation to the Section 75 arrangement

5.7 The original Section 75 agreement was drafted to allow for the transfer of hosting arrangements in the future. Legal Services have advised that the Section 75 arrangement, previously agreed by the Health and Wellbeing Board in February, can be amended simply by a signed Deed of Variation. Havering will lead on the drafting of this deed and partner organisations will take responsibility for ensuring this is signed off through their governance arrangements.

Development of the dataset

5.8 As stated above, there is considerable appetite from NHS partners that revised metrics are agreed for the JAD. A new dataset is currently in development and is being discussed by all partners.

6. Implications

6.1 Health and Wellbeing Strategy

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

The Service is supported by a range of performance outcomes which both align to existing measures – this will be enhanced further by the new dataset.

6.2 Joint Strategic Needs Assessment

At this time there is the necessity, the motivation and momentum to transform the entire organisation and delivery of health and care services. The Joint Assessment

and Discharge service is part of the transformation agenda providing a single point of access. Its creation was supported by the JSNA. The JSNA recommends that this need encompasses primary, community, hospital and social care services and is driven by the need to ensure that meeting the needs of the population goes hand in hand with services that are of high quality, sustainable and affordable.

6.3 **Integration**

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

6.4 **Financial Implications**

Implications completed by: Carl Tomlinson, Group Finance Manager, LBBD

The report recommends the transfer of hosting arrangements to the London Borough of Havering via a deed of variation to the Section 75 arrangement. Havering will lead on the drafting of this deed and partner organisations will take responsibility for ensuring this is signed off through their governance arrangements. Therefore there is no additional cost to the Council. Secondment arrangements will be met within existing budgets and staffing costs will remain as currently budgeted.

6.5 **Legal Implications**

Implications completed by: Angela Willis, Major Projects Solicitor, LBBD

Under Section 75 of the National Health Services Act 2006 (as amended), the Secretary of State can make provision for local authorities and National Health Service bodies to enter into partnership arrangements in relation to certain functions, where these arrangements are likely to lead to an improvement in the way in which those functions are exercised. The specific provision for these arrangements is set out in the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000.

The partners to the Joint Assessment and Discharge Service entered into a Section 75 agreement in June 2015, which formalised arrangements for managing the service from its inception in June 2014.

The agreement provided that future variations, including changes to hosting arrangements, would only be effective if agreed by all the partners acting through the Executive Steering Group. Such variations should be evidenced by a document confirming the details of the variation, and signed on behalf of each partner by its senior representative on the Executive Steering Group.

Legal Services are available to advise and assist with review of the documentation as required.

6.6 **Staffing issues**

Implications completed by: Tony Fisher, HR Business Partner, Adult and Community Services

There are only two relatively minor staffing issues involved in this transfer. The first affects the Service Manager, which is a role identified directly to this joint service. This post and employee will be subject to a TUPE type transfer to LB of Havering. The member of staff has been consulted and is in agreement with this transfer. The other is LBBD staff who will now be seconded to LB Havering for operational management as set out in the main body of this report.

6.7 **Risk Management**

The S.75 provides for the management of risk between the partners to the JAD and includes provisions in the event of exit from the service by the partners. This will continue once the deed of variation is signed.

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HEALTH AND WELLBEING BOARD

8 September 2015

Title: Contract - Waiver for Integrated Sexual Health and Chlamydia Screening Coordination Services	
Report of the Cabinet Member for Adult Social Care and Health	
Open Report	**For Decision**
Wards Affected: All	**Key Decision:** Yes
Report Author: Matthew Cole Director of Public Health	**Contact Details:** Tel: 020 8227 3657 E-mail: matthew.cole@lbbd.gov.uk
Accountable Divisional Director: Matthew Cole, Director of Public Health	
Accountable Director: Anne Bristow, Corporate Director for Adult & Community Services	

Summary:

Local Authorities are mandated to commission comprehensive open-access, accessible and confidential contraceptive and sexually transmitted infections (STIs) testing & treatment services for all age groups. In Barking and Dagenham, the Integrated Sexual Health and Chlamydia Screening Coordination Services are currently provided by Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT) and the Terrence Higgins Trust (THT) respectively. The Council approved the issue of interim contracts for these services in February 2014 for a period of 18 months. Both contracts are due to expire on 30th September 2015.

London Borough of Barking and Dagenham (LBBD) in partnership with the London Borough of Havering (LBH) and London Borough of Redbridge (LBR) undertook a Tri-Borough procurement of the services in January 2014 using the EU Restricted Procedure. Havering led on the Procurement with Barking & Dagenham and Redbridge as associates. This process was abandoned, as the two bids received were substantially beyond the respective budgets of the three Councils.

The 3 boroughs then proceeded to embark on a new tender process using the Negotiated Procedure (without prior publication of a contract notice) in accordance with the EU Regulations, to obtain fresh tenders in early 2015 from those who originally submitted bids. The new negotiation was commenced upon with the intention to award a contract in October 2015. Only one bid was received and that was from the incumbent provider BHRUT, while the other bidder failed to submit a bid on the basis that they were unable to deliver the service within the allocated budget.

The new negotiation procedure also had to be discontinued due to both parties not reaching an agreement on financial grounds. The bidder BHRUT proposed a service cost of £4,393,095 (LBBD £1,422,790, LBH £1,480,888 and LBR £1,489,417) for the provision of the integrated sexual health service. However, one of the boroughs could not

proceed with the process due to financial constraints. The three boroughs then agreed to negotiate individually a new contract with the current providers and issue separate borough-based contracts for the provision of the services.

The initial plan was to include the Chlamydia Screening Coordination Service in the negotiations with BHRUT; however, they have said that they do not want to provide the service. The service will now be included as part of the primary care (GP and community pharmacists) public health services procurement.

Recommendations

The Health and Wellbeing Board is recommended to:

(i) Waive the requirement to tender in accordance with the Council's Contract Rules; and

(ii) Delegate authority to the Corporate Director for Adult and Community Services, in consultation with the Director of Public Health, Chief Finance Officer and the Head of Legal and Democratic Services for the:

- Direct award of a 1 year contract from 1st October 2015 to 30th September 2016 with the option to extend for a further 2 year period on an annual basis to Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT) for the provision of an Integrated Sexual Health Service

- Six (6) months contract extension to Terrence Higgins Trust to cover the notice period for the provision of the Chlamydia Screening Coordination Service in accordance with the strategy set out in this report.

Reason(s)

Integrated Sexual Health Service :

The Council needs to fulfil its legal obligation, as the current contract due to expire on 30th September 2015 cannot cease without alternative arrangements in place for continued service provision. Given the procurement timeline, it is not possible in the limited time available to complete a new tender process to award a new contract.

Chlamydia Screening Coordination Service:

This is not a mandated service; therefore decisions are to be made on service continuation due to uncertainty with Public Health Grant and the need for efficiency savings. Extension period will be used to cover the notice period, develop primary care (GP & Pharmacists) role in the provision of the service and transfer fundamental functions as part of the procurement of primary care public health services.

The ground upon which a waiver is being sought is Contract Rules 6.6.8, which states "there are other circumstances which are genuinely exceptiona"l

1. Introduction and Background

1.1. The delivery of open access sexual health services is a mandated public health responsibility for the Council under the Health and Social Care Act 2012. Local authorities have a legal duty to commission HIV prevention, sexual health promotion, open access services for sexually transmitted infection, and contraception for all age groups.

1.2. These include free testing and treatment for sexually transmitted infections, notification of sexual partners of infected persons, free provision of contraception as well as the provision of information, advice and support on a range of issues, such as sexually transmitted infections (STIs), contraception, relationships and unplanned pregnancy.

1.3. The Integrated Sexual Health and Chlamydia Screening Coordination service contracts currently provided by BHRUT and THT respectively will expire on 30th September 2015.

1.4. The Council approved the issue of interim contracts for a further period of 18 months, ending 30 September 2015 on the basis that a procurement process would be undertaken, completed and a new contract for the services will commence on 1st October 2015.

1.5. In January 2014, a procurement exercise in respect of these services was undertaken in partnership with the London Boroughs of Havering and Redbridge with Havering leading on the procurement. The intention was to competitively tender under a Restrictive Procedure the Integrated Sexual Health and Chlamydia Screening Coordination Services as one contract for a period of five years with the option to extend for two years.

1.6. The intention was to award the new contract in April 2015 with a six month mobilisation period for a new integrated service starting on 1st October 2015. However, the Restricted Procedure had to be stopped because the two bids received exceeded the available funds by a considerable margin. The Restricted Procedure which was used does not provide any scope for negotiation.

1.7. After consultations with Procurement and Legal teams, the three boroughs then decided to enter into a new tender process, using the Negotiated Procedure (without prior publication of a contract notice) in accordance with the EU Regulations to obtain fresh tenders in early 2015 from the two original bidders.

1.8. In February 2015, new Invitation to Tender (ITT) documents were issued to the bidders for fresh bid submissions. By the due date of 19th March 2015, only two bids were received; one from the current provider and the other from another provider. The second bidder later withdrew from the process, stating its inability to deliver the service required within the financial envelope available without undue risks.

1.9. Following this, the three boroughs then entered into further negotiations with the current provider BHRUT. The first negotiation meeting was held on the 19th May 2015 with further meetings planned to continue up to 30th July 2015. However the new procurement process also had to be discontinued due to both parties not reaching an agreement on financial grounds.

1.10. The bidder BHRUT proposed a service cost of £4,393,095 (LBBD £1,422,790, LBH £1,480,888 and LBR £1,489,417) for the provision of the integrated sexual health service. However, one of the boroughs could not proceed with the process due to financial constraints. The three boroughs then agreed to negotiate individually a new contract with the current providers and issue separate borough-based contracts for the provision of the services.

1.11. The initial plan was to include the Chlamydia Screening Coordination Service in the negotiations with BHRUT; however, they have said that they do not want to provide the service. This will now be included as part of the primary care (GP and community pharmacists) public health services procurement.

2. Proposed Procurement Strategy

2.1 Outline specification of the works, goods or services being procured.

A direct award of a 1 year contract from 1st October 2015 to 30th September 2016 with the option to extend for a further 2 year period on annual basis for the Integrated Sexual Health Service to Barking Havering and Redbridge University NHS Trust (BHRUT) for the provision of the following:

- Contraception and abortion services
- Screening - HIV, Chlamydia (young people and high risk groups) and STIs
- Treatment interventions and service delivery for STIs and HIV
- Health promotion and disease prevention
- HIV prevention interventions

A six (6) months contract extension from 1st October 2015 to 31st March 2016 for the Chlamydia Screening Coordination Service to Terrence Higgins Trust for the provision of the following:

- Information on and access to sexual health services
- Outreach provision for Chlamydia screening
- Working with local pharmacies and GPs on Chlamydia Screening Coordination Services
- Performance management of primary care (GP practices & community pharmacies)

2.2 Estimated Contract Value, including the value of any uplift or extension period.

These services will be funded from the Public Health Grant:

Allocated budget for the Integrated Sexual Health Service for 2015/16 is £1,400,000. Therefore, the estimated contract value is **£4,200,000** for 3 years (1+1+1)

Allocated budget for the Chlamydia Screening Coordination Service Contract for 2015/16 is £232,000. Therefore, the estimated contract value is **£ 116,000**for 6 months

2.3 Duration of the contract, including any options for extension.

Three (3) years for the Integrated Sexual Health Service

Six (6) months for the Chlamydia Screening Coordination Service

2.4 Recommended procurement procedure and reasons for the recommendation.

The recommended procurement procedure routes for these services at this time are:

1. A direct award of a 1 year contract from 1st October 2015 to 30th September 2016 with the option to extend for a further 2 year period on an annual basis to Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT) for the provision of Integrated Sexual Health Service.
    - The contract will be commissioned as 'light touch' under the new Public Contract Regulations 2015, which came into force on 26th February 2015 without undertaking a competitive procurement process.
    - The Council will negotiate and issue a new borough based contract for the provision of service with break and variation clauses in the case of any changes in the market

2. Six (6) months contract extension to Terrence Higgins Trust for the provision of the Chlamydia Screening Coordination Service.
    - This is not a mandated service; therefore decision would be made on service continuation due to uncertainty with the Public Health Grant and the need for efficiency savings.
    - Extension period will be used to cover notice period, develop primary care (GP & Pharmacists) role in the provision of the service and transfer fundamental functions as part of the procurement of primary care public health services

Both contracts will be tightened with specific service requirements, and expected outcomes. Key performance indicators will be outlined in the service specification and agreed with the providers. Performance management of both services will be undertaken by the public health commissioners.

Reasons:

Integrated Sexual Health Service:

- Given the procurement timeline, it is not possible in the limited time available to complete a tender process and award a new contract.

- The Council needs to fulfil its legal obligation, as the current contracts due to expire on 30th September 2015 cannot cease without alternative arrangements in place for continued service provision.

- The proposed service cost of £1,422,790 by BHRUT is within the Council's (Public health) allocated budget for the service.

- There is currently a limited provider market for the service and this need to be developed before the Council can embark on another procurement process.

- Opportunity for the Council to negotiate an individual contract and work in collaboration with the current providers to identify and define the service best suited to satisfy the Council's requirements and local population needs.

- Allow time for the findings of the updated work on the London-wide integrated sexual health tariff which is due to be completed at the start of 2016/17, to be used in setting the tariff for the service. It is envisaged that the new tariff system, will help generate savings by providing additional tools for commissioners to implement changes, help encourage innovation in service provision, and implement a model that will be able to better meet high and increasing levels of sexual health needs and service use in a more cost-effective way.

Chlamydia Screening Coordination Service:

- This is not a mandated service; therefore decision is to be made on service continuation due to uncertainty with the Public Health Grant and the need for efficiency savings

- Extension period will be used to cover contract notice period, develop primary care (GP & Pharmacists) role in the provision of the service and transfer fundamental functions as part of the procurement of primary care public health services

The ground upon which a waiver is being sought is Contract Rules 6.6.8, which states "there are other circumstances which are genuinely exceptional

2.5 The contract delivery methodology and documentation to be adopted.

The standard Public Health Services Contract 2015 is the form of contract to be used for both contracts. The contract will have a break clause allowing notice to be given by either party for termination. This allows increased flexibility should a significant change in service provision be required.

2.6 Outcomes, savings and efficiencies expected as a consequence of awarding the proposed contract.

The outcome is to improve the sexual health of the population across the borough by building an effective, responsive and high quality sexual health service, which effectively meets the needs of our local community and offers a range of high quality, needs-led services which will target those most vulnerable in our boroughs.

There is an opportunity to negotiate a new tariff-based pricing model with the chosen provider over the life of the contract. Although the tariff model is

expected to deliver some cost efficiencies, the very nature of this on-demand service may impact on the ability to achieve these savings.

2.7 Criteria against which the tenderers are to be selected and contract is to be awarded

Not applicable

2.8 How the procurement will address and implement the Council's Social Value policies.

The Council's social value responsibilities are taken through its vision: One borough; One community; London's growth opportunity.

Through the award of the contracts to the providers, the Council will ensure service continuity that meet the needs of the local population, including provision of information, advice and support on a range of issues, such as sexually transmitted infections (STIs) testing and treatment, Chlamydia screening, HIV Testing, contraception, relationships and unplanned pregnancy.

In terms of the service contract, we will work with the provider to seek to identify local opportunities for apprenticeships, training and recruitment for residents.

3. Options Appraisal

3.1 Do Nothing

This option is not viable because the Council is mandated to provide open-access, accessible and confidential contraceptive and sexually transmitted infections (STIs) testing & treatment services for all age groups in the borough.

Extend the contracts for a short period and undertake a competitive process.

This option has already been tested and was unsuccessful. Given the timeline, it is not possible in the limited time available to complete a tender process and award a new contract with a six months mobilisation period. Market for this service need to be developed before the Council can embark on another procurement process.

Direct Contract Award for 1 year with the option to extend for a further 2 year period on an annual basis (preferred option)

The options of a direct contract award of the integrated sexual health service to the current provider BHRUT for a 1 year period with the option to extend for a further 2 year period on an annual basis as 'light touch' under the new Public Contract Regulations 2015.

Advantage:

1. Opportunity for the council to negotiate an individual contract and work in collaboration with the current providers to identify and define the service best suited to satisfy the Council's needs.

2. The Council is able to fulfil its legal obligation to its residents by having an open access sexual health service.
3. Residents will have no need to go elsewhere for treatment which will lower the council none contracted spend.
4. Opportunity to develop the market for the service

Disadvantage:

Risk of a challenge as the council has not gone through a competitive process – mitigation; Evidence that competitive processes already undertaken and unsuccessful, underdeveloped market, plan to go out to tender before the end of the new contract. Procure contract in line with Council's contract rules. Liaise with legal departments at all stages and ensure documentation is kept.

4. Waiver

Approval is sought to waive Contract Rule 28.8 in terms of conducting a formal procurement process. The justification for the waiver is to be judged under the following relevant points of the Contract Rules:

Para. 6.6.2 *That there is clear evidence the goods, services or works to be procured are of a specialist technical, artistic or proprietary nature, or*

Para 6.6.3 *That there is only one supplier in the market capable of providing the service, goods or works(e.g. a specific artist with intellectual property rights in a work of art) such that there is no benefit to be gained from competition.*

5 Equalities and other Customer Impact

The local authority will be providing an open access, universally provided Integrated Sexual Health Service that will meet the need of the whole population. The service allows for targeted provision for those parts of the population that have greater sexual health needs, these will include but not limited to; men who have sex with men. Young people, black African community, transgender communities

6. Other Considerations and Implications

Risk	Likelihood	Impact	Risk Category	Mitigation
No contract in place from 1st October leading to a negative impact on the sexual health of the local population and Council's reputation damaged	Medium	Very high	High	Early negotiations have started with the current providers to ensure continuous service provision with new contract in place by 1st October 2015.
Market still under-developed at the end of the contract	Low	Medium	Low	Market warming activities to be held. Alternative providers outside of NHS will be identified and approached about interest in providing the services.
Contract award decision challenged by another provider	Low	Low	Low	Evidence that competitive processes already undertaken and unsuccessful, underdeveloped market, plan to go out to tender before the end of the new contract. Procure contract in line with Council's contract rules. Liaise with legal departments at all stages and ensure documentation is kept.
Increased cost of service, will have a negative impact upon the ability to deliver other areas of work	Medium	Medium	Medium	Essential that cost of the service is contained within the budgetary envelope. Use findings of the updated work on the London-wide integrated sexual health tariff which is due to be completed at the start of 2016/17, to be used in setting the tariff for the service
Provider failing to meet contractual obligations	Low	High	Medium	Robust and regular performance monitoring procedures, performance indicators and consequences of failure to meet them set out in service specification

Council may have to meet redundancy costs on the termination of the Terrence Higgins Trust (THT) Agreement for Chlamydia Screening	Medium	Medium	Medium	Further financial and legal advice to be obtained once the extended agreement with Terrence Higgins Trust is located

6.2 **TUPE, other staffing and trade union implications.**

Council may have to meet redundancy costs on the termination of the Terrence Higgins Trust (THT) Agreement for Chlamydia Screening. Further financial and legal advice to be obtained once the extended agreement with Terrence Higgins Trust is located

6.3 **Safeguarding Children**

The provider has in place the necessary safeguarding protocols, in line with Council Policy and applies the Frazier Guidelines and Gillick Competency where a young person is under 16

6.4 **Health Issues**

The proposal is in line with the outcomes and priorities of the joint Health and Wellbeing Strategy. The direct awards of an interim contract should further enhance the quality and access of services as well as user and patient experiences. The proposal will have a positive effect on our local community

6.5 **Crime and Disorder Issues**

Not Applicable

6.6 **Property / Asset Issues**

Not Applicable

7. Consultation

In line with Council procedure the following have been consulted with:

- Statutory Proper Officer – Director of Public Health
- Corporate Director for Adult and Community Services
- Group Manager Finance Adults and Community Services
- Legal Services
- Councillor Maureen Worby- Portfolio holder for Adult Social Care and Health
- Procurement Board

8. Corporate Procurement

Implications completed by: Euan Beales, Head of Procurement and Accounts Payable

8.1 The Councils Contract Rules states that for all procurements with a contract value which exceeds £50,000, then there will be a requirement to conduct a formal tender, however the Contract rules allows for this requirement to be waived as long as there is valid justification.

8.2 The spend value exceeds the Light Touch threshold in line with the Public Contract Regulations 2015 and as such a direct award is being sought on the grounds that the market cannot support formal competition, it should be noted that a direct award

can be challenged, but can be supported through the interest in the previous failed tri borough process.

8.3 The proposed contract term of 1+1+1 will give the Council suitable time to warm the market to a point where a competitive environment can be utilised.

8.4 At the time of this report there were no alternative options available to the Council , and I support the recommendations made in this paper.

9. Financial Implications

Implications completed by: Carl Tomlinson, Group Manager - Finance

9.1 The estimated contract value for an integrated sexual health service is £1,422,790 based on the previous contract estimate provided by BHRUT, against a 2015/16 budget of £1,400,000.

9.2 As the integrated sexual health service is mandatory, Public Health will be required to assign a further £23,000 to this budget from within the £2,640,000 allocated for sexual health overall or reduce the scope of the contract to adhere to the £1,400,000 allocated budget.

9.3 The budget for Chlamydia screening in 2015/16 is £232,000 and it is proposed to extend the contract with Terrence Higgins trust for 6 months (£116,000), until a decision is made on whether the Council will continue to provide a Chlamydia Screening Coordination Service as it is the only non-mandatory part of the sexual health service.

9.4 The option to award the contract directly to BHRUT is the most financially appealing as an open tender has failed twice before as there is no supply market for this service at a price that is affordable to the Council.

10. Legal Implications

Implications completed by: Assaf Chaudry, Major Projects Solicitor, Legal and Democratic Services

10.1 This report is seeking that the Health and Wellbeing Board (HWB) waives the requirement, under the Council's Contract Rules, to tender contracts noted in this report.

10.2 By way of background a 3 Borough procurement process was commenced to procure health care services under a Restrictive Procedure in accordance the Public Contract Regulations 2006 now 2015 (PCR 2015). The Restrictive Procedure was abandoned and a new tender process namely a Negotiated Process without notice was commenced. This new process commenced by the tri-Boroughs has had to be discontinued due to the failure of receiving a bid which met the evaluation criteria as being the Most Economically Advantageous Tender.

10.4 The proposal therefore in this report is to award a contract for continued provision of Integrated sexual health services and Chlamydia Screening Coordination Services to the current contractor Barking Havering and Redbridge University Trust (BHRUT)

from 1st October 2015 for a period of 1 year with the option to extend for a further 2 year period on an annual basis and (6) six month contract to Terrence Higgins Trust. The value for these two contracts is in the region of £1,422,790. The Council's Contract Rules require contracts with a value of £50,000 or more to be advertised and opened to tender.

10.5 However the Contract Rules also provide for Cabinet/HWB or Chief Officers (as may be appropriate) to waive the requirement to tender or obtain quotes for contracts on any one of several grounds set out in Contract Rule 6.6.8, including the ground that there are "genuinely exceptional circumstances" why a competitive procurement exercise should not be conducted. Each ground is however subject to the proviso that the appropriate decision-maker considers that no satisfactory alternative is available and it is in the Council's overall interests.

10.6 Contract Rule 6.3 provides that in instances where the value of a contract is over £500,000 a waiver of the Council's tender requirements must be obtained from Cabinet/HWB.

10.7 In considering whether to agree the recommendations set out above in this report, the Health and Wellbeing Board needs to satisfy itself that the reasons provided and grounds stated by officers are satisfactory and that no satisfactory alternative is available and it is in the Council's overall interests to grant the waiver.

10.8 However, It has to be noted that this direct award to the present provider given its value is also subject to the EU procurement rules and although HWB/Cabinet may be satisfied that sufficient grounds exist to grant the waiver this does not preclude the prospect that this direct award may be challenged by other unsuccessful providers since the Council has not awarded the contract under a competitive tendering process. The Council therefore needs to consider steps to mitigate such a risk and in this regard consideration needs to be given to reducing the period of award to BHRUT. In addition the Council needs to formulate and implement a future procurement strategy for integrated sexual health services.

10.9 Finally, consideration needs to be given to the potential risk that the Council may have to meet redundancy costs on the termination of the Terrence Higgins Trust Agreement. Further financial and legal advice should be obtained once the extended agreement with Terrence Higgins Trust is located.

Background Papers Used in the Preparation of the Report:

None

List of appendices:

None

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HEALTH AND WELLBEING BOARD

08 SEPTEMBER 2015

Title:	**The Care Act 2014: Cap on care costs deferred until 2020**
Report of the Corporate Director of Adult and Community Services	
Open Report	**For information**
Wards Affected: NONE	**Key Decision: NO**
Report Author: Glen Oldfield, Care Act Project Officer	**Contact Details:** Tel: 020 8227 5796 E-mail: glen.oldfield@lbbd.gov.uk
Sponsors: Anne Bristow, Strategic Director of Service Development and Integration	
Summary: On 17 July the Government responded to a letter from the Local Government Association (LGA) calling for a delay in the implementation of the cap on care costs system. The changes were due to come into force in April next year (2016), but in the light of concerns expressed by the LGA and many other stakeholders about the timetable for implementation and pressures on adult social care, the Government has decided to delay implementation of the cap on care costs system until 2020. This report sets out the detail of the announcement, the reasons for delaying phase two of the Care Act, and what this means for the local implementation programme.	
Recommendation(s) The Health and Wellbeing Board is recommended to: (i) Note the delay to implementation of phase two of the Care Act (ii) Note the implications for the local Care Act implementation programme	

1. Introduction

1.1. On 17 July 2015, in response to concerns raised by the Local Government Association (LGA), the Department of Health announced that implementation of phase two of the Care Act is delayed.

1.2. In his letter, Alistair Burt MP, Minister of State for Community and Social Care, confirmed that the cap on care costs will be deferred until April 2020 and the appeals system will be considered as part of the Government's spending review in Autumn 2015.

2. Confirmation of parts of the Care Act that are deferred

2.1. Since announcing the deferment further information has been released. It has been confirmed that all elements of phase 2 implementation have been deferred until 2020. This includes:

- the cap on care costs, including the proposed nil-cap for under 25s
- care accounts to manage progress towards the cap
- the principle of people paying their daily living costs (£230 per week)
- first party top-ups
- extension to the means test thresholds

3. Status of appeals

3.1. The Government will make a further announcement on the new appeals system following the Spending Review in the Autumn. The Chancellor has set out the timetable for the Spending Review which will be published on 25 November. The timetable for appeals implementation will be confirmed after this date. In the meantime, those using care and support will continue to be able to make use of the existing complaints system and ultimately, the Local Government Ombudsman.

3.2. Planned work to implement appeals is therefore held pending further announcements from Government.

4. Reasons for the delay

4.1. The deferment of phase two implementation is due to the combination of several factors:

– **Funding pressures on local authorities and adult social care budgets**

The focus of the LGA concerns was the crisis of adult social care funding. Local authority budgets have been shrinking year-on-year in response to government austerity measures. The pressure on budgets is exacerbated by rising demand for services and new duties being placed on local authorities. It is expected that notionally the social care funding gap will be at least £4.3bn by 2020.

These funding issues were reflected in a National Audit Office report which highlighted that both phases of the Care Act were underfunded putting extraordinary pressure on local authorities to meet new duties. For Barking and Dagenham we estimated that the pressures would have been as much as £2.5 million by 2022/23.

– **Readiness of local authorities to implement changes**

While local authorities were confident they could deliver the phase two changes by April 2016 it was recognised that the timescales and work required was very challenging given the new IT solutions that would have been required. The delay means that local authorities can consolidate phase one of the Care Act.

– **New pension rules**

The Government believe that the new pension flexibilities introduced from 1st April 2015 will have consequences on the way people use capital and income. Given that the impact of this is not yet fully understood, the delay gives the Government opportunity to study this.

– **Lack of engagement from the insurance industry**

When the cap on care costs was being planned for it was expected that the private insurance industry would enter the market with products that would help people to pay for the costs of care and reduce the impact of care costs later in life. This did not materialise. The Department of Health is looking to re-engage with the insurance industry before the cap is introduced in 2020.

– **Introduction of national living wage**

The Chancellors announcement that there will be a compulsory national living wage of £7.20 an hour, rising to £9 by 2020 has a huge impact on the cost of delivering care. Cost pressure for necessary care will now rise year-on-year. In Barking and Dagenham early modelling work indicates that this could add £3.3 million to care costs by 2019/20.

5. Impact on the local Care Act implementation programme

5.1. The local Care Act implementation programme was working to deliver the cap on care costs and appeals system so that they would be operational from 01 April 2016. The announcement of the deferment of phase two implementation has changed the deadlines for delivery and means it has been necessary to revise local plans.

5.2. As such we have been advised by the national programme office that the below implementation activities are no longer required:

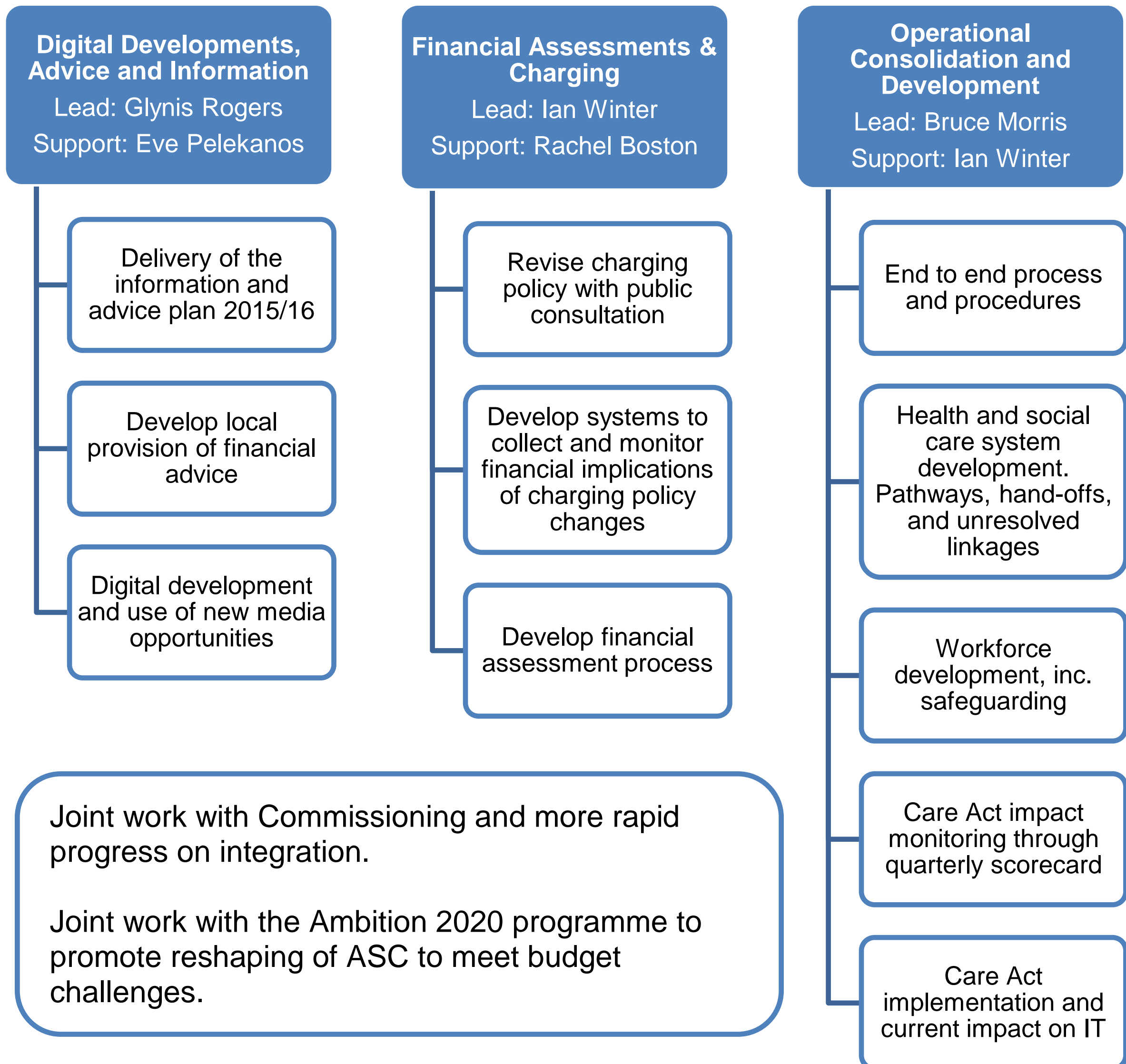
- Communications about the April 2016 changes
- Revised or new information and advice about the funding reforms
- Development and implementation of care accounts and related financial systems/processes
- Changes to the deferred payments policy and agreement
- Early assessment of known self-funders

5.3. A new programme structure and arrangements have been agreed and put into action by the Care Act Programme Board. Implementation activity will now have a greater focus and emphasis on embedding and consolidating the parts of the Care Act that became operational on 01 April 2015, building on the work of the programme in the previous year.

5.4. The revised Care Act implementation programme will give capacity and release resources to support adult social care transformation more generally. Going forward the programme will play a more prominent role in supporting integration between adult social care and health, and help adult social care to find cost savings to help the Council meet the £72 million budget gap which must be bridged by 2020.

5.5. To fulfil this revised remit the programme will work closely with the Ambition 2020 programme and strengthen connections with other corporate programmes (Better Care Fund, Digital by Design, SEND).

5.6. The new programme structure is summarised in the diagram below:



5.7. To ensure corporate strategic alignment and accountability for delivery, the workstreams above will report to a group of senior officers on a monthly basis; the group will be chaired by Anne Bristow in her new role as Strategic Director of Service Development and Integration. The Care Act Programme Team will continue to support and drive forward activity.

6. Mandatory implications

6.1. Joint Strategic Needs Assessment

The deferment of the cap on care costs until 2020 takes away the immediate need to gather intelligence about the borough's population of self-funders in both residential care and community-based settings. Demand for services and cost pressures expected from the introduction of the cap on care costs in terms of additional assessments and maintaining care accounts are relieved for the time being. That said we will need to use the intervening years between now and 2020 to understand the profile and circumstances of self-funders in order to ensure that financial modelling and service planning for future years is based on credible and accurate assumptions.

6.2. Health and Wellbeing Strategy

No implications.

6.3. Integration

Following on from implementation work in 2014/15, the programme will support the local integration agenda through the following pieces of work:

- Support BCF scheme delivery
    - implement the local prevention framework and 'commissioning for prevention' approach (agreed by H&WBB, May 2015)
    - implement Carers Strategy
- Develop a local approach to S117 (mental health aftercare)
- Review adult social care processes and procedures including crossovers with health
- Support Adult Social Care Commissioning to develop its market shaping role
- Work with the local SEND programme to strengthen local transitions processes and procedures

6.4. Financial Implications

(Comments completed by Rachel Boston, Care Bill Finance Specialist)

Barking and Dagenham had predicted that the cost of phase two of the Care Act would be as much as £2.5million by 2022/23. The deferment of implementing the cap on care costs will move these cost pressures to future years. Whilst there is no longer the need to consider the financial pressure the cap on care costs introduces from April 2016 it does not remove the current and future cost pressures expected within adult social care between 2016 and 2020.

The LGA raised concerns that it is expected nationally the social care funding gap will be at least £4.3bn by 2020. Barking and Dagenham are currently assessing the financial impact of the Government's announcement to increase the national living wage from April 2016; providers have started to submit indicative price increases for their care and support services for next year.

The Government provided local authorities with the Care Act Implementation Grant in 2015/16, Barking and Dagenham received a grant of £773k. The grant has been

committed to meet both one-off and ongoing cost incurred through the introduction of phase 1 of the Care Act. Until the Government's spending review in the Autumn 2015, it is unclear if the grant will continue in its current format at the same, be reduced, or redirected within local government funding to support adult social care pressures.

6.5. **Legal implications**

(Comments completed by Chris Pickering, Principal Solicitor)

The Government has said that they are firmly committed to implementing the cap on care costs system so it must be emphasised that this is a deferment and not a cancellation of implementing phase 2 of the Care Act.

Local authorities have been advised that in autumn 2015, as scheduled, the Department of Health will respond to the consultation on draft regulations and guidance to implement the cap on care costs and policy proposals for a new appeals system.

With the response we expect the Care and Support Statutory Guidance to be re-issued with new chapters on the cap on care costs, independent personal budgets and care accounts. There will also be series of consequential amendments to existing chapters of the guidance where there is an impact related to the funding reforms (e.g. financial assessments, charging, personal budgets).[1] The final statutory guidance, once published, will provide a blueprint for implementing the funding reforms for April 2020.

The situation with appeals is more complicated because we know less about the system and how it will operate. Also the consultation on appeals was more open so it is more likely that there will be changes to the policy proposals following the responses of stakeholders. The timetable for implementing the appeals system will be confirmed after the Government's spending review in November 2015.

7. Background Papers Used in Preparation of the Report:

- Cap on care costs delay FAQs for local authorities (LGA, 30 July 2015)
- Letter from Rt Hon Alistair Burt MP to Cllr Izzi Seccombe (Department of Health, 17 July 2015)
- Care and Support Statutory Guidance (Department of Health, October 2014)
- 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 (Department of Health, February 2015)

8. List of appendices

None.

[1] A full outline of the likely consequential amendments to the Care and Support Statutory guidance can be found in Chapter 13 of the consultation document).[1]

HEALTH AND WELLBEING BOARD

8 SEPTEMBER 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 22 July 2015 and 20 August 2015.	
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: 22 July 2015
- Appendix 2: 20 August 2015

System Resilience Group (SRG) Briefing

Meeting dated – 22 July 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 Sarah Tedford (Chief Operating Officer, BHRUT) and attended by members as per the Terms of Reference.

Agenda	Areas/issues discussed
Matters arising	Members received a report on Friday discharge rates which have improved compared to the same period last year.
Performance reporting	Key areas from the dashboard were highlighted and members received a revised version of the dashboard. It was agreed to use the revised version going forward.
Trust Improvement Plan	The Trust Improvement Plan is in the process of being updated following the CQC report.
Plan for 2015/16	It was agreed to produce a summary which lists all the schemes and their impact. Plan to be brought back to the next SRG for approval. The JAD KPI's were agreed and will be included in the dashboard.
Strategic Development	Members noted the BHR Urgent Care conference feedback, the latest position of the Urgent and Emergency Care Vanguard bid and the NEL Urgent and Emergency Care Network.
Planned Care	Members were updated on the RTT and Cancer improvement plans and were advised that the 62 day cancer waits standard has been escalated nationally. In future, the SRG will have a significant role in assuring improvement.
Next meeting:	Thursday 20th August 2015 2.30pm – 4.30pm Committee room 3b, Havering Town Hall RM1 3BD

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System Resilience Group (SRG) Briefing	Meeting dated – 20 August 2015 Venue – Havering Town Hall
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 Officer, BHR CCGs) and attended by members as per the Terms of Reference.

Agenda	Areas/issues discussed
Matters arising	Members received a report on non-elective admissions/attendances. It was agreed a more detailed report be brought back to the next meeting.
Performance reporting	Key areas from the dashboard were highlighted.
Trust Improvement Plan	Members received the final version of the Trust Improvement Plan which has been updated based on the CQC report.
Plan for 2015/16	Plan to be brought back to the next SRG for approval.
Strategic Development	Members noted the latest position of the Urgent and Emergency Care Vanguard bid and the NEL Urgent and Emergency Care Network.
Planned Care	Members were updated on the RTT and Cancer improvement plans.
Next meeting:	Wednesday 23 September 2015 9am – 11am Board room A, Becketts House, Ilford

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HEALTH AND WELLBEING BOARD

8 SEPTEMBER 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. Please note that there is no report for the Learning Disability Partnership Board as they have not held a meeting since the last Health and Wellbeing 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: Integrated Care Sub group
- Appendix 3: Public Health Programmes Board
- Appendix 4: Children and Maternity Sub Group

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Mental Health sub-group

Chair: Gillian Mills, Integrated Care Director (Barking and Dagenham), NELFT

Items to be escalated to the Health & Wellbeing Board

(a) Inconsistent/non-attendance from some sub group members remains an issue which has been raised with the specific sub group members.

(b) The Mental Health work streams for which the sub group has taken a leadership role in taking forward have significantly increased over the last 6-9 months. It has been identified that there is a capacity gap within the sub group to co-ordinate and ensure work streams deliver against plans and timescales. This needs to be considered by the Health and Wellbeing Board to consider how this can be resolved.

Performance

Meeting Attendance

69.5%

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

(a) Developing a Mental Health Strategy – discussion regarding workshops that are to be scheduled over summer period to consider future service delivery models that take account of CCG and LA commissioning frameworks for mental health and the mental health needs assessment findings.

(b) CCG Mental Health commissioning priorities and new national investment available for the crisis care concordat and early intervention in psychosis schemes within Barking and Dagenham

(c) Scoping is currently being undertaken for a CAMHs integrated needs assessment (building on the recently completed mental health needs assessment), led by LBBD public health commissioners. Timeframe for completion of the needs assessment is September 2015 and implementation of recommendations by January 2016.

(d) Barking and Dagenham employability partnership report was considered by the sub group which covers employment, recruitment, apprenticeships and employment benefits, including supporting clients with mental health issues. It is recognised that currently there is no support available for those clients with mental health issues who are not claiming welfare entitlements.

Action and Priorities for the coming period

1. Visit by sub group members to Lambeth to observe how Peer Support operates was postponed by Lambeth and is being rearranged for September 2015.
2. 2 half day sub group development session are being planned for later this year.

Contact:

Julie Allen, PA to Integrated Care Director (NELFT)

Tel: 0300 555 1201 ext 65067; **E-mail:** Julie.allen@nelft.nhs.uk

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APPENDIX XX

Integrated Care Sub Group

Chair: Sharon Morrow, Chief Operating Officer, Barking and Dagenham CCG

Items to be escalated to the Health & Wellbeing Board

- The Health and Wellbeing Board is asked to note progress of the Integrated Care Sub Group

Meeting Attendance

14 July 2015: 65% (11 of 17)

Performance

Reported through performance dashboard. Non-elective admissions is above plan – a deep dive review is being undertaken to inform a review of plans and a wider stakeholder event is planned to engage providers in the findings.

Action(s) since last report to the Board

- The Group received a presentation from Alzheimer's Society and discussed improving links between Alzheimer's Society funded roles, other voluntary services and health and social care services. The BCF Dementia Action Plan will be discussed at the August meeting.
- The Group received a presentation recapping on the 11 BCF schemes, the pooling of money, and the range of performance metrics which are sighted on shifting activity to community services.
- The Group received an update on Mental Health Development project which will pick up the role of the mental health social workers as part of wider system.

Action and Priorities for the coming period

- Strengthen links between the Alzheimer's Society and the Integrated Care Clusters
- Emergency Admissions Avoidance - consideration to the content of a potential workshop to address the issues around unplanned admissions identified.
- Mental Health development – a workshop will be arranged to develop the strategy

Contact: ***bdccg@barkingdagenhamccg.nhs.uk***

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APPENDIX X

Public Health Programmes Board

Chair: Matthew Cole Director of Public Health

Items to be escalated to the Health & Wellbeing Board

None

Performance

2015/16 Budget and Performance of Programmes

The public health programme performance and expenditure was reviewed. Most services/projects meet targets, however those that are red include:

- **Smoking:** Target of 3000 quitters which includes 2000 from primary care and 1000 Level 3. We are not engaging enough and a performance improvement plan will be put in place. A targeted approach will be taken within primary care which will include training for putting data on systems etc. A blanket approach will be looked at via the faith groups and a more targeted and assertive communications approach will also be taken.

- **National Child Measurement Programme:** This programme is performing just under targets. NELFT refresh to 95% height and weight and 95.11% on refresh. Secondary schools are under target at 92%. Meetings with Tenergy to ensure that school nurses focus on tracking and reporting back quarterly on those children to be found overweight.

- **Mental Wellbeing:** Big White Wall is an online portal which has been extended for 6 months. The target has been set of 50 registrants per month. This was being achieved up until April but has since dropped off to 28-29 per month. Action to promote this within the borough particularly through GPs and wider primary care services.

Meeting Attendance

Good attendance

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

Procurement Strategy – Sexual Health: Procurement has failed with Redbridge and Havering. B&D will now go it alone with BHRUT. The current contract expires in September 2015. A direct award is being considered at the Health & Wellbeing Board. We are looking for a 5% savings from BHRUT on sexual health and GUM to go to primary care.

Teenage Pregnancy. A film had been presented on teenage pregnancy. Young people had been met with and the film showed experiences of young mums. B&D have the highest prevalence in London for under 16's conception and are the 7th highest for abortions for Under 19's. We have agreed that an analysis of the data should be carried out, services to be looked at and then what a strategy would look like. .

In year reductions of the Public Health Grant. Savings. The Department of Health published savings on the grant and the amount. The four options put forward by DoH are as follows:

A. Devise a formula that claims a larger share of the saving from LAs that are significantly above their target allocation.
B. Identify LAs that carried forward unspent reserves into 2015/16 and claim a correspondingly larger share of the savings from them.
C. Reduce every LA's allocation by a standard, flat rate percentage. Nationally the £200million saving amounts to about 6.2% of the total grant for 2015/16, so that would also be the figure DoH applies to individual LAs. See annex C in the link below to see the effect on LA

allocations. (DoH preferred option)

D. Reduce every LA's allocation by a standard percentage unless an authority can show that this would result in particular hardship, taking account of stated criteria.

For B&D The Public Health Grant for 2015/16 is	£14.213M
Health Visiting (from 1st October)	£ 2.5
Total	**£16.725M with savings £15.688M**

Action and Priorities for the coming period

(a) Implement the In year savings plan

(b) If the Council is required to make further savings of 6.25% of the Public Health Grant (PHG) in 2016/17 the impact will be to achieve full year effect we will have to cease or reduce funding of some programmes on 1 April 2016. In order to achieve the savings required as estimated by initial guidance from the DoH, the non mandated public health programmes will need to find estimated efficiencies in the region of 15%. The comprehensive spending review will confirm the actual savings that will be required and this will be published in November 2015 along with confirmation of the Council's PHG allocation for 2016/17.

(c) Monitor recovery plans on areas of poor performance.

Contact: Pauline Corsan

Tel: 0208 227 3953 ; **Email:** pauline.corsan@lbbd.gov.uk

Children and Maternity Group

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

Performance
As per HWB performance indicators for CMG. Outcomes measures incorporated into HWB Delivery Plan.

Meeting Attendance

19th May – 33% (5 out of 15)

14th July - 33% (5 out of 15)

It should be noted that a number of deputies have attended meetings and there have been a number of personnel changes across organisations during this time. One of the actions for the next meeting is to review members and deputizing arrangements.

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

- The Sub-Group members discussed Children's Mental Health in particular the requirement for there to be a joint Children and Young People's Mental Health Transformation Plan based on the *Future in Mind* guidance. The Sub-Group considered how the planned Children and Young People's Needs Assessment, Children's IAPT programme can support the development of the plan and how the MH and CMG sub-groups can work effectively together. This will be a particular priority over the coming months.
- The Sub-Group considered the Special Educational Needs and Disabilities strategy and recommended it to the Health and Wellbeing Board for formal approval.
- The Sub-Group was provided with an update on the Integrated Early Years model and received an update on the joint work between primary care, health visitors and Family Support Workers.
- The Sub-Group reviewed the Health Watch report on children's A&E , which provided useful information on how parents view urgent care services locally.

Action and Priorities for the coming period

- Sign up to the Disabled Children's charter to be considered further at Executive Planning Group.
- Ongoing focus on children's mental health
- TOR to be reviewed
- Review maternity elements of the delivery plan.
-

Items to be escalated to the Health & Wellbeing Board

None

Contact: bdccg@barkingdagenhamccg.nhs.uk

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HEALTH AND WELLBEING BOARD

8 SEPTEMBER 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.	

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In this edition of my Chair's Report, I talk about our response to the Department of Health on Public Health Grant reductions and an exciting new development around Accountable Care Organisations. I also provide an update on the Make a Change campaign and Care City. 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

#makeachange makes a change!

The healthy lifestyle campaign #makeachange has been out and about this summer, engaging with residents at the borough's 50th anniversary celebrations. We've been at all of the big events so far and some of the smaller ones too, where we can target a particular audience. Twelve events down and nine to go!

Community Health Ambassadors, as well as our own volunteer Community Health Champions, have been encouraging people to pledge even the smallest healthy change, and to share their pledge with a 'healthy selfie'. Everyone who makes a pledge has been rewarded with a #makeachange cotton shopping bag or a healthy 'sweet treat', including freshly made fruit juices from Community Food Enterprise's Juice4Life stall. There are also t-shirt and badges to be won for the best healthy selfies.

The team has been joined by the Harmony Clinic providing free health assessments and advice, the Terrence Higgins Trust advising on sexual health, Chlamydia testing and free condoms, as well as Big White Wall promoting free online emotional support for borough residents. We've also been promoting and signposting Diabetes UK, Cancer Research UK, PHE & NHS Cancer awareness campaigns, the British Heart Foundation, and the pan-London HIV testing campaign 'Do It London'.

Part of the joy of these big community events is seeing cross-referrals happen before our very eyes, especially working alongside teams from Culture and Sport's Active Leisure Centres and Healthy Lifestyles teams, and the Adult Social Care's eye health survey and signposting, as well as the ELF programme for adults with learning disabilities. It's also been great to see local diabetes and kidney health groups at some of the events. On top of that, we've just hosted the Diabetes UK Roadshow for two days in Barking, with support from Tesco, complete with hoolahoop and skipping challenges!

You can meet the #makeachange team and make your pledge, or let us know how you're getting on, at these events:

- East European Harvest Festival, Sun 13 September, 1-5, Valence House
- African & Caribbean event, Sat 19 September, details TBC.
- Youth Parade (11am to 4pm) Pondfield Park to Old Dagenham Park, Sunday 27 September
- Older People's Week, including Older People's Day, Thursday 1 October, venues and times TBC
- International Day for Disabled People, Thursday 3 December, times TBC, Dagenham and Redbridge Football Club
- Santathon Fun Run, Sunday 13 December, 11am to 1pm, Dagenham and Redbridge Football Club, Fundraising event.

Barking and Dagenham's response to the Department of Health's in-year Public Health Grant Reductions

On 4 June 2015 as part of wider government deficit reduction, the Government announced further reductions across public spending. The Department of Health (DoH) is to deliver savings of £200 million in the financial year 2015/16 through reductions to the Public Health Grant (PHG) to local authorities (LAs) in-year. On 31 July the DoH launched a four-week consultation on the proposed savings options. The consultation sets out possible options as to how the £200m savings might be spread across LAs most fairly and effectively. The DoH's current preferred approach is option C:

A. Devise a formula that claims a larger share of the saving from LAs that are significantly above their target allocation.
B. Identify LAs that carried forward unspent reserves into 2015/16 and claim a correspondingly larger share of the savings from them.
C. Reduce every LA's allocation by a standard, flat rate percentage. Nationally the £200million saving amounts to about 6.2% of the total grant for 2015/16, so that would also be the figure DoH applies to individual LAs (option preferred by DoH)
D. Reduce every LA's allocation by a standard percentage unless an authority can show that this would result in particular hardship.

Based on the DoH's preferred option, the indicative impact of a flat 6.2% reduction to Barking and Dagenham's total 2015/16 PHG is as follows:

Total PHG excluding 0-5 children's allocation	£14,213m
Children's 0-5 allocation (part year)	£2,512m
Total 2015/16 PHG allocation	£16,725m
Indicative revised allocation (original minus 6.2%)	£15,688m
Total savings from Barking and Dagenham in 2015/16	**£1,037m**

The Council's formal response is summarised as follows:

- Options A and B would impact on Barking and Dagenham adversely, particularly option B as Barking and Dagenham carried forward an underspend of £978K from 2014/15. In regards to option B, historic spend should not be used as the sole criterion for determining the size of the public health funding going forwards.
- Option C – favoured by Board members as the least inequitable option.
- Option D – too complex and also potentially subjective in terms of how DoH would weight the various factors when calculating the percentage reductions.
- There should be an alternative option (D) that clearly recalibrates spending in accordance with levels of need e.g. those areas with higher levels of deprivation, poorer health outcomes, complexity of need, etc.

Barking and Dagenham Council has also submitted a statement in support of the London's Council's challenge to the grant reductions.

CQC Abuse

The Observer reported this week that there has been a significant increase in the number of safeguarding allegations reported to CQC, with over 30,000 allegations of abuse involving people using social care services in the first six months of this year. Allegations ranged from physical, emotional and sexual abuse to financial fraud. The Safeguarding Adults Board will be looking at this at their December meeting.

News from NHS England

Female Genital Mutilation (FGM)

This is the time of year when young girls may be taken abroad for female genital mutilation (FGM). The NHS reported in February 2015 that 2,600 cases of FGM were treated in six months.

A great step forward has been taken in protecting those at risk of female genital mutilation. The NSPCC's FGM helpline practitioners have recently received additional training to provide an enhanced service for NHS staff to discuss any questions or concerns they have about FGM and what action to take.

The initiative has been developed to support health professionals who are directly working with women and girls that may be at risk or have been victims of FGM, with a dedicated 24/7 team of advisors who can discuss the often complex circumstances surrounding cases of FGM. The training enables the helpline staff to work with nurses and other clinicians. In busy clinical environments, dealing with a sensitive, upsetting and unfamiliar situation, healthcare staff often face difficult dilemmas. By calling the helpline they can talk through concerns, clarify risks and seek advice on action.

New Programme to Improve Young People's Mental Health Services

Never in recent times and memory has the profile of the emotional and mental health of children and young people been so high. There are a wide range of local and national established work programmes from health and education, and more coming on line since the publication of **Future in Mind**, as well as the very welcome **announcement of further resources to allow us to move more quickly to build capacity**.

This work is challenging because there is evidence on how we are currently, across the system, need to do more to support children and young people who need and deserve care and support.

One of the finest achievements this year has been the publication of **Future in Mind**, with 49 proposals which are all underpinned by the commitment to involve children, young people and parents not just in their own treatment but in service design and commissioning.

The principal themes indicate than we must do better with what we already have, while promoting resilience, prevention and early intervention, improving access to effective support, care of the most vulnerable, accountability and transparency, particularly in commissioning, and with all of this developing the workforce, so essential to the delivery of excellent skilled care.

Care City Innovation Test Bed Site

Founded by NELFT (Community and mental health NHS Trust) and London Borough of Barking and Dagenham, Care City is working with all of our local system partners and UCL Partners to improve health outcomes for people as they age and to support social regeneration through innovation, education and research www.carecity.london

In June, Care City applied to NHS England to be one of five planned national Innovation Test Bed sites. We are delighted to announce that we are now through to the next stage. The aim of the Test bed will be to support with the intention of being able to better scale up innovation and ultimately support service users and professionals to better access emerging technology and innovation.

On 29 July Care City was invited to attend a test bed 'meet and greet' event hosted at the Oval by NHS England to showcase the test bed proposal and meet with innovators. Over the coming weeks Care City will be selecting their innovation partners and developing a bid which will then be presented to NHS England. The final decision will then be made in December 2015.

VisBuzz

Visbuzz is an extremely simple way for people who don't use computers to make and receive video calls to and from their family and friends on a tablet. It is easy to set up and use and the user needs little technical knowledge. The Council is looking at how this could be used to help to combat loneliness or isolation and we'll keep the Board up to date with developments! More information can be found at: http://visbuzz.com/

EPG Development Session

The Executive Planning Group held a very productive development session on Thursday 13 August. The time was used to discuss the Joint Strategic Needs Assessment, sub group development and Health and Wellbeing Board channels of communication.

In terms of communications it was felt that the H&WBB newsletter was a useful source of information but the group felt that investigating alternative ways to present the information may be useful, possibly in an email format with links which may make it more readable. The group discussed the theming of future meetings to allow more discussion on particular topics. There was some discussion around the sub groups and the development of sub-group performance reporting. The group also received a presentation on the JSNA and discussed how the information could be used to help the H&WBB to discuss the issues and focus on setting priorities. This has shaped the item elsewhere on the Board's agenda.

The EPG will now work on taking all of this forward – we hope the Board sees some useful changes in the coming months!

Accountable Care Organisation

Exciting proposals are taking shape that may put Barking & Dagenham, together with Havering and Redbridge, at the centre of the moves to devolve increasing control of health, wellbeing and social care to local areas. The concept of an 'Accountable Care Organisation' was floated in the NHS 5-Year Forward View, launched by Simon Stevens earlier this year: in essence, it is about giving a single organisation responsibility for end-to-end preventive support, healthcare and social care for its citizens. It follows our successful 'Vanguard' proposal around urgent and emergency care, which is itself based on our long history of good partnership working around the 'BHR' health economy. It also fits well with the innovation programmes that we will be seeing through CareCity. A coalition of the three local authorities, CCGs and the two major hospital trusts, with input from UCL Partners, are putting a proposal together for the BHR area to pilot the accountable care organisation framework in the London area.

There are a number of hurdles to jump yet, not least making a convincing case to NHS England, the Mayor of London and, ultimately, the Treasury, but we have received positive encouragement for our ideas to date and are confident of a good hearing. The Board will be kept informed as the proposals take shape, and when the key decisions are required about governance and other matters.

You can read more about Accountable Care Organisations on the Kings Fund website at http://www.kingsfund.org.uk/publications/accountable-care-organisations-united-states-and-england

Health and Wellbeing Board Meeting Dates

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.

HEALTH AND WELLBEING BOARD

8 September 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 coming year. The Forward Plan is an important document for not only planning the business of the Board, but also ensuring that information on future key decisions is published at least 28 days before 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 next draft edition of the Forward Plan for the Health and Wellbeing Board at the time of the 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 21 September 2015. Any changes or additions to the next issue should be provided before 6.00p.m, on 16 September.

Public Background Papers Used in the Preparation of the Report:
None
List of Appendices
Appendix A – Draft Forward Plan

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HEALTH and WELLBEING BOARD FORWARD PLAN

DRAFT October 2015 Edition

Due to be published on 21 September 2015

THE FORWARD PLAN

Explanatory note:

Key decisions in respect of health-related matters are made by the Health and Wellbeing Board. Key decisions in respect of other Council activities are made by the Council's Cabinet (the main executive decision-making body) or the Assembly (full Council) and can be viewed on the Council's website at http://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;

DRAFT

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
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

DRAFT

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.

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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: 20.10.15	Market Position Statement Refresh Consultation An addendum to the Market Position Statement (MPS) is being produced for reflect the Care Act 2014 and market updates. This paper will seek sign-off of the addendum by the Health and Wellbeing Board and agreement on the production of a new MPS for the Autumn of 2016 to reflect Ambition 2020 and the Growth Commission. • Wards Directly Affected: All Wards	Open	Mark Tyson, Group Manager, Integration & Commissioning (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)
Health and Wellbeing Board: 20.10.15	Local Account 2014/15 The Local Account is the Council's statement to the local community about the quality of adult social care services. It explains how much the Council spends, what it spends money on, what services are provided and commissioned, performance over the past year, together with achievements and future plans for improvements. This year a Local Account film will be shared with our partners, the community and will be on the Council's website. The film is being presented to the Health and Wellbeing Board for information only. • 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: 20.10.15	Child Sexual Exploitation The report will set out the current position and prevention of Child Sexual Exploitation; for which the Barking & Dagenham Local Safeguarding Children Board (LSCB) has strategic oversight. • Wards Directly Affected: All Wards	Open	Teresa DeVito, Acting Divisional Director – Strategic Commissioning, Safeguarding & Early Help (Tel: 020 8227 2318) (Teresa.Devito@lbbd.gov.uk)
Health and Wellbeing Board: 20.10.15	Performance Report 2015/16 - Quarter 1 The performance dashboard and Better Care Fund (BCF) update will be presented for the Board to analyse and discuss • 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: 20.10.15	**Contract - Public Health Primary Care Services Procurement** : Financial The Board will be asked to agree to waive the requirement to tender and give delegated authority for the direct award of contracts to local GPs and Pharmacists for a period of one year, from 01 April 2016 to 31 March 2017, with the option for the Council to extend the contract for a further one year. • 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: 20.10.15	**Contract - Mental Health Supported Accommodation Scheme - Request for Delegated Authority** : Community,: Financial The Board will be provide with an overview of the plan to commission a 24 hour supported living scheme in the Borough for service users with mental health needs. The Board will be asked to approve the seeking of tenders and to authorise delegated authority for the acceptance of the tender. • Wards Directly Affected: All Wards	Open	Mark Tyson, Group Manager, Integration & Commissioning (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)

Health and Wellbeing Board: 20.10.15	**Contract - Advocacy Services Re-tender** : Financial The Board will be presented with options for the tender of a future advocacy service which will include independent advocacy (made statutory by the Care Act) and advocacy around the Mental Capacity Act, Mental Health Act and Deprivation of Liberty Safeguards. The Board will be asked make a decision to delegate authority for the re-tender of advocacy services, and approve some of the terms of the proposed tender. • Wards Directly Affected: All Wards		Mark Tyson, Group Manager, Integration & Commissioning (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)
Health and Wellbeing Board: 8.12.15	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, Commissioning and Partnerships (Tel: 020 8227 2827) (glynis.rogers@lbbd.gov.uk)
Health and Wellbeing Board: 8.12.15	Local Safeguarding Children Board Report The Local Safeguarding Children Board report will include the Children's Death Overview Panel (CDOP) report and will be presented to the H&WBB for information. • Wards Directly Affected: All Wards	Open	Helen Jenner, Corporate Director of Children's Services (Tel: 0208 227 5800) (helen.jenner@lbbd.gov.uk)

Health and Wellbeing Board: 8.12.15	Revisions to the Care and Support Charging Policy In February 2016 the Cabinet will be asked to agree revisions to the Care and Support Charging Policy as part of a review of areas of local discretionary charging under the Care Act 2014. The Health and Wellbeing Board is asked to give its views on the proposals as part of the consultation process. • Wards Directly Affected: All Wards	Open	Ian Winter, Care Act Programme Lead (Tel: 020 8227 5310) (ian.winter@lbbd.gov.uk)
Health and Wellbeing Board: 26.1.16	**Barking and Dagenham Sport and Physical Activity Strategy** : Community The Board will be asked to approve a new Sport and Physical Activity Strategy aimed at increasing Borough residents' participation in physical activity to improve the health of local residents. The Strategy will also set out plans to help the Council, its partners and local sports clubs to raise funds to support improvements in service delivery as well as enable a joined up approach that will encourage participation levels. • Wards Directly Affected: All Wards	Open	Paul Hogan, Divisional Director of Culture and Sport (Tel: 020 8227 3576) (paul.hogan@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)

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