# Notice of Meeting

# HEALTH & WELLBEING BOARD

**Tuesday, 26 January 2016 - 6:00 pm**
**Conference Room, Barking Learning Centre, 2 Town Square, Barking, IG11 7NB**

Date of publication: 18 January 2016

Chris Naylor
Chief Executive

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

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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) Strategic Director for Service Development and Integration and Deputy Chief Executive |
| 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) |
| CS 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 8 December 2015 (Pages 3 - 11)**

**BUSINESS ITEMS**

4. **Delivering the 2020 Ambition for World Class Cancer Outcomes (Pages 13 - 19)**

5. **Improving Post - Acute Stroke Care (Stroke Rehabilitation) Consultation (Pages 21 - 90)**

6. **Learning Disability Partnership Board Strategic Delivery Plan Update (Pages 91 - 118)**

7. **Market Position Statement Update 2015 (Pages 119 - 163)**

8. **Health and Wellbeing Performance Report 2015/16 - Quarter 2 (Pages 165 - 187)**

9. **Draft Homelessness Strategy (Pages 189 - 283)**

10. **Prevention Approach Update (Pages 285 - 298)**

11. **Overview of Complaint Handling (Pages 299 - 333)**

12. **Devolution Through an Accountable Care Organisation in Barking and Dagenham, Havering and Redbridge (Pages 335 - 340)**

13. **Agreement Between the London Borough of Barking and Dagenham and the North East London NHS Foundation Trust Under Section 75 of the National Health Service Act 2006 for the Provision of Integrated Mental Health Services (Pages 341 - 348)**

14. **Contract: Waiver for Healthy Child 5-19 Programme (School Nursing and National Child Weight Measurement Service) - TO FOLLOW**

**STANDING ITEMS**

15. **Systems Resilience Group - Update (Pages 349 - 351)**

**16. Sub-Group Reports (Pages 353 - 358)**

**17. Chair's Report (Pages 359 - 364)**

**18. Forward Plan (Pages 365 - 372)**

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

**20. 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.***

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

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London Borough of Barking & Dagenham
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# Our Vision for Barking and Dagenham

## One borough; one community; London's growth opportunity

## Encouraging civic pride

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

## Enabling social responsibility

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

## Growing the borough

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

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# MINUTES OF
# HEALTH AND WELLBEING BOARD

Tuesday, 8 December 2015
(6:00 - 8:15 pm)

**Present:** Dr Waseem Mohi (Deputy Chair in the Chair), Anne Bristow, Conor Burke, Cllr Laila Butt, Cllr Evelyn Carpenter, Matthew Cole, Dr Andy Heeps, Helen Jenner, Marie Kearns, Chief Superintendant Sultan Taylor, Cllr Bill Turner and Jacqui Van Rossum, Russ Platt

**Also Present:** Terry Williams

**Apologies:** Cllr Maureen Worby, John Atherton, Dr Nadeem Moghal and Frances Carroll, Councillor Keller, Councillor Chand, Sarah Baker

## 42. Declaration of Members' Interests

There were no declarations of interest.

## 43. Minutes - 20 October 2015

The minutes of the meeting held on 20 October 2015 were confirmed as correct.

## 44. Local Account 2014/15

The Local Account 2014/15 was the Council's statement about the quality of social care services in the Borough over 2014/15 and its way of being accountable to the local community and services users. The Local Account also provided the basis for discussion about the quality and future development of social care services. It had been decided for 2014/15 to present the Local Account information through a film rather than the more traditional paper based documents.

The film, which had been played immediately prior to the meeting, provided an insight into the services from a service user perspective. The film also covered the changes that had occurred and these had included, personal budgets, dementia care, education, training, volunteer placement work, residential and end of life care provision, carers' support, removing individual isolation and providing social contact as well as projected demands for the near future. The film was already on the LBBD u-tube and sections of the film would also be taken to separate / targeted audiences.

The Board noted the partnership working, which had included the Joint Assessment and Discharge (JAD) service that had resulted in several hundred competently handled discharges from hospital. The Board also noted that further work was being undertaken by North East London Foundation Trust (NELFT) and Barking and Dagenham Clinical Commissioning Group (CCG) in regards to mental health.

The Chair thanked everybody involved in the making of the film and in the successful 2014/15 year.

Board Members were supportive of the novel use of a film in presenting the Local Account to the public and stakeholders and the Chair thanked everybody involved in its making.

The Board noted the Local Account 2014/15.

**45. Addiction to Medicines**

Sonia Drozd, Strategic Managers, Substance Misuse, and Jill Williams, Shared Care Coordinator, jointly presented the report and explained that addiction to medicine (ATM) was the dependence on prescription and / or over-the-counter drugs that were not needed for pain control. Medication dependence could impact on health, mental wellbeing or result in overdose and could also produce risk for the community, for example through people driving whilst drowsy. The point was made regarding a lack of data, both locally and nationally, in terms of the number of people with ATM and of the level of their addiction.

Barking and Dagenham was one of Public Health England's pilot sites for addressing the issue of ATM. The aims of the pilot were to identify the number of people affected locally and where they were obtaining the medication from, raising awareness amongst primary care and health professionals of medication addiction and prescribing issues, delivery of better support to patients and to monitor the effectiveness of the treatment pathway.

It was noted that not all those affected or seeking support would present themselves to the Substance Misuse Team and many could be obtaining support elsewhere, for example through GP surgeries.

The Board also discussed its concerns around the addiction to non opiate based pain control medication, such as paracetamol and ibuprofen, and noted that the pilot would initially concentrate on the opiate based products.

The Board:

(i) Noted the report;

(ii) Noted that a further report would be presented to the Board in early 2017 on the outcome of the Public Health England pilot; and

(iii) Requested that an interim report be presented to the Substance Abuse Sub-Group to give an indication of the number of people addicted to over-the-counter opiate based medication in the Borough and also if any data was emerging in regard to the prevalence of addiction to non opiate based pain relief medication, such as paracetamol and ibuprofen.

**46. Barking & Dagenham Clinical Commissioning Group (CCG) Commissioning Intentions**

Sharon Morrow, Chief Operating Officer, Barking and Dagenham CCG, presented the report and advised that the CCG refreshed its plans on an annual basis to take into account changes to local needs and their annual financial allocation. The CCG were currently in the business planning cycle and this included engagement with their Partners. Whilst the CCG had still not received guidance from NHS

England, it was looking towards a longer-term approach and the transformation of services over the next three to five years. Sharon outlined the CCG intentions, which would need to take into account a number of factors, these included the 'Right Care Programme' and continuation of the Better Care Fund plan. Mental Health continued to be a priority with a new focus on child and adolescent mental health services and eating disorder services. CCG plans included addressing the needs of vulnerable children. A review of paediatric therapy services was being undertaken to inform the commissioning of services for children with a special educational need and disabilities (SEND). Cancer was a key priority and a themed discussion on this was planned for the 26 January 2016 Board meeting. The CCG was also committed to the transformation of primary care services and was planning a workshop for members in January 2016. Other commissioning intentions included increasing the utilisation of Barking Birthing Centre, antenatal care, stroke care and pathways.

Councillor Turner asked if the CCG would be investing in paediatric speech and language therapy services (SALT) as recommended in the Healthwatch review. Sharon confirmed that CCG investment was subject to a business case being approved by the CCG Governing Body and this would be informed by the review.

Councillor Carpenter asked what changes had been made to improve early intervention in psychosis. Sharon confirmed that the CCG had made additional investment in the service and was working with NELFT to develop and review the services provided by them including, increasing capacity, changes following NICE guidelines revisions, and improved information and treatment pathways.

The Board discussed the points within Sir Stephen Bubb's Report (Chapter 2), which related to a 'radical prevention' in the health agenda and how that could be made clearer in commissioning. The CCG confirmed that it would consider this when the national planning guidance was received from NHS England.

Helen Jenner, Director of Children's Services, raise the issue of SEND children and how the Ofsted Inspections and the children and their families needed to be taken into account, Sharon confirmed that issues such as therapy and specific local needs would be fed into the CCG Strategies. It was noted that consultation would need to be undertaken with children and young people to get their feedback and views on the services provided for them.

Steve Norman, Barking and Dagenham Borough Commander, London Fire Brigade (LFB), raised the issue of fire risk for vulnerable people. The highest risk of fire incidents were known to occur to those with mobility problems or dementia and particularly those that smoked. Discussion was held in regard to adding fire risk and prevention as a consideration by partners to their processes and how this could be achieved locally.

The Board noted:

(i) That guidance from NHS England was anticipated at the end of December 2015 and the decision on funding allocation was also awaited;

(ii) The CCG preparation and intentions in regards to planning headlines and commissioning priorities for 2016/17, including urgent and emergency care, planned care, mental health children and young people, maternity, primary

care transformation programme, integrated care, cancer and stroke pathways;

(iii) The potential for a radically different prevention agenda being part of the CCG consultation and commissioning;

(iv) That there was discussion at the 20 October Board meeting in regards to additional resources for children's speech and language therapy (SALT) and reminded the CCG of this discussion; and

(iv) The suggestion from the LFB that all partners should, as part of their procedures, consider fire risk for individual clients and put appropriate prevention measures into place and agreed that this issue be this subject of a report to a future meeting.

**47. NHS England Commissioning Intentions**

Russ Platt, Head of Engagement Delivery, NHS England, gave a presentation on his organisation's initial intentions, which had been released on 30 September 2015. As part of the presentation the Board's attention was drawn to a number of issues including changes to antenatal and new born screening, immunisation programmes particularly for meningitis and influenza, adult and cancer screening and concern over the cervical screening rates dropping, the recommendations from the national taskforce on pan London cancer care, healthcare of people in custody or leaving prison, trauma and neuro-rehabilitation, blood services and infections including HIV and Hepatitis, work with Havens Paediatric Sexual Assault Referral Service and pathways to children's services, working with the CCGs to develop and improve the pathways and access for mental health patients particularly for children and adolescents and reducing avoidable admissions.

Russ advised that John Atherton and his team were leading on the linked provision across London and that the CCG commission process would make sure that the plans were coordinated. NHS England had now issued their intention for service provision for the 'here and now', which included winter pressures, and also for their strategic longer-term plans.

Matthew Cole, Director of Public Health, raised the issue of the Paediatric Intensive Care Beds review which had indicated that it was not appropriate for children to be in adult intensive care wards and asked about the implementation of those recommendations. Russ agreed to investigate the current position and report and back to the Board in due course.

The Board noted:

(i) The NHS England (London) draft commissioning intentions for 2016/17 and the work that would be done to co-ordinate the various service areas;

(ii) How NHS England would ensure the delivery of day-to-day services and their strategic long-term plans through the use of commissioning and contractual means; and

(iii) That NHS England would review and report back on Paediatric Intensive Care beds and children being in adult intensive care wards.

## 48. Draft Homelessness Strategy 2016/21

This item was withdrawn to enable the consultation period to be extended. It was expected that a revised report would be ready for the 26 January 2016 meeting.

## 49. Revisions to the Care and Support Charging Policy

Ian Winter, Care Act Programme Lead, presented the report and explained how the Care Act 2014 had set out a single legal framework for charging users and carers for their care and support and allowed the Council to set and maintain a charging policy, within set levels of discretion, and accordingly apply charges.

The Board noted that LBBD Cabinet, at its meeting held on 10 November 2015, had agreed to consult on proposed revisions to the Council's Care and Support Charging Policy as well as plans to introduce a scheme whereby a legal charge would, in certain circumstances, be placed on a property that had undergone adaptations funded from the Council's Disabled Facilities Grant scheme. In respect of the latter, Ian Winter advised that the law currently allowed between £5,000 and £10,000 to be taken as a charge against a property if it was sold within 10 years. This could be ring-fenced and reused for future disabled adoptions. Comments arising from the consultation would be presented to the Cabinet so it could make the final decision.

With regard to the proposed revisions to the Council's Care and Support Charging Policy, Ian Winter also explained the standard rate, how the very real day-to-day costs such as additional washing or travel costs would be considered and that to undertake individual calculations each time would be costly and time consuming. He also referred to allowance levels and the proposed appeals process.

The Board supported the consultation and noted that an update report would be presented in due course.

## 50. Better Care Fund Progress Report

Sharon Morrow, Chief Operating Officer, Barking and Dagenham CCG, presented the report and gave an outline of the progress on 11 Better Care Fund (BCF) schemes, work that was being undertaken to align with services locally and integrated case management.

The Board considered a number of points, including:

- The progress on the Joint Assessment Discharge (JAD) Unit and noted that this was now operating seven day working and the hosting arrangements had been completed.

- One of the key performance monitors was the re-admissions to hospital rates and currently this was 680 above plan: although it was felt that there may be an element of double counting in ambulatory care. The national reduction in readmissions target had been 3.0% but a 2.5% target had been agreed by the Board earlier in the year. However, the 2.5% reduction in re-admissions rate had not been achieved locally and as a result there would be financial penalties

in the order of £710,000 for the CCG, which would partly be off-set by £330,000 that had been carried forward from last year. The CCG and Council would be undertaking an analysis as to why the 2.5% target was not achieved and in particular what was driving the re-admission rates up for the 40 to 60 age group. Work was being undertaken with GPs to produce care plans that would reduce the number of emergency re-admissions.

- It was noted that winter pressures also had an impact on the admissions to residential care figures.

- The injury from falls target had improved during 2013/14 but performance in the first quarter had dipped slightly, therefore, this area was being monitored closely.

- There were difficulties in achieving targets when the 'goal posts' were changed by the Government / NHS England during the period.

The Board:

(i) Noted the latest information on delivery of the Better Care Fund, as set out in the report, and the steps that were being taken to address underperformance;

(ii) Noted the proposed continuation of the Better Care Fund into 2016/17 and that, on behalf of the Board, the Joint Executive Management Committee would be considering the approach to the Better Care Fund refresh for the next year; and

(iii) Requested a report in March or April 2016 to update the Board on performance levels and to inform any necessary actions by Partners.

**51. Accountable Care Organisation and Spending Review Update**

Conor Burke, Chief Accountable Officer, Barking and Dagenham CCG, reminded the Board that with its support BHRUT had put itself forward as a pilot Accountable Care Organisation (ACO), which if successful could attract £2b investment across the three council areas and would also bring eight organisations together into one entity. An overview of the approach by the Integrated Care Coalition was set out in Appendix A to the report.

Conor advised that it was expected that NHS England would announce within the next few weeks whether it had agreed to the principle of the proposed pilot ACO and to the business case being developed further. As part of the early preparations an initial Programme Office had been set up in the Care City offices to develop an outline business case and, subject to the NHS England decision, this would be developed further in the New Year.

If and when approval was given by NHS England to progress the ACO pilot, there would be extensive consultation to develop the case for change. It was also noted that devolution could cover a larger area than the three BHRUT boroughs and was not contrary to the Vanguard Programme.

The Board noted:

(i) The current position in regards to the bid to set up a potential pilot Accountable Care Organisation and that a programme management office had been set up in Care City to develop an outline business case in preparation for the decision in the New Year; and

(ii) If the bid was successful, there would be extensive consultation undertaken on the case for change and development of the ACO.

**52. Barking and Dagenham Safeguarding Children Board Annual Report 2014/15**

Helen Jenner, Corporate Director of Children's Services presented the report to the Board and pointed out the significance of it being the first Local Safeguarding Children Board (LSCB) annual report that was a Partnership report, rather than a Council only report. The purpose of the annual report was to provide a rigorous and transparent assessment of the effectiveness of child safeguarding and promotion of children's Welfare in the local area.

Helen explained that the annual report was set out in five chapters and covered key conclusions reached by the LSCB, which included an assessment of how well children and young people were safeguarded, the level of need and useful demographic information, significant developments that had taken place within partner agencies during the year, the statutory functions of the LSCB, how the LSCB operated in the Borough and the work it had undertaken during 2014/15. The Board's attention was specifically drawn to priority groups of vulnerable children and young people, which included children subject to, or at risk of sexual exploitation, children affected by domestic violence, privately fostered children or missing children as well as the Prevent agenda and the LSCB's work to safeguarded those groups. The report also set out the priorities for 2015/18.

The Board noted:

(i) The Barking and Dagenham Safeguarding Children Board Annual Report 2014/15 was a partnership report and the strength of the partnership was better reflected in the report this year than previously;

(ii) The maturity of the partnership was clearly underpinning the five priorities, the capacity to learn from Case Reviews, the sharing of information and challenge and joint work on aspects such as Prevent and Child Sexual Exploitation; and

(iii) Partners were recognising of the need to improve prevention and early intervention support across the partnership to reduce families going into crisis and to drive down the need for safeguarding and children being taken into care.

**53. Barking and Dagenham Safeguarding Adults Board Annual Report 2014/15**

Glynis Rogers, Lead Divisional Director, Adult and Community Services, presented the annual report of the Safeguarding Adults Board (SAB) and explained that this was the first annual report of the SAB under its new statutory status.

Glynis drew the Board's attention to the report and a number of issues, which included:

- The preparation for Care Act compliance, which had included the complete review of processes and governance.
- Engagement undertaken with Partners and their contributions and activity over the course of 2014/15.
- Training and development sessions, which had included the Care Act and the statutory duty of partnership.
- Production of 'must do' materials, frontline staff training and a single checklist for all partner organisations to help them ensure compliance.
- All key areas, which were statutory requirements, had been achieved.
- The realignment of the SAB, and the work of the Safeguarding Adults Review Group, Learning and Development Group and Performance and Assurance Group.
- Public awareness raising.
- Depravation of liberty safeguards and the impact of the 'Cheshire West' high court judgement in March 2014.
- Safeguarding performance indicated 1,367 safeguarding alerts had been received and processed, 283 had required further investigations but many of the alerts were in regard to social care support needs.
- The publication of London Safeguarding Adults Policy and Procedures was still awaited.
- Joint Strategic Needs Assessment and Health and Wellbeing Strategy issues.
- There was one Safeguarding Adults Review in progress, the results of which would be reported the SAB and H&WB, as appropriate, in due course.

The Board noted:

(i) The Barking and Dagenham Safeguarding Adults Board (SAB) Annual Report 2014/15 and that work had included the realignment of the SAB, the complete review of partners' processes and governance, and that statutory requirements had been achieved;

(ii) The key priorities for 2015/16, which included improved sign posting for reporting adults at potential risk; and

(iii) There was currently one Safeguarding Review being undertaken and the outcomes or any recommendations from that would be reported to both the SAB and Health and Wellbeing Board in due course.

**54. Systems Resilience Group - Update**

The Board received the report on the work of the System Resilience Group (SRG), which included the issues discussed at the SRG meetings held on 22 October and 6 November 2015 and a verbal update following the Sub-Group meeting held on 7 December 2015.

The Board noted:

- The marginal increase in the number of people presenting at A&E.
- In July 2015 the A&E performance target had been achieved, which was the first time in four years.
- Noted staffing difficulties were being experienced but that action was being taken to stabilise the position.
- The winter and Christmas pressure plans were being finalised.

**55. Sub-Group Reports**

The Board noted the reports on the work of the:

- Mental Health Sub-Group
- Learning Disability Partnership Board
- Children and Maternity Group

**56. Chair's Report**

The Board noted the Chair's report, which included information on:

- White Ribbon Day on 25 November 2015, and awareness and fundraising events during November and December 2015.
- Spending Review and Autumn Statement 2015
- News from NHS England on:
    - New quick guides to help services through the winter.
    - Winter messages highlighted at the Annual Self Care Conference in November.
    - Self Care Forum research which had suggested that young people were using A&E to access healthcare.
- Update from Care City
- Urgent and Emergency Care Vanguard Bid

**57. Forward Plan**

The Board noted the draft Forward Plan.

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# HEALTH AND WELLBEING BOARD

## 26 JANUARY 2016

| **Title:** | **Delivering the 2020 ambition for world class cancer outcomes** |
|---|---|
| **Report of the Cabinet Member for Adult Social Care and Health** | |
| **Open Report** | **For Decision** |
| **Wards Affected: ALL** | **Key Decision: NO** |
| **Report Author:**<br>Sharon Morrow, Chief Operating Officer Barking and Dagenham CCG | **Contact Details:**<br>Tel: 020 3644 2370<br>E-mail: sharon.morrow@barkingdagenhamccg.nhs.uk |
| **Sponsor:**<br>Conor Burke, Chief Officer, Barking and Dagenham CCG | |

**Summary:**

Cancer outcomes in Barking and Dagenham compare poorly with the England average. Overall, Barking and Dagenham has the lowest net survival amongst London and West Essex CCGs, ranking lowest out of 33 CCGs. More than 40% of all cancer cases are linked to behaviour and environmental exposures which could be avoided or reduced. Factors that contribute to poor outcomes for cancer include the late detection and diagnosis of cancer.

"Achieving world-class cancer outcomes: A strategy for England 2015-2020" was published by the Independent Cancer Taskforce in 2015. This identifies six strategic priorities for cancer to be delivered over the next 5 years. The goal nationally is to significantly improve one-year survival to achieve 75% by 2020 for all cancers combined.

The report summarises work that is being taken forward locally through the BHR CCGs Cancer Collaborative Commissioning Group in 2014 to improve the prevention, early detection and diagnosis of cancer and through London wide initiatives that support cancer transformation.

The purpose of the presentation is to provoke discussion from partners on key questions that we will need to consider as a system if we are to achieve the required improvements in cancer outcomes.

**Recommendation(s)**

Members of the Health and Wellbeing Board are asked to consider the following questions:

i. How can we reduce the growth in the number of cancer cases?

| | |
|---|---|
| ii. How can we best engage the community to support the prevention agenda?<br><br>iii. What are the key areas B&D need to focus on to deliver the 2020 ambition? | |
| **Reason(s):** | |

## 1. Introduction

1.1 The purpose of this paper is to support a discussion on how the system leadership of the Health and Wellbeing Board can support cancer outcomes to improve in Barking and Dagenham.

1.2 Information has been provided on local cancer outcomes and progress made locally to modify the risk factors for cancer. There are a number of challenges locally that contribute to poor cancer outcomes: Barking and Dagenham has a higher prevalence of smoking and obesity compared to the national average which are risk factors for cancer; patients are often diagnosed in the later stages of disease which has an impact on survival rates and more patients who survive cancer require long term care and support.

1.3 A programme of work has started through the BHR Cancer Collaborative Commissioning Group to improve the prevention, early detection and diagnosis of cancer, which draws on London wide work that is being taken forward through the Healthy London Partnership. This programme will need to be enhanced to take into account new requirements set out in the Cancer Strategy for England [1] and NICE guidance on suspected cancer [2] which will require a step change approach to delivery to achieve the ambition for 2020.

1.4 Consideration needs to be given as to how which will require local stakeholder engagement, particularly with patients, the public and primary care.

## 2. Background

2.1 Cancer is the leading cause of death from illness in every age group except men aged 15-24 years. (Office of National Statistics (ONS), 2011) Although one year survival is improving across England, it still lags behind other comparative countries and five year survival rates are approximately 10% lower than the European average (National Audit Office, 2014).

2.2 More than 40% of all cancer cases are linked to behaviour and environmental exposures which could be avoided or reduced. The main risk factors are tobacco, weight, diet, alcohol consumption, UV exposure and lack of physical activity.

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[1] Achieving world-class cancer outcomes: A strategy for England 2015-2020. Report of the Independent Cancer Taskforce. (2014).

[2] Suspected cancer: recognition and referral. NICE (June 2015)

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

2.4 Barking and Dagenham has a one year survival rate of 62%, which is below the England average of 68%. Overall, Barking and Dagenham has the lowest net survival amongst London and West Essex CCGs, ranking 33 (1 highest, 33 lowest).

2.5 The National Awareness and Earlier Diagnosis Initiative launched in 2009 identified a number of reasons for poor survival and key factors included:-

- Demographics (ethnicity, age)
- Poor awareness of the symptoms of cancers
- Numbers of 2- week wait referrals and conversion rates in comparison with peers
- Number of new cancer diagnosis following an emergency admission/A&E attendance.

2.6 Cancers diagnosed via A&E generally present at a later stage of the disease which significantly affects one-year survival rates. Barking and Dagenham has a higher rate of cancers diagnosed in A&E than the England average (B&D – 29.2%; England – 20.6%)

## 3. Strategic context

3.1 "Achieving world-class cancer outcomes: A strategy for England 2015-2020" was published by the Independent Cancer Taskforce in 2015. This identifies six strategic priorities for cancer to be delivered over the next 5 years:

- A radical upgrade in prevention and public health with a focus on reducing smoking and obesity. *2020 ambition to reduce smoking prevalence to less than 13%.*
- Drive a national ambition to achieve earlier diagnosis. *2020 ambition that 95% of patients referred for testing by a GP are definitively diagnosed with cancer, or cancer is excluded, and the result communicated to patients within 4-weeks*.
- Establish patient experience as being on a par with clinical effectiveness and safety. *2020 ambition all consenting adults have on-line access to all test results and other communications involving secondary or tertiary providers*
- Transform our support for people living with and beyond cancer. *2020 ambition for every person with cancer to have access to elements of the recovery Package, and stratified pathways of follow-up care will be in place for common cancers*
- Make the necessary investments required to deliver a modern high-quality service

- Overhaul processes for commissioning, accountability and provision. *By 2016 Cancer Alliances should be established across the country bringing together key partners at a sub-regional level, including commissioners, providers and patients.*

3.2 NHS planning guidance for 2016/17-2020/21 asks every health and care system to create a Sustainability and Transformation Plan (STP) to accelerate implementation of the Forward View. STPs will cover the period between October 2016 and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016.

3.3 Delivering the recommendations of the Independent Cancer Taskforce has been identified as one of the national challenges that systems should seek to take forward through their Sustainability and Transformation Programme. This identifies two key goals to be achieved by 2020:

- To significantly improve one-year survival to achieve 75% by 2020 for all cancers combined (up from 69% currently)

- Patients given a definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP

3.4 From April 2015 one-year cancer survival rates by CCG will be included in the Delivery Dashboard of the NHS' Assurance Framework – the only disease-specific outcome measure to be included in the dashboard.

## 4. Work to date

**BHR Cancer Collaborative Commissioning Group**

4.1 The BHR Cancer Collaborative Commissioning Group was set up in 2013 to take a whole system strategic approach to securing improvements in cancer focusing primarily on the early diagnosis and detection of cancer. The Group is chaired by the LBBD Director of Public Health and has clinical and officer representation from the Barking and Dagenham, Havering and Redbridge CCGs, BHRUT, and the London Cancer Transformation Team.

4.2 The group has agreed a joint programme of work across health and social care to improve prevention, routes to diagnosis and one-year survival rates for the population of BHR CCGs. The programme focuses on three areas for improvement:

- To increase the uptake of the national bowel cancer screening programme –to enable earlier diagnosis / diagnosis of early stage disease

- To improve awareness of signs and symptoms of cancer in those from lower socio-economic status groups, men, those who are younger and those from ethnic minorities. – to deliver improvements against the (National Cancer Equalities Initiative) Cancer Awareness Measure (CAM) and increase rates of early stage diagnosis

- To improve safety-netting in order to reduce the number of patients diagnosed via A&E to lower than the national average & increase appropriate 2WW referrals in line with new NICE guidelines (2015) – this is expected to bring diagnosis via emergency route in line with England average and increase early stage diagnosis

4.3 The programme is supported by two specialist GPs funded by McMillan (McMillan GPs) who work with a Cancer UK Facilitator to improve cancer outcomes by engaging with and supporting primary care locally. This includes:

- Visiting all practices in Barking and Dagenham with their most up to date cancer data
- Raising awareness of the importance of early diagnosis in primary care and tools available to support this
- Encouraging practices to adopt actions to support early diagnosis

4.4 So far the team have completed 23 visits out of 39 practices – with an initial focus on practices which appeared to be outliers. All practices visited have agreed to an action plan for improvement with a particular focus on increasing screening uptake and audit work, which will be followed up through the facilitator. Baseline data will be available shortly to measure progress in primary care and the impact of the programme of work.

4.5 There have been a number of educational events lead by the Macmillan GPs and they have also been instrumental in devising and getting agreement to a cancer local incentive scheme which supports work done to date engaging in practices. This is due to be launched in January 2016. The GP leads and the facilitator play a key role in the BHR collaborative working and individual task and finish groups.

**Barking and Dagenham Health and Wellbeing Strategy**

4.6 The Health and Wellbeing Strategy includes a number of actions that will support a reduction in cancer incidence including:

- A percentage reduction in smoking prevalence over the three year period from 2009/10 baseline by 2018

- An increase in the number of adults participating in regular physical activity by 2018

- A percentage reduction in prevalence of adult obesity from baseline by 2018

**Transforming cancer services programme**

4.7 The Transforming cancer services programme was set up in April 2014 to address issues surrounding the quality and effectiveness of early diagnosis and awareness of cancer, treatment and outcomes. During 2015/16 the programme has delivered against the 5 priority areas set out in its plan for 15/16:

- Early detection and awareness
- Reducing variation in outcomes and service consolidation to deliver centres of excellence
- Living with and beyond cancer
- Supporting commissioning including contract negotiation, management and monitoring
- Improving patient experience across hospitals, general practice and the community

4.8 Priorities for 16/17 have been reviewed to take into account the report of the Independent Cancer Taskforce:

- Return cancer waiting times to target and sustain performance; undertake a diagnostics demand and capacity review
- Address primary care variation
- Commission improvements for the colorectal pathway
- Commission improvements for the prostate cancer pathway
- Commission improvements for the lung cancer pathway

**Cancer vanguard**

4.9 The Royal Marsden, Manchester Cancer and UCLH (Cancer) accountable clinical network was approved as a national cancer vanguard site in September 2015. The vanguard is an acute care collaboration that aims to link local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency. The vanguard site will take a lead on the development of new care models which will act as the blueprints for the NHS moving forward and in London covers the North East, North West and North Central sectors.

4.10 The aim of the cancer vanguard is to close the health and wellbeing, care and quality gaps through three strands of work:

**By transforming the clinical model of delivery** – to develop the capacity and capability of the workforce to deliver screening and diagnostics earlier in the patient journey thereby reducing the need for costly specialist treatment at the later stages of disease; deliver replicable evidence based practice across the pathway – from prevention, through to living with and beyond cancer and end of life care

**By changing the system architecture** – development of new financial models that incentivise the system to improve and governance arrangements that drive good performance; enhanced cancer alliances to ensure collaborative accountability for delivery across the sector that has the patient voice.

**By enabling infrastructure** – benchmarking and sharing performance information, at organisation and multi-disciplinary team level, to drive best practice decision making; workforce development and developing IT solutions that support shared care.

## 5. Discussion

5.1 A new approach to delivering transformational change in cancer outcomes will be required to deliver the 2020 ambition of the national cancer strategy. The Health and Wellbeing Board has a key role to play in developing a shared vision for transformation and in engaging with the local population on the prevention and early detection of cancer.

5.2 The Board is asked to consider the following questions:

i. How can we reduce the growth in the number of cancer cases?

ii. How can we best engage the community to support the prevention agenda?

iii. What are the key areas B&D need to focus on to deliver the 2020 ambition?

Further information will be circulated prior to the meeting and a presentation will be made at the meeting itself to better inform discussion of the above questions.

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# HEALTH AND WELLBEING BOARD

## 26 January 2016

| **Title:** | **Improving Post – Acute Stroke Care (Stroke Rehabilitation) Consultation** |
|---|---|

**Report of the Barking and Dagenham CCG**

| | |
|---|---|
| **Open Report** | **For Decision** |
| **Wards Affected:**<br>All wards | **Key Decision:** No |
| **Report Author:**<br>Sharon Morrow, Chief Operating Officer<br>Barking and Dagenham CCG | **Contact Details:**<br>Tel: 0203 6442370<br>E-mail:<br>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.

In November 2014 the Clinical Commissioning Groups (CCG) of Barking and Dagenham, Havering and Redbridge (BHR) identified a gap in the provision of stroke rehabilitation services and created the BHR Stroke Transformation Project Team. In June 2015, a Case for Service Change was accepted by the Governing Body of each CCG.

An options scoring process was conducted through a stakeholder workshop and a subsequent affordability assessment in October 2015 identified a preferred model of care

In November the CCG Governing Body agreed a pre consultation business case for Improving Post – Acute Stroke Care (Stroke Rehabilitation).

This has formed the basis of the proposed changes to stroke rehabilitation consultation.

**Recommendation(s)**

The Health and Wellbeing Board is recommended to respond to the stroke rehabilitation consultation.

**Reason(s)**
The CCG want to make stroke rehabilitation services more joined up with each other and focused on what individual people need, regardless of where they live.

## 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 November 2014 the Clinical Commissioning Groups (CCG) of Barking and Dagenham, Havering and Redbridge (BHR) identified a gap in the provision of stroke rehabilitation services and created the BHR Stroke Transformation Project Team. In June 2015, a Case for Service Change was accepted by the Governing Body of each CCG.

The Case for Service Change found that:

In the year 2014-2015, 967 patients suffered a stroke in BHR. With advancements in treatment and improved stroke survival, the demand for stroke rehabilitation services is anticipated to grow by 35% in the next 20 years.

The current model of stroke rehabilitation services in BHR is disjointed and inequitable. The service provision between the three boroughs has become a ‘postcode lottery’ for stroke survivors.

With the anticipated growth in demand, the current clinical model is unable to efficiently support patients to achieve best clinical outcomes in the post-acute stroke care phase. To continue to ‘do nothing’ will result in inadequate provision of stroke rehabilitation services for future stroke patients.

## 2. Proposal and Issues

2.1 Cumulative evidence has proven that rehabilitation at home provided by an Early Supported Discharge (ESD) service 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. NICE clinical guidance recommends that 40% of all stroke rehabilitation should be delivered through ESD. This would result in an increase from the current delivery of 20% ESD across BHR.

2.2 While the primary aim of the project was to review the provision of stroke rehabilitation services in the community, the project team identified that these could not be reviewed in isolation of inpatient rehabilitation services. The project team took this opportunity to review the model and location of all stroke rehabilitation services. BHR CCGs in partnership with key stakeholders developed

a list of options in response to the challenges raised in the Case for Service Change.

2.3 An options scoring process was conducted through a stakeholder workshop and a subsequent affordability assessment in October 2015 identified a preferred model of care that includes the following features:

- Shift towards more rehabilitation provided at home
- Streamline the ESD service with one provider
- Extend ESD provision to the whole of Redbridge
- Enhancing community service to provide high quality specialist stroke multi- disciplinary teams
- All patients will receive up to 6 weeks of ESD based on need
- Common service provider with common standards covering all of BHR
- Combine the provision of Early Supported Discharge and Community Rehabilitation Services across BHR.
- Inpatient stroke rehabilitation services to be located at King George Hospital with access through a single set of criteria

The key Benefits of a combined ESD and CRS service covering all of Barking and Dagenham, Havering and Redbridge are

- All patients will receive the same quality of care regardless of where they live or which hospital they have been in;
- All people in BHR that are eligible for ESD will receive the rehabilitation and support they need in their homes;
- Reduced length of stay in hospital;
- Each team will have the right number of staff with the right specialist skills to (include. equal access to speech and language therapy and psychology);
- Carers benefit from less travelling between sites and have a single point of contact throughout the whole pathway;
- The pathway for stroke services is strengthened, as it becomes less complicated and there is a single set of criteria against which to assess patients across BHR.
- Opportunity to redesign stroke rehabilitation services to meet the needs of growing demand
- Meets national best practice standards

The key benefits associated with a single stroke inpatient rehabilitation services located at King George Hospital in Ilford are

- All inpatient services are consolidated onto one site so it is easier to ensure quality care is being delivered;
- All patients will access inpatients through a single set of access criteria, and quality of inpatient care provided will be standardised;
- Patients have immediate access to 24 medical support which stops the need to transfer patients to out of hours emergencies services;
- Investigations able to take place on one site e.g. dopplers, CT, MRI etc. improving care for patients and providing quicker results;
- Better provision of transport access to hospital site for family and carers to visit patients
- Relatively accessible for populations from all three Boroughs

- There will be improved relationships and communication between acute and community services. It will be easier for the ESD team to liaise with the hospital and assess patients' needs through in-reach

## 3. Consultation

3.1 Barking and Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Groups (CCGs) have launched a consultation on proposed changes to local stroke rehabilitation services. The 12-week consultation runs until 5pm on Friday, 1 April 2016

3.2 The consultation approach includes meeting with community and voluntary groups to discuss the proposals. There is a dedicated webpage for people to give feedback on the consultation and an easy read version has been produced.

.

## 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.

http://www.barkinganddagenhamjsna.org.uk/Pages/jsnahome.aspx

### 4.2 Health and Wellbeing Strategy

The consultation proposes 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.

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

### 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.

http://moderngov.lbbd.gov.uk/documents/s81377/18b%20-%20Strategy%20Template_Master_final.pdf

**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 business case identifies the following benefits associated with the proposals that will have a positive impact on for patients and service users:

- A more streamlined pathway with a reduction in the number of transfers between providers.
- Access to the best care is improved. All people that are eligible for ESD will receive the rehabilitation and support they need in their homes
- More people will receive their care at home. Evidence shows that people who receive care at home are able to live more independently than those who have had all of their rehabilitation in hospital.
- The length of stay in hospital is reduced which means better outcomes for patients
- A better quality of service provision for patients with equity of access across all three boroughs.
- Patients will receive the same quality of care regardless of where they live or which hospital they have been in. Each team will have the right number of staff with the right specialist skills to deliver rehabilitation at home. This includes equal access to speech and language therapy and psychology.
- There are benefits for carers too, as there will be less travelling required and the carer will liaise with a single team throughout each phase of the rehabilitation; so less duplication.
- Service provision can be based on patient need rather than prescribed only by time

The only negative impact highlighted in the workshop held to assess the options related to travel times to the inpatient unit at King George Hospital if beds transfer from Grays Court. The impact would be on families and other visitors travelling from Barking and Dagenham and the south of Havering.

## 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

**Appendix B-** Improving Stroke Rehabilitation Services across Barking & Dagenham, Havering and Redbridge: Pre – Consultation Business Case

NHS

Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

# Improving Stroke Rehabilitation Services across Barking & Dagenham, Havering and Redbridge

## Pre – Consultation Business Case

# Contents

# 1 Executive Summary

The purpose of the pre consultation business case is to:

- Provide evidence of the case for service change including service performance and public/patient engagement to date.
- Propose the need for consultation on the future model of post–acute phase stroke rehabilitation services.
- Provide detail of the options appraisal and the identified preferred option of CCGs and stakeholders.

In November 2014 the Clinical Commissioning Groups (CCG) of Barking and Dagenham, Havering and Redbridge (BHR) identified a gap in the provision of stroke rehabilitation services and established the BHR Stroke Transformation Project. In June 2015, a Case for Service Change (CfSC) was approved by all BHR Governing Bodies.

The Case for Service Change found that:

- In the year 2014-2015, 967 patients suffered a stroke in BHR. With advancements in treatment and improved stroke survival, the demand for stroke rehabilitation services is anticipated to grow by 35% in the next 20 years.
- The current model of stroke rehabilitation services in BHR is disjointed and inequitable. The service provision between the three boroughs has become a 'postcode lottery' for stroke survivors.
- With the anticipated growth in demand, the current clinical model is unable to efficiently support patients to achieve best clinical outcomes in the post-acute stroke care phase. To continue to 'do nothing' will result in inadequate provision of stroke rehabilitation services for future stroke patients.

Cumulative evidence has proven that rehabilitation at home provided by an Early Supported Discharge (ESD) service 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. National Institute for Health and Care Excellence (NICE) clinical guidance recommends that 40% of all stroke rehabilitation should be delivered through ESD. This would result in an increase from the current delivery of 20% ESD across BHR.

While the primary aim of the project was to review the provision of stroke rehabilitation services in the community, the project team identified that these could not be reviewed in isolation of inpatient rehabilitation services. The project team took this opportunity to review the model and location of all stroke rehabilitation services.

Following the approval of the CfSC, BHR CCGs in partnership with key stakeholders developed a list of options in response to the challenges raised. An options scoring process was conducted through a stakeholder workshop and a subsequent affordability assessment in October 2015 which identified a preferred model of care that includes the following features:

- **A shift towards more rehabilitation provided at home**
- **Streamlining the ESD service with one provider**
- **Extending ESD provision to the whole of Redbridge**
- **Enhancing community service to provide high quality specialist stroke multi-disciplinary teams**
- **All patients will receive up to 6 weeks of ESD based on need**
- **Common service provider with common standards covering all of BHR**

- **Combining the provision of Early Supported Discharge and Community Rehabilitation Services across BHR.**
- **Inpatient stroke rehabilitation services to be located at King George Hospital with access through a single set of criteria**

**The Governing Body is now asked to;**

1 Endorse the recommendation of the preferred option;

2 To formally consult on proposals to change the delivery of stroke rehabilitation services;

3 To note that subject to the agreement of point 1 and 2, the consultation will launch the week commencing 4 January 2016 for 12 weeks;

4 To note the intention for the Governing Body to receive a Decision Making Business Case in June 2016.

# 2 Background

## 2.1 Description of stroke

Stroke is a brain attack when supply of blood to the brain is cut off. The impact of a stroke is both instant and unpredictable. Risk factors include age, smoking, high blood pressure, diabetes, high cholesterol, ethnicity and atrial fibrillation (irregular heart rate) [1].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. Since the 1960's advancements in stroke care means more people are surviving each year.

A stroke can occur in a variety of areas of the brain, consequently 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] The table below 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[1].

| Difficulty | % of people affected |
|---|---|
| Upper limp/arm weakness | 77% |
| Lower limb/leg weakness | 72% |
| Visual problems | 60% |
| Facial weakness | 54% |
| Slurred speech | 50% |
| Bladder control | 50% |
| Swallowing | 45% |
| Aphasia | 33% |
| Sensory loss | 33% |
| Depression | 33% |
| Bowel control | 33% |
| Inattention/neglect | 28% |
| Emotionalism within 6 months | 20% |
| Reduced consciousness | 19% |
| Emotionalism post-6 months | 10% |
| Identified dementia one-year post stroke | 7% |

**Key Statistics** [1]

- Stroke occurs approximately 152,000 times a year in the UK; that is one every 3 minutes 27 seconds.
- First-time incidence of stroke occurs almost 17 million times a year worldwide; one every two seconds.
- Stroke is the largest cause of complex disability – half of all stroke survivors have a disability.
- Over a third of stroke survivors in the UK are dependent on others, of those 1 in 5 are cared for by family and/or friends.
- For every cancer patient living in the UK, £241 is spent each year on medical research, compared with just £48 a year for every stroke patient
- There are around 1.2 million stroke survivors in the UK.

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

## 2.2 Stroke care services

Treatment of people who have had a stroke is split in to two distinct phases;

i. Acute stoke care
ii. Stroke Rehabilitation (also referred to as post – acute stroke care)

### Acute stroke services

The acute phase of stroke care focuses on providing the patient life-saving treatment and then stabilising the patient's condition sufficient enough so that they are ready for rehabilitation. The acute phase initially takes place in a Hyper-Acute Stroke Unit (HASU) which 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[3]. Most patients are then transferred to an Acute Stroke Unit (SU) after one or two days of intensive treatment. SUs, provide multi-therapy (physiotherapy, occupational therapy, speech and language therapy) rehabilitation and ongoing medical supervision.

The introduction of HASUs and ASUs as the primary access point into the stroke pathway has taken place over the last five years and has significantly improved the survival rates for people having a stroke.

Most residents in Barking & Dagenham, Redbridge and Havering will receive their acute care in the HASU and ASU located at Queen's Hospital in Romford, although there are small numbers of patients being treated in the HASU at the Royal London Hospital and the ASU at Whipps Cross Hospital.

However this pre consultation business case specifically focusses on stroke rehabilitation services.

### Stroke rehabilitation services

People who have survived their initial stroke and stabilised are either transferred from the HASU, or the SU to community stroke rehabilitation services. The aim of stroke rehabilitation is to support the stroke survivor to overcome and adapt to their physical, mental and social complications which have been adversely affected by stroke.

The range of difficulties experienced by patients after a stroke means that rehabilitation support needs to be provided by a multi-disciplinary team of healthcare professionals that should include:

- Physiotherapists
- Occupational therapists
- Speech and language therapists
- Rehabilitation support workers
- Nurses
- Doctors
- Psychologists

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

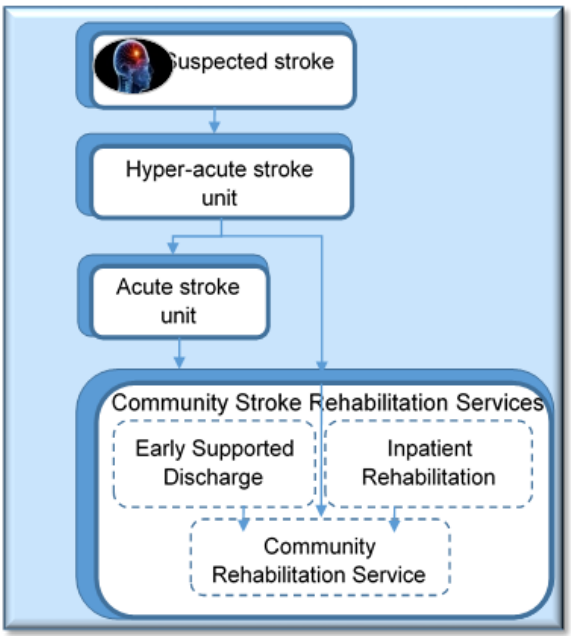
There are three types of stroke rehabilitation services:

| Service Type or Function | Description |
|---|---|
| **Early Supported Discharge (ESD)** | • Aimed to provide patients with rehabilitation at home at the same intensity of inpatient care.<br>• Designed to improve transfer of care arrangements, offer patient choice, deliver efficiencies in acute bed usage and deliver improved clinical and wellbeing outcomes.<br>• 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. |
| **Community Rehabilitation Services (CRS)** | • Patients who are ready for discharge but deemed unsuitable for ESD are often referred to a CRS.<br>• Provides needs - led rehabilitation within the home environment to maximise functional ability and independence and facilitate reintegration in the community.<br>• The community rehab team is multi-disciplinary and assesses the stroke survivor's needs (where possible with family and/or carers) and develops a treatment programme with the stroke survivor |
| **Inpatient Rehabilitation (IR)** | • Patients who require further non-acute care after their condition has stabilised are treated in specialist stroke rehabilitation units.<br>• 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.'<br>• Delivered by a multi-disciplinary team.<br>• 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. |

A patient's journey through the stroke pathway will vary according to the nature and severity of their individual needs. Some patients will respond well to ESD and should be discharged from hospital early to have their intensive care at home. Other patients will have greater levels of need and may need to receive rehabilitation care in hospital for longer.

The core principle that should be applied is that access to all stroke rehabilitation services should be based on patient needs assessment and not on the availability of services in each area.

The diagram below illustrate the simple patient pathway for stroke care:



# 3 The BHR stroke pathway transformation project

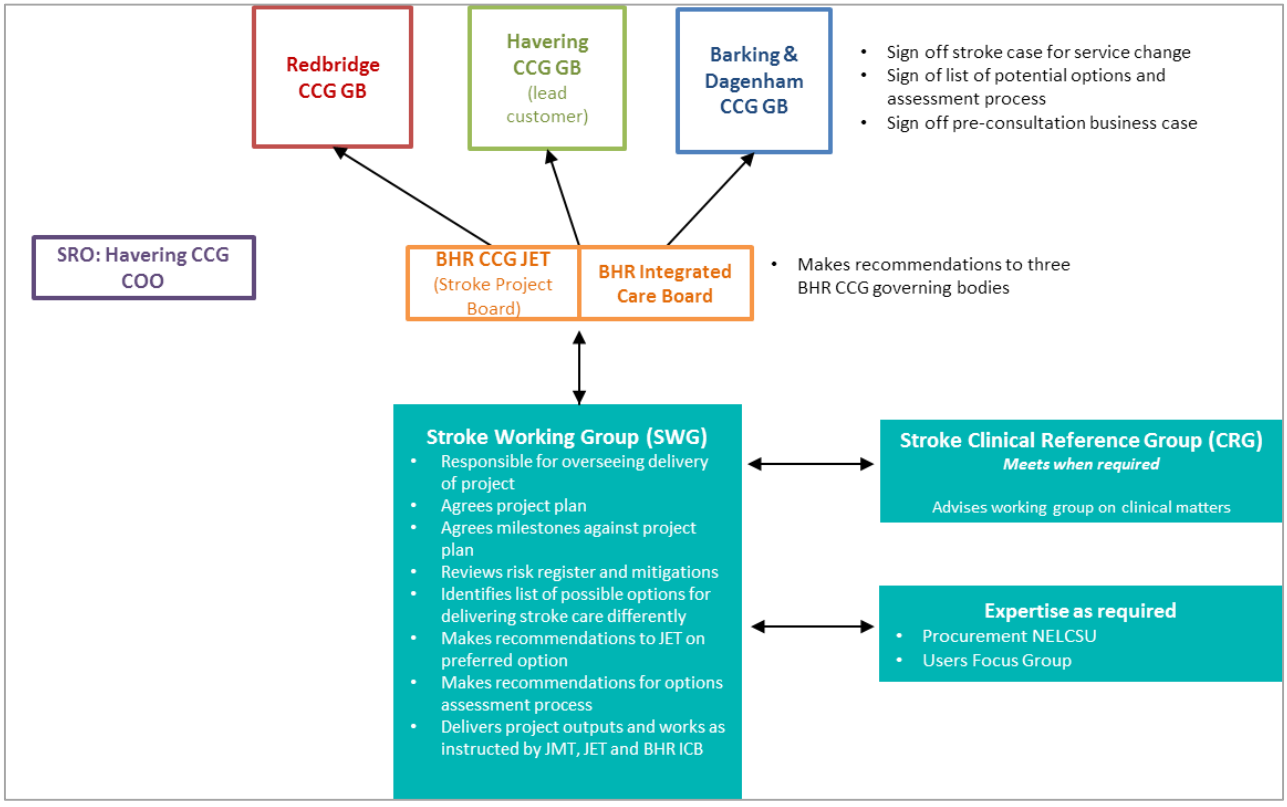
The BHR SPT project was established in 2014 following recognition that patients who needed stroke rehabilitation services were enduring a 'postcode lottery' depending on where they lived and as a result people who have had a stroke were not achieving the best possible outcomes.

The purpose of the project was to:

- Review access to each of the elements stroke patient rehabilitation services
- Review delivery of stroke patient rehabilitation services
- 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
- Identify the best model for stroke rehabilitation locally that ensures that 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.

## 3.1 Governance of the stroke project

The diagram below illustrates the governance structure adopted by BHR CCGs to oversee the project:




## 3.2 Project progress to date

### Collecting and reviewing evidence: November 2014 – June 2015

The first task for the project was to collect evidence about good practice for stroke services and the range of services available to the residents of BHR. In particularly:

- What services were available
- How patients accessed those services
- How the services interacted with each other

- How services compared to models of best practice
- Where services needed to be different

This culminated in the presentation of a Case for Services Change (CfSC) that was presented to the Governing Bodies of BHR CCGs in June/July 2015. The findings of the CfSC are considered in section 4 below. In summary the CfSC identified that although all three types of community stroke rehabilitation exist within BHR, there is:

- Variation and inequity in provision of and access to services
- Variation in quality in comparison to best practice
- An unnecessarily complex configuration of services that has led to a confused patient pathway and service inefficiencies
- A lack of information about costs, patient numbers and outcomes.

The variation in service configuration and quality and the lack of information is impacting on patient outcomes.

### Considering options for improving services: July 2015 – November 2015

The project went on to consider the areas where services should be improved. In September 2015 the CCG Governing bodies agreed a shortlist of options for changing the configuration of services and a process for agreeing the preferred option.

In October 2015 these options were critically assessed by a selected group and a preferred option was selected. Based on the conclusions of this assessment this business case has been prepared.

The options and the assessment process are described in section 5 and 6.

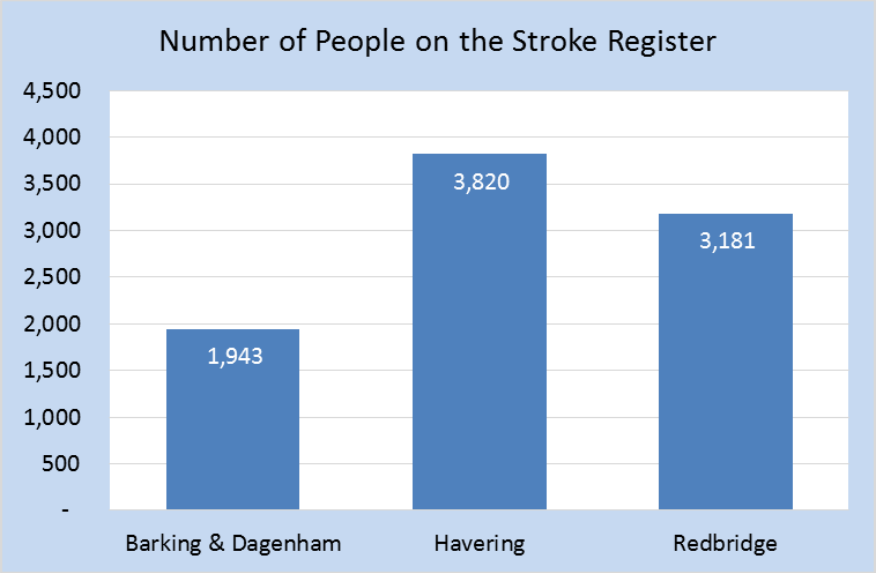
# 4 The case for changing stroke rehabilitation services in BHR

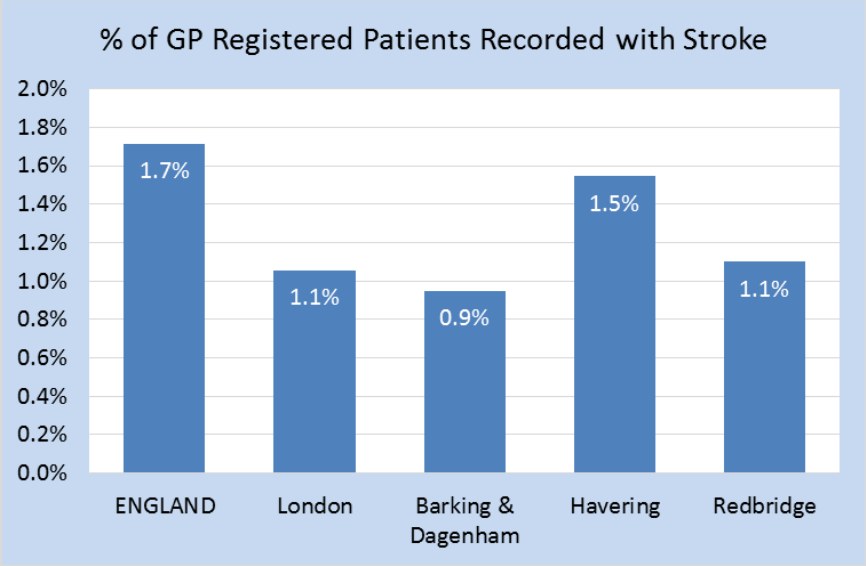
This section brings together the national and local context to set out why changing the way that post-acute stroke care is commissioned and delivered across BHR will improve the outcomes for people living with the effects of stroke.

## 4.1 The local picture for stroke in Barking and Dagenham, Havering and Redbridge [4]

In 2013-14 there were 8,944 people registered as having had a stroke in BHR. The highest number of patients are in Havering, which is to be expected given the age profile of the population.

Age is the primary determinant of stroke in the population. 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.




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

## Numbers of stroke patients BHR[5]

Figures in the table below demonstrate the number of people who had a stroke in 2014-15 and were taken to one of the London HASUs, and the number of those who went on to be treated by one of the ESD teams.

| Borough | Stroke Numbers 2014-15 | ESD Numbers 2014-15 |
|---|---|---|
| **Havering** | 408 | 82 (20%) |
| **Barking & Dagenham** | 263 | 53 (19%) |
| **Redbridge** | 296 | 59 (23%) |
| **Total** | 967 | 194 (20%) |

## Future demand for stroke care

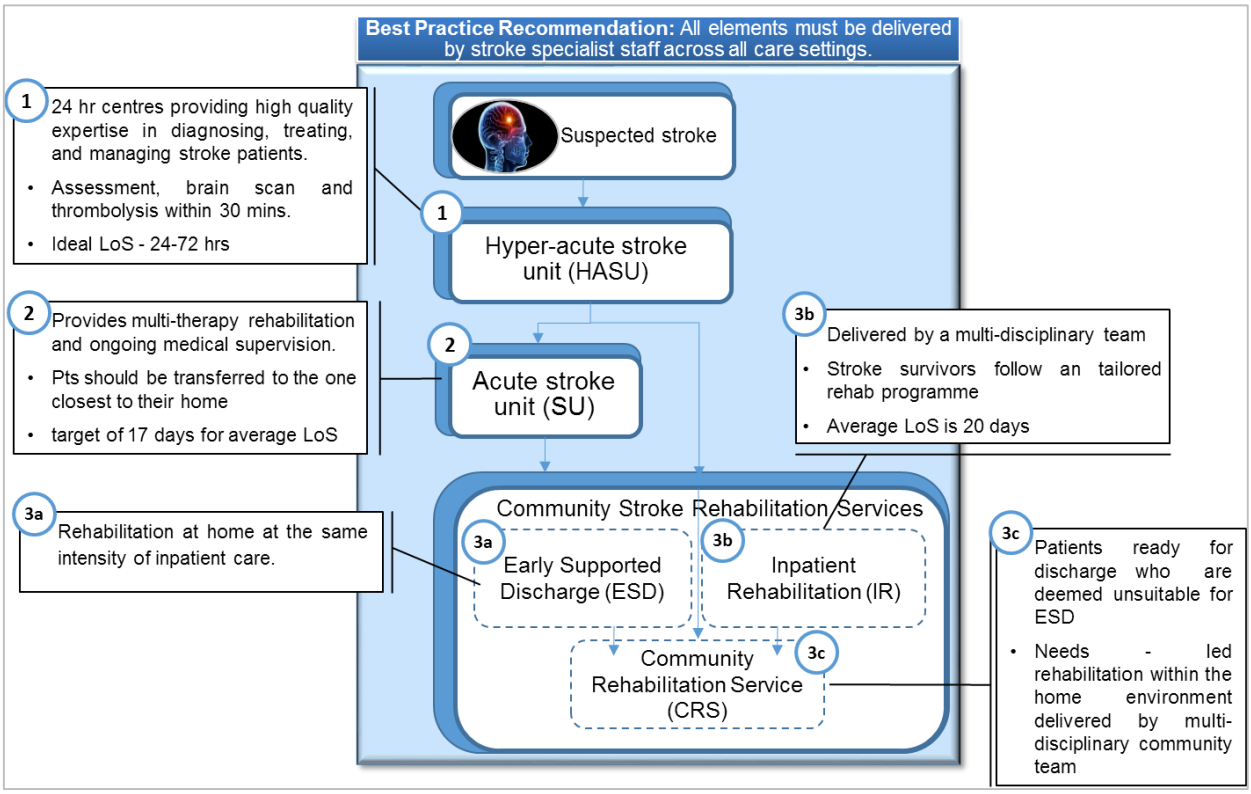
The numbers of people having strokes in the area will increase over the next twenty years as the population grows older. In the twenty years from 2011 to 2031 it is expected that the numbers of people aged 65 or more will increase by 38% and the number of people aged 85 or more will increase by 47%. The highest increase will be in Havering.

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.

[5] SSNAP (Sentinel Stroke National Audit Programme) 2014

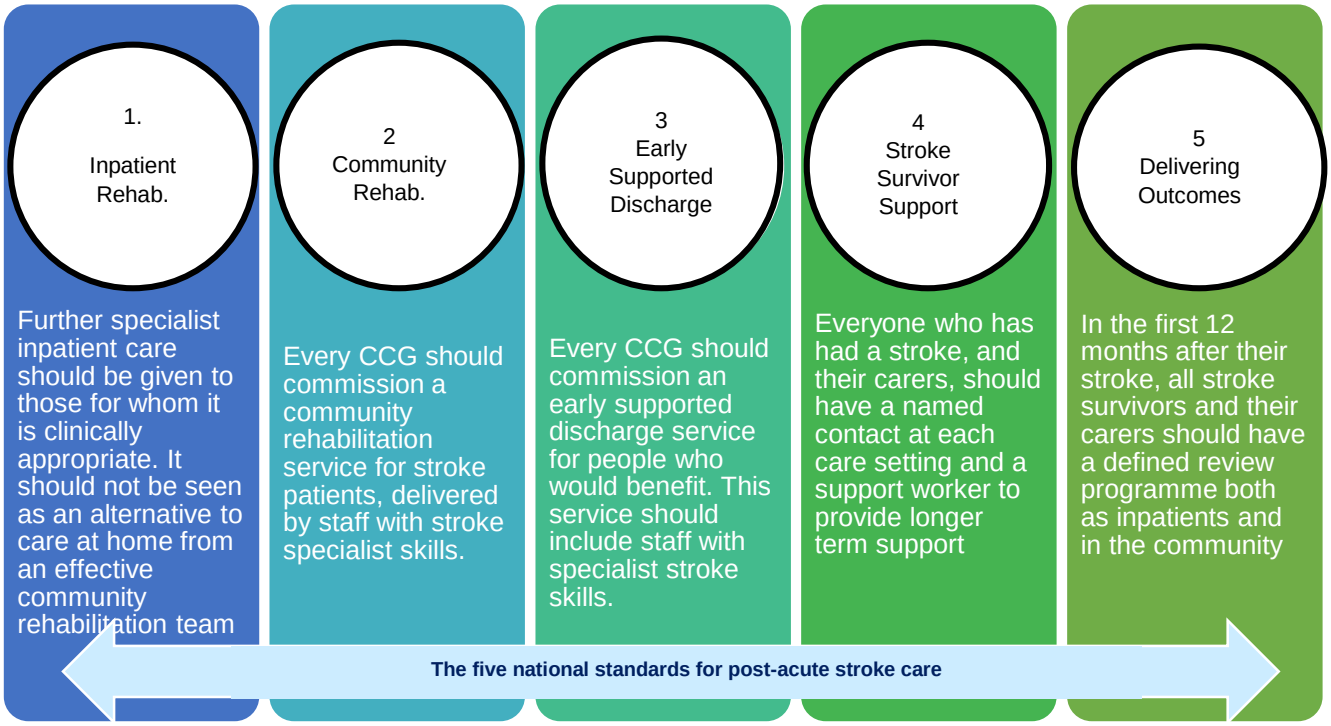
## 4.2 Best practice stroke care

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. 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 to achieve the best possible outcomes for patients (figure below).




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.

The figure below 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 twelve monthly reviews for people living with the effects of stroke in their communities.




Based on national good practice, each CCG should ensure people living with the effects of stroke have adequate access to all three types of post-acute stroke care, or stroke rehabilitation. 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.

## Benefits of Early Supported Discharge

*"Patients who receive Early Supported Discharge services will return home earlier and are more likely to remain in the home long term and regain independence in daily activities"*

Early rehabilitation is effective when provided as part of an Early Supported Discharge (ESD) service. Evidence shows improved clinical and well-being outcomes after 6 months and 1 year as well as reduced costs through shorter hospital stays[6]:

- ✓ 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[7].
- ✓ 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[8].
- ✓ 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

[6] National Audit Office (2010) Progress on improving stroke care; a good practice guide
[7] DH (2007) National Stroke Strategy
[8] Langhorne (2005) Early supported discharge services for stroke patients: a meta-analysis of individual patients' data

seven days and were more likely to remain at home in the long term and to regain independence in daily activities [9].

✓ 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[10].

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[11].

**Case study: Good Practice of ESD Provision**
**Camden stroke reach early discharge service (REDS)** [10]

**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

## National Quality Standards

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

[9] Cochrane (2012) Services for reducing duration of hospital care for acute stroke patients (Review)
[10] NICE (2010) Management of patients with stroke:REDS (Reach Early Discharge Scheme)
[11] Skrypak et al (2012) Why early discharge in stroke care can be vital for recovery in HSJ.

- 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.

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 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 The current stroke patient pathway in BHR

The current service provision of stroke rehabilitation services in BHR is a 'postcode lottery' whereby access to stroke rehabilitation services depends on geography. Appendix A shows a diagram of the current patient pathway and depicts the complexity of current stroke rehabilitation service provision.

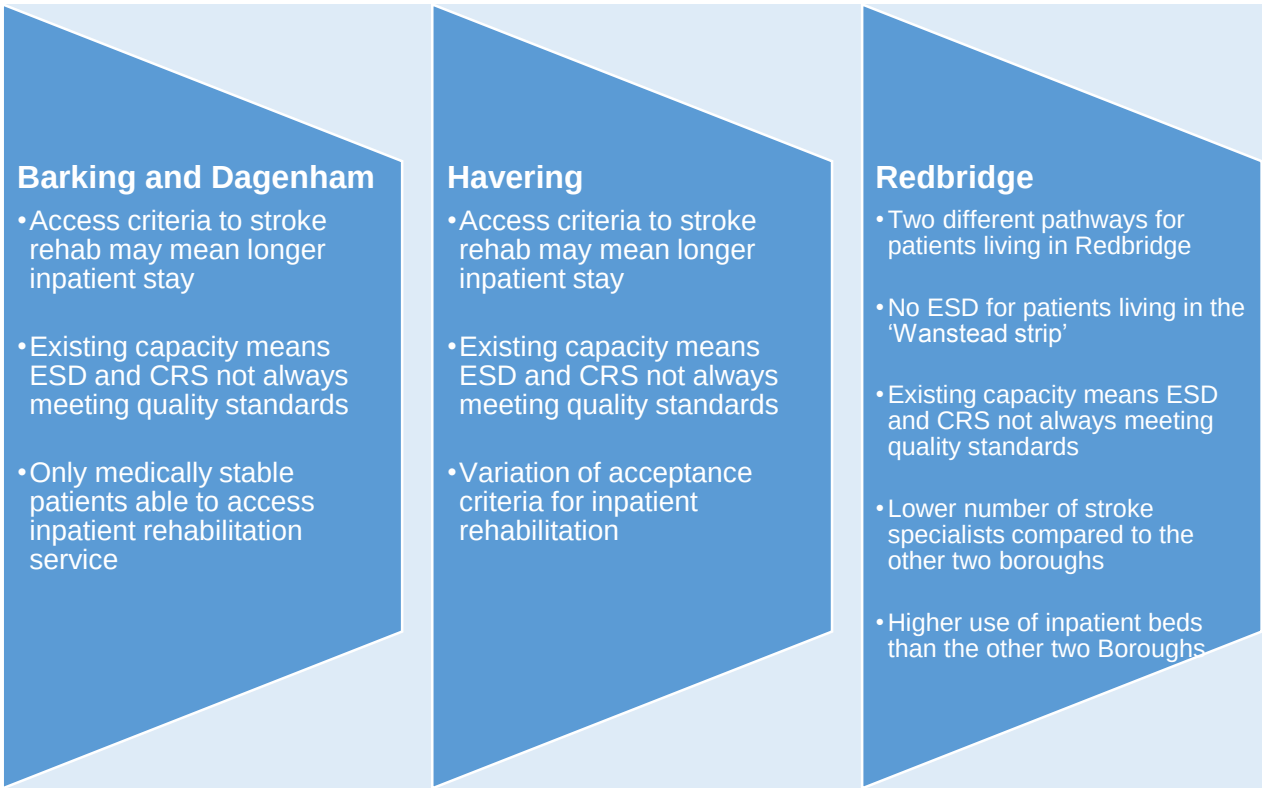
The key shortfalls this illustrates are:

- Whilst there is ESD available for most stroke survivors in BHR this is split between two different providers. The first two weeks of ESD is provided by Barking Havering and Redbridge University Hospitals Trust (BHRUT). For patients living in Barking & Dagenham and Havering, there is then a handover to the ESD service provided by North East London Foundation Trust (NELFT).
- The ESD service provided by BHRUT does not extend to the West of Redbridge so people in the "Wanstead Strip" have no access to ESD.
- For patients in the rest of Redbridge there is no ESD service after the first two weeks offered by BHRUT.
- The NELFT ESD service is not comprehensive; in particular Speech and Language Therapy (SALT) and Psychology are not provided by the ESD team and patients requiring these services either have to remain in an inpatient bed or wait for this therapy.
- There are two providers of inpatient rehabilitation; the service at King George Hospital (BHRUT) is predominately used by residents of Redbridge, the service provided at Grays Court (NELFT) is predominately used by residents of Barking & Dagenham and Havering. The range of services provided by the two providers varies.
- CRS is provided by three separate teams in each Borough with variations in the provision in each team.

Appendix B details the journey of four different patients, with same therapy needs, but living in different parts of BHR. Each receive a very different experience and as a consequence are likely to receive a different quality of life. The stroke rehabilitation pathway is dependent on each patient's home address. This variation does not provide equal access for all stroke survivors needing rehabilitation services.

Appendix C details the experience of patients with a slightly higher level of need who would be suitable for ESD but currently would not have access to it.

The following table describes some of the key variations of the provision of stroke services in the three boroughs.




### Inpatient Bed Utilisation

An analysis of the bed utilisation for NELFT has shown that there is significant fluctuation at Grays Court in the use of inpatient stroke rehabilitation services from month to month. There are currently 17 stroke rehabilitation beds at Grays Court. Average occupancy of these beds for the year April 2014 to March 2015 was 56.6% although this varied from 24.5% to 83.3%. 97.4% of admissions to Grays Court are from Queens Hospital and almost of all are residents of Barking & Dagenham or Havering. Bed occupancy rates for Beech Ward (King George Hospital) is unknown. However centralising the inpatient unit will extend the catchment area to three boroughs and this should balance out some of the demand fluctuation.

## 4.4 Commissioning for quality

The table below provides a benchmark of the post-acute stroke services in BHR against the Royal College of Physicians guideline for Stroke.

| Quality Standard/s | Is this standard being met? | | |
|---|---|---|---|
| | H | R | B&D |
| Minimum of 45 mins. of active therapy for 5 days per week | No | No | No |
| Progress measured against goals set at regular intervals determined by their rate of change | No | No | No |

| | | | |
|---|---|---|---|
| Regular reassessment and management for people living with the effects of stroke | Yes | No | No |
| Patients who wish to return to work should be referred to a disability employment advisor or vocational rehabilitation team | No | No | No |
| Assessment by a clinical psychologist of social interaction is causing stress | No | No | No |
| 6 and 12 monthly reviews of health and social care needs | Yes | No | No |
| Appropriate stroke specialist services and generic voluntary services and peer support are available | Yes | Yes | No |
| Assessment and treatment from stroke rehabilitation services are delivered in the same way as patients living in their own homes | Yes | No | Yes |

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.

## 4.5 Commissioning for outcomes

Whilst acute stroke providers are systematically using the Sentinel Stroke Audit Programme (SSNAP) to record nationally recognised outcomes for stroke, 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 requiring the Trusts to use the nationally recognised SSNAP database for recording information on post-acute stroke care.

A review of the contracts and service specifications of those providers commissioned to provide both acute and post-acute stroke care was undertaken alongside discussions with clinicians to understand:

- Whether they used nationally recommended outcome measure such as the modified Rankin Scale (mRS);
- 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<br>Barts Health | ✓ Morality Rates<br>✓ mRS |
| **Stroke Rehabilitation** | In-Patient | Grays Court (NELFT) | ✓ mRS |
| | | BHRUT | ✓ mRS |
| | Early Supported Discharge | BHRUT | ✓ mRS |
| | | NELFT | ✓ mRS |
| | Community Rehabilitation Service | NELFT | ✓ mRS |

| | | | |
|---|---|---|---|
| **Stroke Survivorship Support** | 6 / 12 monthly reviews | Stroke Association | ✗ |
| | | Carers Trust | ✓ mRS |

Availability of data on stroke-specific key performance indicators (KPI's) both within services and across the stroke pathway is sparse. The focus is generally on measuring process measures (such as 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.

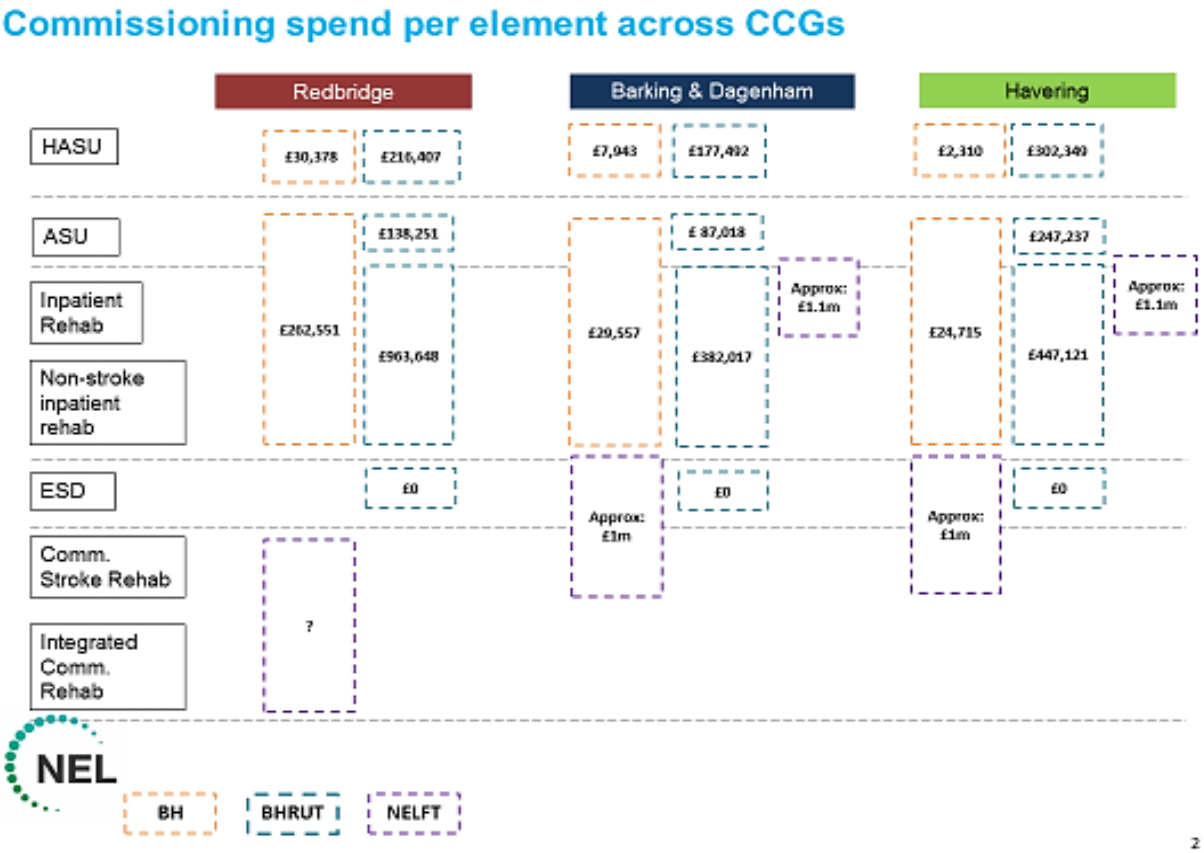
Whilst some individual stroke service providers, such as BHRUT and Barts Health meet monthly to discuss their stroke service improvement plans, there is currently no formal meeting or forum where outcomes being achieved can be presented across the entire pathway; something that local stroke physicians 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 service change in relation to developing and agreeing a number key patient outcomes the BHR CCGs may wish to measure in the future.

## 4.6 Commissioning for value

The different contracting and reporting arrangements across the number of different types of providers means 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 diagram below articulates the existing contracting information as understood by BHR CCGs:




**Existing contracting information understood by the BHR CCGs in relation to spend**

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

- Barts Health, which provides an inpatient service to some Redbridge patients from Whipps Cross Hospital, does not differentiate in its charges between ASU and inpatient rehabilitation;
- BHRUT does not differentiate between inpatient stroke rehabilitation and rehabilitation for other conditions. The basis of the charge is by an individual patient tariff. 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 commissioner, nor does it differentiate between the cost of ESD and the rest of the community stroke rehabilitation team.

Commissioners do not know whether the existing resources going into stroke care represents the best way to achieve the best outcomes for patients.

## 5 List of Potential Options

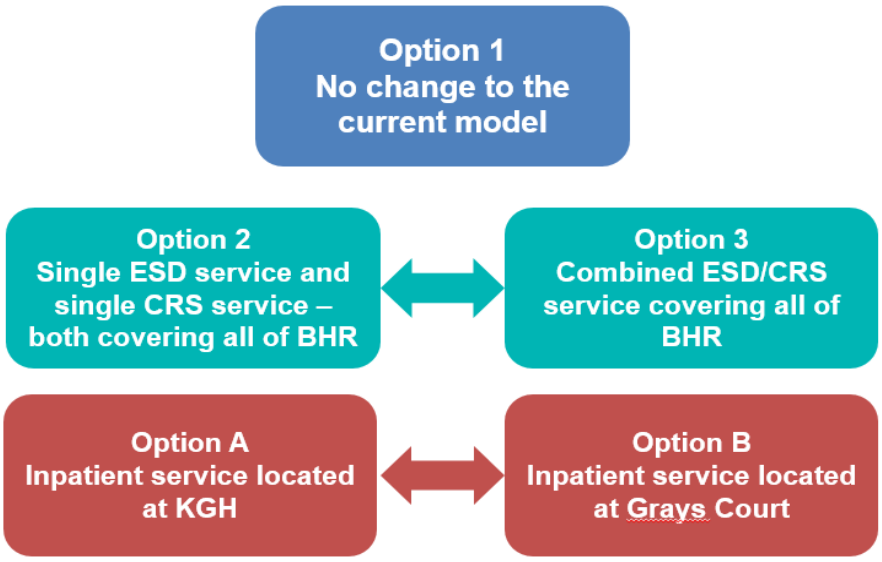
Following the approval of the Case for Service Change in June 2015, BHR CCGs worked in partnership with national, regional and local stroke experts to develop a list of options in response to the challenges raised through the case for service change.

There are common features for all of the change options that will provide a service that meets national standards and will deliver the best possible outcomes for all patients in BHR. These are:

- ✓ A streamlined ESD service delivered through one provider that will improve continuity of care;
- ✓ The ESD service will be extended to cover the whole of the borough of Redbridge;
- ✓ Provide a high quality stroke specialist multidisciplinary team, including equal access to speech and language therapy and psychology; enhancing what is already available in the community;
- ✓ All patients will receive up to six weeks ESD based on need;
- ✓ All patients will access the inpatient service through a single set of access criteria and the quality of inpatient care provided will be standardised;
- ✓ The models reflect the CCGs strategic direction in relation to providing increased rehabilitation at home;
- ✓ There will be common service providers working to a shared set of standards across all of BHR.
- ✓ A single provider of inpatient services from a single location

There are five potential options which are described below:

- Option 1 is the do-nothing option
- Option 2 and 3 relate to alternative ways of organising and commissioning community services
- Option A and B relate to alternative locations for the inpatient stroke rehabilitation service



The decisions over 2/3 and A/B are mutually exclusive.

There are four possible combinations for these options – 2A, 2B, 3A and 3B

**Option one – Do nothing**

This option maintains the current service model of post-acute stroke care across BHR CCGs. The challenges are described fully in section 5. In summary however, this option does not address the identified quality issues for patients requiring stroke services. This option also maintains the existing inequity of service provision, which will become more apparent over time as numbers of patients requiring stroke services increases.

**Option two – Provision of single Early Supported Discharge (ESD) and single Community Rehabilitation Service (CRS) both covering all of BHR.**

Key considerations:

- Best practice recommends that patients receive six weeks of intensive support. Using this model, if a patient needs more than this, it is possible that there may be a wait for this;
- There will still be a handover between providers of ESD and CRS.

**Option three – Provision of combined ESD/CRS service covering all of BHR**

Key considerations and benefits:

- The three working day wait for patients to be discharged from acute stroke services to being seen by the Community ESD provider is removed. The transfer between the different stages of care is seamless;
- The ESD and CRS services are delivered by the same team, so there is no handover between teams and there is better continuity of care;
- This option follows nationally recognised best practice models that combine ESD and CRS functions.

**Inpatient care will be provided from a single location by one provider. This means that:**

- ✓ All patients will access inpatients through a single set of access criteria, and quality of inpatient care provided will be standardised.
- ✓ There will be a focus in BHR for specialist stroke services;
- ✓ There will be improved relationships and communication between acute and community (post-acute) services;
- ✓ It will be easier for the ESD team to liaise with the hospital and assess patients' needs through in-reach;
- ✓ The pathway for stroke services is strengthened, as it becomes less complicated and there is a single set of criteria against which to assess patients across BHR.

**The following two options were identified as the two locations that could meet the needs of this service configuration.**

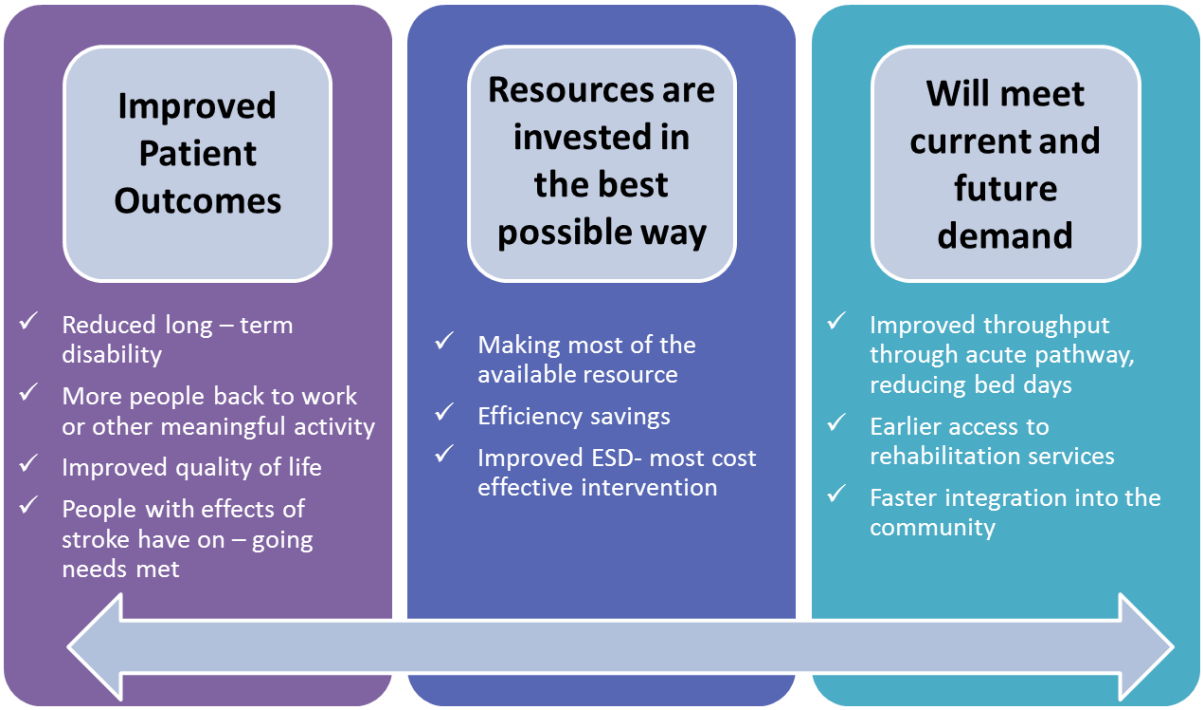
**Option A –** Consolidate the inpatient rehabilitation resource and locate inpatient services at King George Hospital.

**Option B -** Consolidate the inpatient rehabilitation resource and locate inpatient services at Grays Court.

# 6 Options assessment process

## 6.1 The benefits of changing the current stroke pathway

The table below represents the benefits that the project seeks to achieve through changing the model of care. This influenced the choice of criteria and weighting of the criteria used in the options assessment.




## 6.2 Criteria

The criteria and appraisal methodology was approved by the BHR CCGs Governing Body in September 2015 and reflected the identified benefits of changing the current stroke pathway.

The criteria were divided into two types; non-financial and financial, with a weighting ratio of 60:40 applied respectively. Each criterion was scored out of five points.

The financial and non-financial assessment of each of the options were undertaken separately.

The criteria used in the options appraisal process are described below.

| Criteria | Description | Underlying factors | Weight |
|---|---|---|---|
| **Non-Financial** | | | **60%** |
| **Clinical outcomes and safety** | The option improves patient outcomes and patient safety | • Levels of expertise of available clinical resources<br>• Types of estate, and equipment and expertise available at each site<br>• Standards set by regulators and professional bodies<br>• Improved patient outcomes | 20% |
| **Patient/ Carers' experience** | The option will improve patient / carers' experience | • Better quality of estates and equipment<br>• Co-ordination of health and social care<br>• Patient's choice: therapist/staff/location/appointment time/ quality and suitability of the care provided within the stroke services. | 20% |

| | | | |
|---|---|---|---|
| **Access to service** | There will be equitable access to services to all population groups | • Equality of access<br>• Travel times | 20% |
| **Deliverability** | • The option can be delivered without significant risk or disruption to business as usual<br>• The option is likely to deliver the benefits identified | • Risk to service continuity<br>• Workforce implications<br>• Existing use of estate and ability to vary usage<br>• Strategic fit with BHR economy<br>• Availability of enabling technology<br>• Provider sustainability | 20% |
| **Flexibility** | Ability to respond to system resilience and future population growth | • Ability to increase beds / work force capacity to cope with changes in demand | 20% |
| **Financial** | | | **40%** |
| **Commissioner affordability** | BHR CCGs can afford the option proposed within its projected financial envelope | • Indicative modeling of the options v. allocation projections<br>• Identifying value of each option in relation to outcomes to be achieved | |

## 6.3 Assessment of options against non-financial criteria

An options assessment workshop took place on 16th October 2015. The workshop was spilt into two parts.

**Part 1: Pre-consultation engagement opportunity**

The aim of this session was to:

- Present the emerging BHR stroke rehabilitation case for service change
- Present options to be appraised and scoring process
- Q&A.

The attendees included representation of the following:

- Stroke clinical reference and steering group members
- All stakeholders involved in first stroke pathway workshop
- Service users
- Voluntary organisations
- NHSE stroke leads
- Local authority representatives
- Carers Support leads
- Healthwatch

There were discussions regarding the pros and cons of each option and the impact they would make on services for stroke patients in BHR. At the end of this session, the representatives from provider organisations left the workshop, to prevent any conflict of interest in the scoring of the options.

## Part 2: Options assessment against non-financial criteria

The following session, undertook the assessment process to appraise the options against the non – financial criteria and took into consideration the feedback from the first half of the workshop. Representation included:

- BHR clinical director lead GPs for stroke
- Nominated BHR CCG commissioning officers
- Nominated leads from BHR local authorities
- Public Health lead (Havering)
- BHR finance lead
- NHSE leads for stroke
- Patient Representatives
- Carer organisation representatives

### Stakeholder discussion regarding the location of inpatient rehabilitation services

The stakeholders at the workshop were invited to discuss what they thought were the pros and cons of each location. These views were based on their experience either as a patient, carer, relative, member of staff or someone visiting from another organisation.

In considering a location for the inpatient rehabilitation services, several key factors were considered by the stakeholders:

- The location should be reasonably accessible to all the residents of Barking & Dagenham, Redbridge and Havering;
- There should be good transport links and disabled parking facilities;
- The location should be able to provide emergency medical cover (24/7)
- The location is able to deliver the service model to all BHR patients
- The location is able to respond flexibly to changes in demand over time

## 6.4 Assessment of options against financial criteria

The assessment of the options against the financial criteria took place on 22nd October 2015 and was undertaken by the BHR project lead and BHR Finance representatives.

The scores given to the “do nothing” option gave a baseline from which to measure how much better (or worse) each change option was considered.

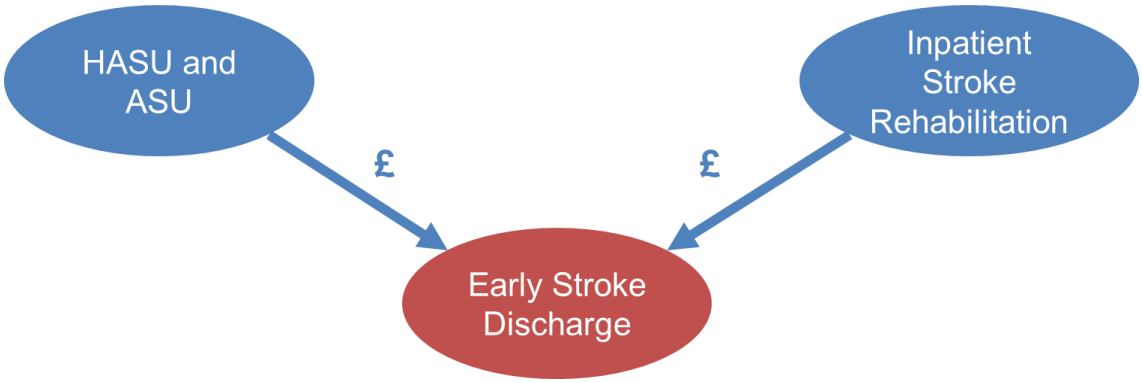
The scores given by individual participant at the workshop were analysed to identify any preferences by borough and an overall preference.

## 6.5 Results of the Non-Financial Scoring

The table in appendix C show that option 3 and option A scored the strongest. These were scored as the best options by every participant in the exercise, across every criteria.

## 6.6 Results of the Financial Scoring

All four of the change options involve the shift of resources from inpatient care to Early Supported Discharge.




The commissioners' position is that the revised service should cost no more than what is paid for the current service. The core assumption that underpins the financial scoring is that all changes to the prices paid to each of the providers resulting from this service change will balance out with no net change in the amount paid by commissioners.

The scoring of the options recognised that there are risks associated with this position; that it may not be possible to maintain neutrality once service changes are being implemented. However, in all but one aspect, these risks were common to options 2, 3, A and B. The exception was that option A (centralising inpatients at King George) was likely to be less risky than option B because maintaining inpatient services at Grays Court was likely to be more expensive the alternative.

After debate it was agreed that the affordability scores for the options should be 3 for options 1, 2, 3 and A, and 2 for option B.

## 6.7 Consolidated Scores

The consolidated scores for the options show options 3 and A to the clear preferred option; a combined ESD/CRS team and an inpatient service located at King George Hospital. The full scores (before and after weighting) are presented in Appendix D.

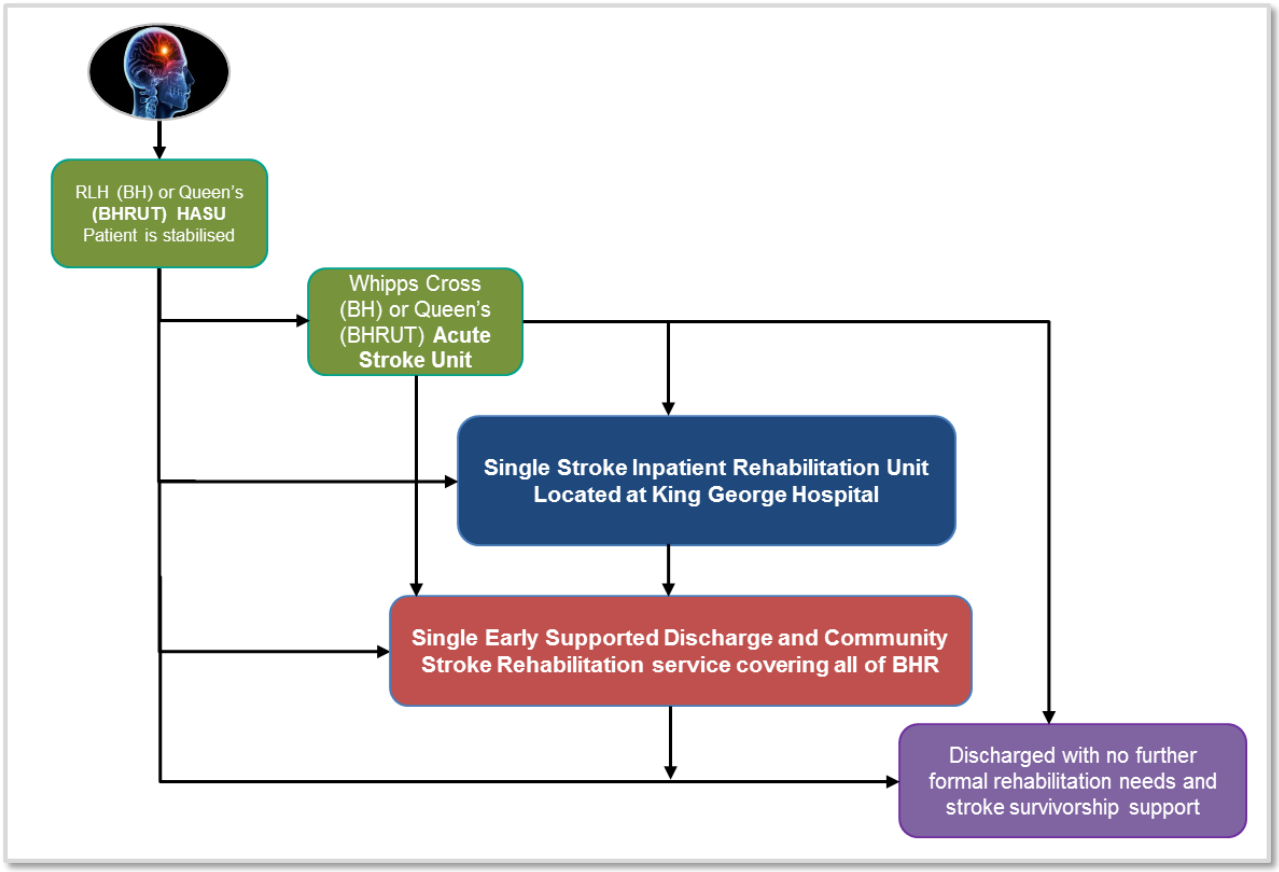
| Option | Non-financial criteria Weighted score (60%) | Financial criteria Weighted score (40%) | Total Score |
|---|---|---|---|
| Do nothing | 1.0 | 1.2 | 2.2 |
| Option 2 | 1.9 | 1.2 | 3.1 |
| Option 3 | 2.6 | 1.2 | 3.8 |
| Option A | 2.4 | 1.2 | 3.6 |
| Option B | 1.5 | 0.8 | 2.3 |

# 7 Identified Preferred Option

Option 3A was scored as the preferred option

## 7.1 Service description

Option 3 is the provision of a combined ESD and CRS service covering all of Barking and Dagenham, Havering and Redbridge. Option A locates the inpatient stroke rehabilitation service at King George Hospital in Ilford. The model below demonstrates the pathway for patients if the stroke services for BHR are reconfigured to the preferred option. This is in stark contrast to the complex pathway demonstrated in Appendix A.




## 7.2 Benefits of preferred option

The scoring group noted the following benefits for Option 3;

- ✓ A more streamlined pathway with a reduction in the number of transfers between providers.
- ✓ Access to the best care is improved. All people in BHR that are eligible for ESD will receive the rehabilitation and support they need in their homes
- ✓ More people will receive their care at home. Evidence shows that people who receive care at home are able to live more independently than those who have had all of their rehabilitation in hospital.
- ✓ The length of stay in hospital is reduced which means better outcomes for patients as well as reduced costs to the hospital which enables them to focus more on the most acutely ill patients;
- ✓ A more efficient use of workforce with the opportunity to 'flex' staff between service demands.

- ✓ A better quality of service provision for patients with equity of access across all three boroughs.
- ✓ Patients will receive the same quality of care regardless of where they live or which hospital they have been in. Each team will have the right number of staff with the right specialist skills to deliver rehabilitation at home. This includes equal access to speech and language therapy and psychology.
- ✓ Opportunity to redesign stroke rehabilitation services to meet the needs of growing demand.
- ✓ There are benefits for carers too, as there will be less travelling required and the carer will liaise with a single team throughout each phase of the rehabilitation; so less duplication.
- ✓ Better quality data collection of patient measures and outcomes to benchmark service provision.
- ✓ Service provision can be based on patient need rather than prescripted only by time
- ✓ Clarity of service delivery costs with sole provider opposed to multiple providers
- ✓ Reallocation of funding to improve rehabilitation services rather than increase in service budget.

The scoring group noted the following benefits for Option A;

- ✓ The pathway for stroke services is strengthened, as it becomes less complicated and there is a single set of criteria against which to assess patients across BHR. All patients will access inpatients through a single set of access criteria, and quality of inpatient care provided will be standardised.
- ✓ There will be improved relationships and communication between acute and community (post-acute) services. It will be easier for the ESD team to liaise with the hospital and assess patients' needs through in-reach.
- ✓ Patients will have immediate access to medical and support services at the KGH site opposed to Option B.
- ✓ Better provision of transport access to hospital site for family and carers to visit patients
- ✓ Equity of access to inpatient rehabilitation for all patients in BHR
- ✓ Create a more efficient and experienced single provider opposed to multiple provider sites.
- ✓ All patients will access inpatients through a single set of access criteria, and quality of inpatient care provided will be standardised.

## 7.3 Affordability of preferred option

Affordability for this option was scored as the same as Option 1 (Do nothing). This project aims to remain cost neutral but redesign service delivery to maximise outcomes for stroke rehabilitation patients.

## 7.4 Identified risks for preferred option

Following consultation a full risk register will be developed. Risks fall into three key areas. These can be summarised as the following;

1. **Risks associated with reaching a final decision about the redesign of the BHR stroke pathway**

At this time it is felt that there is low risk of the decision being delayed or derailed. Engagement to date has indicated that there is strong support for the project. However this will become clearer during the consultation period.

2. **Risks associated with implementing changes**
   The final business case that will be developed after the consultation will expand further upon the implementation programme that will be required. Implementation will involve some challenges including:

   - Workforce challenges; there are likely to be skills and resource gaps and some staff will need to be transferred between providers
   - Ensuring that the changes remain affordable
   - Organisational redesign
   - Maintaining safe and efficient services during the change programme

3. **Risks associated with delivering the anticipated benefits**
   The final business case will also consider where there are risks that the benefits that were articulated in section 7.2 are not realised.

A process for identifying and managing risks will be agreed by the Steering Group in the next phase of the project.

# 8 Pre – consultation engagement

Engagement with clinicians, professionals, patients and other stakeholders has been a key driver for the BHR STP and has underpinned the development of the CfSC and pre – consultation business case (PCBC).

Throughout the course of the project, BHR CCGs have undertaken a number of engagement activities with stakeholders to find out their thoughts regarding how stroke rehabilitation services need to improve, and their experience of using the services to date.

During the early stages of the project, a workshop was held with people who have had a stroke, stroke expert clinicians, commissioners and providers who provided services and support for stroke survivors. The workshop focussed on mapping the current stroke journey from when someone had a stroke, through to their acute hospital care and stroke rehabilitation care options, to home. As a result the project team had a good indication of how the current stroke rehabilitation service needed to change to ensure high quality stroke care for all residents living in BHR. Following this, BHR CCGs engaged in a period of wider stakeholder engagement to strengthen these findings and use to inform the development of the CfSC. This included on-going engagement with the Stroke Association and an on-site visit to NELFT community stroke team.

Following the approval of the CfSC by BHR Governing Bodies, it was presented to the three BHR Health and Wellbeing Boards, Health Scrutiny Committee in Barking and Dagenham, Joint Health Scrutiny Committee (covering Barking and Dagenham, Havering, Redbridge and Waltham Forest) and Barking and Dagenham Patient Engagement Forum. Since then it has been refreshed to incorporate feedback received.

In response to the challenges raised within the CfSC, BHR CCGs also worked in partnership with national, regional and local stroke experts to develop a draft list of options. A stakeholder workshop held to score the options for stroke rehabilitation services was attended by representatives from Healthwatch, carers groups, patient representatives, GP clinical leads, Age Concern, the Stroke Association and the London Boroughs of Barking and Dagenham, Havering and Redbridge and NHS England. While not present for the scoring part of the workshop, representatives from NELFT, BHRUT and Barts Health also attended the stakeholder engagement session of the workshop.

From these discussions, it was clear there was support for change to the services, but without a clear proposal to take forward (as a preferred option was yet to be identified and agreed) the specifics could not be discussed. Stakeholders were keen to understand the operational detail of how any new services might work, including eligibility, capacity and staffing and joint working together with other services and social care. They were also interested in how a potential consultation might be run, and the involvement of Healthwatch.

# 9 Stakeholder consultation process

## 9.1 Consultation process

The following is proposed:

- A 12 week, three-borough consultation, running from January – April 2016, to begin the week commencing 4January 2016.
- Hard copies of the consultation document (written in plain English) to be widely circulated throughout the three boroughs.
- Consultation to be promoted through media releases, posters, advertisements, and via newsletters, stakeholders and existing forums.
- People can respond to the consultation through an online survey or via freepost address.
- Present at the BHR Patient Engagement Forums (PEF), and at NELFT and BHRUT PEFs

- Actively engage with Healthwatch and other local stakeholders.
- Hold public events in each borough, at different times and locations, (one in each month of the consultation), and more if requested/a need is identified
- Key stakeholders identified with a special focus on hard to reach groups.
- Attend meetings with local stakeholders as requested.

## 9.2 Legislation/mandatory requirements

BHR CCGs are aware of their responsibilities as set out in section 14Z2 of the NHS Act 2006; NHS organisations should continually involve and engage patients and the public in service planning and operation, and in the development of proposals for change.

BHR CCGs believe that over and above their legal requirement there is significant benefit from engaging and involving service users and local stakeholders, including:

- Increased public confidence in local NHS services and decision-making.
- Better decisions when designing safe, high quality services.
- Improved patient experience and outcomes.
- Building stronger relationships with key stakeholders, including staff; and
- Mitigate risks and issues.

BHR CCGs will also take into account the NHS Constitution, which brings together a number of rights, pledges and responsibilities for staff and patients alike. This includes the 'right to be involved, directly or through representatives in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided and in decisions to be made affecting the operating of those services'. This also includes the 'right to be provided with the information to influence and scrutinise the planning and delivery of NHS services'.

## 9.3 Health Scrutiny Committee engagement

The CCGs will work closely with Health Scrutiny Committee (HSC) members and officers to agree HSC oversight and engagement, making sure they are kept briefed on the proposals and planned communications and engagement.

Health Scrutiny Committees have the power to refer proposed changes and/or decisions to the Secretary of State for Health after a public consultation. These can be referred onto the Independent Review Panel (IRP) to consider whether the changes will enable the provision of safe, sustainable and accessible services for the local population. The CCGs will seek to mitigate this risk through running the consultation in line with best practice guidance.

## 9.4 NHSE assurance

BHR CCGs advised NHSE of their intention to consult on improving stroke rehabilitation services across Barking & Dagenham, Havering and Redbridge. NHSE were provided with a copy of the case for service change and the draft pre consultation business case. Regular updates will be provided to NHSE throughout the next stages of the stroke review and consultation period.

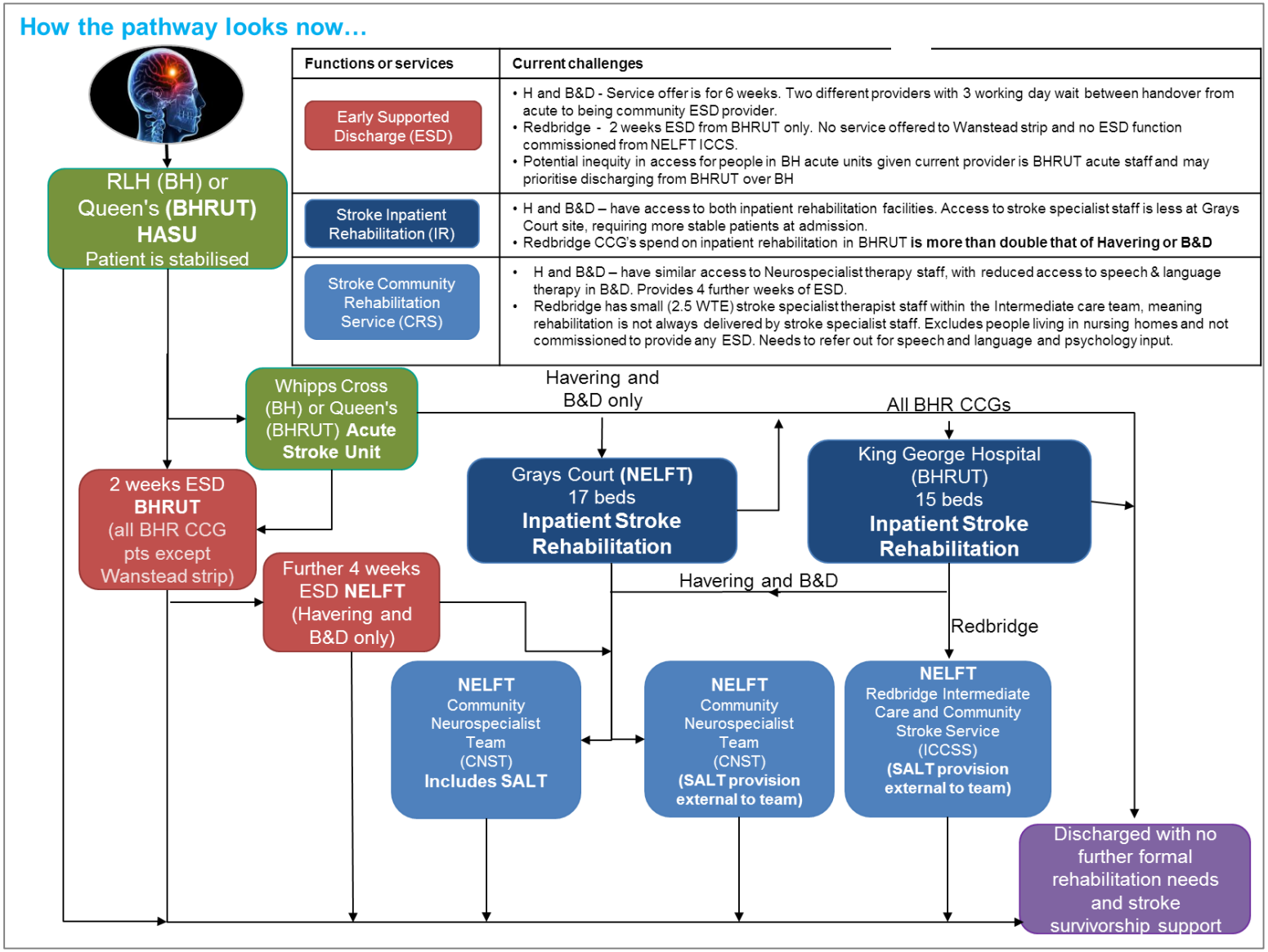
## 10 Recommendations & Next Steps

The Governing Body is asked to:

- Endorse the recommendation of the preferred option.
- To formally consult on proposals to change the delivery of stroke rehabilitation services.
- To note that subject to the agreement of point 1 and 2, the consultation will launch the week commencing 4 January 2016 for 12 weeks.
- To note the intention for the Governing Body to receive a Decision Making Business Case in June 2016.

## Appendix A – Diagram of the current stroke pathway

**Current stroke pathway for people living in Barking and Dagenham, Havering and Redbridge**



## Appendix B – Illustration of how where patients live dictates their care

Example pathways of four patients with same stroke diagnosis, who are suitable for Early Supported Discharge but living in different areas of Barking and Dagenham, Havering and Redbridge. So although the needs of these four people are the same the care that they receive will depend on where they live.

### What these changes should mean to patients

Consider four BHR residents each with the same prescription rehabilitation as a result of their stroke, AND;

- Meet the clinical criteria and agree to Early Supported Discharge (ESD)
- Are keen for, and will benefit from a minimal hospital stay and can go home straight from hyper acute stroke unit (HASU)
- Will require ongoing speech and language support on discharge.

**BUT:**

***Currently*** their access to the types of stroke rehabilitation is very different, as are their outcomes

***In future*** the aim to ensure all BHR residents have equal access to evidence-based stroke rehabilitation.

| Age profile and effects of their stroke | | |
|---|---|---|
| **All 4 people** | **Age: 55** | **BHR** |
| | **Condition** | **Prognosis** |
| **Upper limbs** | Some weakness | Good |
| **Lower limbs** | Some weakness | Good |
| **Speech/ swallow reflex** | Some speech impairment | Good |
| **Sensory loss** | None | Good |
| **Continence** | No issues | Good |
| **Complications** | No issues | Good |


Mrs Jenkins lives in North Redbridge

Mr Innes lives in Wanstead


Mr Khan lives in Barking and Dagenham


Mrs Williams lives in Havering

# Current provision

Hyper-Acute Stroke Unit

Acute Stroke Unit

Early Supported Discharge (2 Weeks)

Further Early Supported Discharge (4 weeks)

Inpatient Stroke Rehabilitation

Community Stroke Rehabilitation

Discharged no further formal rehabilitation needs

Mrs Jenkins lives in North Redbridge

- Mrs Jenkins was supported back into her home and community as soon as it was possible.

**HOWEVER……**

- She had an ongoing speech therapy need that could have been met with a further 4 weeks ESD support IF she lived in Havering.
- This could not be met through a referral to CRS, therefore she was discharged from the formal stroke rehabilitation pathway.
- Mrs Jenkins may have to wait 6 months for routine speech therapy for referrals in the community. (Oct 2015)

Hyper-Acute Stroke Unit

Acute Stroke Unit

Early Supported Discharge (2 Weeks)

Further Early Supported Discharge (4 weeks)

Inpatient Stroke Rehabilitation

Community Stroke Rehabilitation

**Discharged** no further formal rehabilitation needs


Mr Innes lives in Wanstead, Redbridge

- Mr Innes was supported back into his home with community stroke rehabilitation (CRS)

**HOWEVER……**

- He had a longer stay in hospital to meet his early rehabilitation needs because he did not have access to ESD. Longer stays are linked with worse outcomes for people who have a stroke.
- The Redbridge CRS model has reduced access to stroke specialist therapy than the other two boroughs
- Like Mrs Jenkins, he may wait 6 months routine speech therapy in the community (Oct 2015)

# Current provision

Hyper-Acute Stroke Unit

Acute Stroke Unit

Early Supported Discharge (2 Weeks)

Further Early Supported Discharge (4 weeks)

Inpatient Stroke Rehabilitation

Community Stroke Rehabilitation

Discharged no further formal rehabilitation needs

Mr Khan lives in Barking and Dagenham

- Mr Khan was supported back into his home and community as soon as possible
- Unlike Mrs Jenkins and Mr Innes, he has his speech and language therapy needs met by a further 4 weeks of ESD support

**HOWEVER……**

- He may have to wait longer for SALT than if he lived in Havering as the therapist works outside the ESD team in B&D.

# Current provision

Hyper-Acute Stroke Unit

Acute Stroke Unit

Early Supported Discharge (2 Weeks)

Further Early Supported Discharge (4 weeks)

Inpatient Stroke Rehabilitation

Community Stroke Rehabilitation

Discharged no further formal rehabilitation needs

Mrs Williams lives in Havering

- Mrs Williams was supported back into her home and community as soon as possible
- Unlike Mrs Jenkins and Mr Innes, she has her speech and language therapy needs met during her further 4 weeks of ESD support
- Unlike Mr Khan, she has not had to wait for her Speech and Language therapy support because they are integrated within the CRS team.

This is currently the closest to the pathway that we would aim to achieve for patients with level of acuity and prognosis across all of BHR

## Appendix C – Experience for patients with greater levels of need

The example shows how the experience of the patients that have a greater level of need but should still be suitable for ESD.

Consider Mr Ellis - following his treatment in the Acute Stroke Unit he:

- Meets the clinical criteria and agrees to Early Supported Discharge (ESD)
- Is keen for, and will benefit from a minimal hospital stay
- Is likely to require ongoing support from CRS once discharged from ESD.
- Will require speech and language therapy, nutritional support & psychology on discharge from acute care

***Currently*** all BHR residents only have one stroke rehabilitation option

***Future*** options all aim to ensure this BHR resident would have equal access to **all types** of evidence-based stroke rehabilitation

| | Age: 63 | Anywhere in BHR |
|---|---|---|
| | **Condition** | **Prognosis** |
| **Upper limbs** | L sided paralysis | Fair |
| **Lower limbs** | L sided paralysis – needs two to transfer now | Should be able to transfer & mobilise independently in the future |
| **Speech/ swallow reflex** | Mild dysphagia/impaired swallow | Swallow is likely to improve in the future |
| **Sensory loss** | Vision impairment | Fair |
| **Continence** | Incontinent | Fair |
| **Complications** | Moderate depression | Good with psychological support |

## Current Provision

Hyper-Acute Stroke Unit

Acute Stroke Unit

Early Supported Discharge (2 Weeks)

Further Early Supported Discharge (4 weeks)

Inpatient Stroke Rehabilitation

Community Stroke Rehabilitation

**Discharged** no further formal rehabilitation needs

- Whilst ESD services exist they are not organised to meet this level of rehabilitation need in people's homes; e.g. there is inconsistent provision of speech and language therapy and no psychology provision available in the current 2 week ESD offer.
- This means **only option** for people with this level of need living in BHR CCGs is to spend longer in inpatient care which does not guarantee the best possible outcomes for people.

# Future pathway for higher acuity patients suitable for ESD

Hyper-Acute Stroke Unit

Acute Stroke Unit

Early Supported Discharge (6 weeks)

Inpatient Stroke Rehabilitation

Community Stroke Rehabilitation

**Discharged** no further formal rehabilitation needs


- Better outcomes achieved through equitable access to stroke specialists within ESD and CRS for all BHR residents
- Improves continuity of care by reducing possible handovers from 2 to 1 throughout out ED to CRS pathway
- Equitable access to ESD regardless of admitting hospital e.g. Queen's or Whipps Cross

Estimate is that up to 25% of all stroke patients could be eligible for ESD but currently do not or cannot access it

# Appendix D – Options scoring

**The following table provides a comprehensive breakdown of the scoring from the options scoring workshop and affordability assessment that were conducted in October 2015.**

| | | Average | Weighting | Weighted Average | |
|---|---|---|---|---|---|
| Do Nothing | Clinical Outcomes and Safety | 1.83 | 20% | 0.37 | 1.71 |
| | Patent Carers Experience | 1.69 | 20% | 0.34 | |
| | Access to service | 1.21 | 20% | 0.24 | |
| | Deliverability | 2.25 | 20% | 0.45 | |
| | Flexibility | 1.58 | 20% | 0.32 | |
| Option 2 | Clinical Outcomes and Safety | 3.38 | 20% | 0.68 | 3.22 |
| | Patent Carers Experience | 3.15 | 20% | 0.63 | |
| | Access to service | 3.25 | 20% | 0.65 | |
| | Deliverability | 3.29 | 20% | 0.66 | |
| | Flexibility | 3.04 | 20% | 0.61 | |
| Option 3 | Clinical Outcomes and Safety | 4.50 | 20% | 0.90 | 4.29 |
| | Patent Carers Experience | 4.50 | 20% | 0.90 | |
| | Access to service | 4.42 | 20% | 0.88 | |
| | Deliverability | 3.88 | 20% | 0.78 | |
| | Flexibility | 4.17 | 20% | 0.83 | |
| Option A | Clinical Outcomes and Safety | 4.21 | 20% | 0.84 | 4.07 |
| | Patent Carers Experience | 4.00 | 20% | 0.80 | |
| | Access to service | 4.25 | 20% | 0.85 | |
| | Deliverability | 3.75 | 20% | 0.75 | |
| | Flexibility | 4.13 | 20% | 0.83 | |
| Option B | Clinical Outcomes and Safety | 2.63 | 20% | 0.53 | 2.58 |
| | Patent Carers Experience | 2.50 | 20% | 0.50 | |
| | Access to service | 2.67 | 20% | 0.53 | |
| | Deliverability | 2.71 | 20% | 0.54 | |
| | Flexibility | 2.38 | 20% | 0.48 | |

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**APPENDIX B**

NHS

*Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups*

# Proposed changes to stroke rehabilitation services:

## a consultation for Barking and Dagenham, Havering and Redbridge

# What do you think?

Consultation closes at 5pm,1 April 2016

# Foreword from GP stroke leads

As local GPs, we know that people don't always get the right rehabilitation care after a stroke and we want this to change.

Changes across London have seen all patients with a suspected stroke taken to one of eight specialist stroke centres, known as hyper acute stroke units (HASUs), for immediate, expert care from specialised staff. Seven days a week, 24 hours a day, all stroke patients are assessed, undergo a brain scan, are diagnosed and given life-saving clot-busting drugs within 30 minutes of arriving at hospital, and within four and a half hours of having a stroke. This has transformed stroke care and outcomes, saving hundreds of extra lives each year and improving people's chances of rapid and lasting recovery.

The priority now is for us to build on this and continue improvements by looking at stroke rehabilitation services and longer term recovery and making them better and fairer, so that wherever you live, you get the same excellent care, whether at home or in a hospital.

Over the past year, we've been working with partners to identify what needs to change about stroke rehabilitation and develop solutions to make sure stroke rehabilitation users gets the best possible outcomes.

Locally, the demand for stroke rehabilitation services is anticipated to grow by 35% in the next 20 years as the number of older people living locally increases. We want to make changes to stroke rehabilitation services now, to make sure people recover and live the fullest life possible.

This consultation document explains why and how we want to make changes to stroke rehabilitation services across Barking and Dagenham, Havering and Redbridge. Please read it and let us know what you think by filling in the questionnaire at the back.

**Dr Ravali Goriparthi**
Barking and Dagenham CCG

**Dr Alex Tran**
Havering CCG

**Dr Sarah Heyes**
Redbridge CCG

# Foreword from hospital stroke lead

The NHS in London has transformed its system of hospital stroke care. This has saved hundreds of extra lives each year and hugely improved people's chances of rapid and lasting recovery following a stroke.

What matters with a stroke is getting the right treatment, in the right place, at the right time. All patients with a suspected stroke are now taken to one of eight hyper acute stroke units (I lead one, at Queen's Hospital in Romford) for expert care from specialised staff, without delay. This centralised model of care has made a very real difference with more people than ever now surviving a stroke.

Now, the priority needs to be getting the next step – rehabilitation – right, so that people recover and live the fullest life possible.

These improvements are all about the opportunity to receive world class health care – I encourage you to make the most of it.

**Dr Sreeman Andole**
Divisional Director and Clinical Lead in Stroke
Barking, Havering and Redbridge University Hospitals NHS Trust

# About this consultation

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (CCGs) are working together to improve how people recover from a stroke after their initial treatment. This is known as stroke rehabilitation.

This consultation document explains how and why we want to change stroke rehabilitation services in Barking and Dagenham, Havering and Redbridge (BHR).

We want to make stroke rehabilitation services more joined up with each other and focused on what individual people need, regardless of where people live. We believe doing this would mean people receive specialist care, tailored to their needs, that would help them to recover better and more quickly.

Our population is growing and changing. Around 9,000 people living in in the three boroughs are registered as having had a stroke and this will increase. We need a stroke rehabilitation system that will provide good quality care for people now and can also care for more people in years to come.

In this consultation document we have set out different options and explained what we think is the best option and why. We want to know what you think, whether you agree or disagree, and if there is anything else you want us to consider.

We'd like to hear from as many local people as possible about our proposals. We would especially like to hear from people who have had a stroke, or have been a carer/family member/friend of someone who has. We'd also like to hear from carers and people aged 65 years and over (as most of the people who suffer from a stroke are in this age group).

Comments from health professionals and our partners in the community and voluntary sector about whether they think our proposals would improve stroke rehabilitation services for local people are also welcomed.

To tell us what you think, you can fill in the online questionnaire on our websites or complete the questionnaire at the back of this document and send it back to **FREEPOST BHR CCGS**, free of charge.

**All comments must be received by 5pm, on Friday 1 April 2016.**

## How to find out more

To get more information about our work to change stroke rehabilitation services you can:

- Look on our websites (addresses on next page)
- Come and see us – visit our websites or give us a call to find out when we will be near you
- Ask us to come and see you - if you would like someone to come and talk to your community group, email haveyoursay@onel.nhs.uk or call 020 3688 1615.

**N.B.** This consultation is about making changes to stroke rehabilitation services for adults, not children.

# Glossary

| | |
|---|---|
| **ASU** | acute stroke unit |
| **BHR** | Barking and Dagenham, Havering and Redbridge boroughs |
| **BHRUT** | Barking, Havering and Redbridge University Hospitals NHS Trust |
| **CCG** | clinical commissioning group |
| **CRS** | community rehabilitation service |
| **ESD** | early supported discharge |
| **Inpatient unit** | provides treatment and support to people in a hospital setting |
| **HASU** | hyper acute stroke unit |
| **NELFT** | NELFT NHS Foundation Trust |

**Rehabilitation** – after having a stroke you recover by regaining strength, relearning skills or finding new ways of doing things. This process is called rehabilitation. Rehabilitation often focuses on:

- physical therapy to help your movement, strength and fitness
- occupational therapy to help you with daily activities
- speech and language therapy to help with speaking, understanding and swallowing
- treatment of pain

A stroke rehabilitation programme could involve:

- physiotherapy to help with muscle weakness
- speech and language therapy to help with swallowing and communication
- sessions with a clinical psychologist to help with emotional problems
- support from an occupational therapist on how to do everyday tasks such as washing, getting dressed dressing, shopping and cooking.

To respond to this consultation online or find out more about our work on stroke rehabilitation visit:

**www.barkingdagenhamccg.nhs.uk/stroke**

**www.haveringccg.nhs.uk/stroke**

**www.redbridgeccg.nhs.uk/stroke**

# What is a stroke?

A stroke is a serious, life-threatening medical condition that occurs when the blood supply to part of the brain is cut off. The brain needs the oxygen and nutrients provided by blood to function properly. If the supply of blood is restricted or stopped, brain cells begin to die. This can lead to brain injury, disability and possibly death.

Strokes are a medical emergency. The sooner you receive treatment for a stroke, the better your chances of recovery. If you think you or someone else is having a stroke, call 999 immediately and ask for an ambulance.

The impact of a stroke is instant and unpredictable. You are more likely to have a stroke if you are over 65 years old, smoke, have high blood pressure, diabetes, high cholesterol or an irregular heart rate or are of South Asian, African or Caribbean descent.

When you have a stroke, the first stage of care (known as acute care) focuses on providing life-saving treatment and then stabilising you. This takes place in a hyper-acute stroke unit (HASU), which is a 24-hour specialist centre providing high quality expertise in diagnosing, treating, and managing stroke patients. On arrival, you are assessed by a specialist, have access to a brain scan and receive clot-busting drugs (thrombolysis) if appropriate, all within 30 minutes.

Locally, there is a HASU at Queen's Hospital in Romford and some people go to the HASU at the Royal London Hospital in Whitechapel.

## TIAs (mini-strokes)

You may have heard of what some people call a mini-stroke, this is a related condition known as a transient ischaemic attack (TIA).

This is where the supply of blood to the brain is temporarily interrupted, causing a mini-stroke often lasting between 30 minutes and several hours. TIAs should be treated seriously as they are often a warning that you are at risk of having a full stroke in the near future. People who have had a TIA do not need stroke rehabilitation.

After one or two days of intensive treatment at the HASU, some people go home to recover, but most patients will then be transferred to an acute stroke unit (ASU). ASUs provide physiotherapy, occupational therapy, speech and language therapy, rehabilitation and ongoing medical supervision and people stay there while they recover. Most people are ready to move on from the ASU after two to three days.

There are ASUs at Queen's Hospital in Romford and Whipps Cross Hospital in Leytonstone.

# Recovering from a stroke

What happens after you have a stroke will depend on how serious it is. Once you've been stabilised, the next step is rehabilitation. Stroke rehabilitation aims to support people to adapt to the physical, mental and social complications resulting from their stroke.

A stroke can result in arm/leg weakness, visual problems, facial weakness, slurred speech, bladder control issues, difficulty swallowing and problems using language correctly (aphasia).

Your rehabilitation will depend on what you need to get better. Some people will leave hospital fairly quickly to have intensive rehabilitation at home. Others will need more support and may need to stay in a hospital for longer. Unfortunately, some people never fully recover and will need long term support adjusting to living with the effects of their stroke. Thirty per cent of people who have had a stroke live with the effects of it, and so they especially need effective rehabilitation to help them live as full a life as possible.

# Types of stroke rehabilitation

**Locally, there are three types of stroke rehabilitation services:**

### 1. Early Supported Discharge (ESD) – provided by BHRUT and NELFT

Early Supported Discharge offers regular intensive rehabilitation in your own home, five days a week for up to six weeks, depending on your needs. It is as intensive as the rehabilitation you would receive in an inpatient unit and is for people expected to make a good recovery from their stroke. The ESD service helps you recover by practising everyday tasks such as speaking, walking, washing, dressing and cooking and is staffed by physiotherapists, speech and language therapists and occupational therapists.

Evidence shows that a good ESD service can significantly reduce the amount of time a stroke patient stays in hospital and helps them to recover better after a mild to moderate stroke. The National Institute for Health and Care Excellence (NICE) recommends that 40% of all stroke rehabilitation should be delivered through ESD. Locally, only around 20% of stroke rehabilitation is through ESD at the moment.

### 2. Community Rehabilitation Service (CRS) – provided by NELFT

The Community Rehabilitation Service is for people who don't need to be in hospital but the level of disability following their stroke means they are unlikely to make a full recovery. CRS is less intensive and less frequent and works to help people regain confidence by providing treatment, advice and support. The CRS team includes occupational therapists, physiotherapists, rehabilitation nurses and therapy assistants.

**Note:** People do not receive home-based services such as ESD and CRS unless doctors are sure that they are well enough to go home and it is safe for them to do so. If a patient is not ready to go home they will go to a stroke inpatient unit and we expect this to continue.

### 3. Inpatient rehabilitation unit

Some patients with a higher level of need after their stroke need to spend more time in a hospital-like setting so they will stay in an inpatient rehabilitation unit. On average, people should spend around 20 days here but at the moment they often spend longer, in part because the rehabilitation they get isn't right or isn't available.

There are two stroke rehabilitation inpatient units locally: Grays Court and Beech Ward.

## Grays Court in Dagenham (run by NELFT)

John Parker Close, Dagenham, RM10 9SW

Grays Court is mostly used by stroke patients who live in Barking and Dagenham and Havering.

**Capacity and facilities:**

17 beds; 13 single rooms with en-suites (which make it harder to watch patients and for patients to interact) and one room with four beds for high risk patients. There is a physiotherapy gym, day room/dining area and consultation rooms. It does not have 24/7 medical cover, so in an emergency an ambulance is called to take patients to hospital.

**Public transport:**

There are infrequent buses and the nearest underground station is 15 minutes' walk away.

**Parking:**

Free limited parking on site, used by staff and visitors so it is often full. Limited parking on nearby residential streets.

## Beech Ward at King George Hospital (run by BHRUT)

Barley Lane, Goodmayes, IG3 8YB

Beech Ward is mostly used by patients who live in Redbridge.

**Capacity and facilities:**

15 stroke beds in one ward, with separate bays for men and women and three single rooms. There is a day room, physiotherapy gym and access to a larger hospital gym. Being located at King George Hospital means easy access to other hospital services and facilities. There is 24/7 medical cover and in an emergency doctors on the hospital site are able to respond quickly.

**Public transport:**

Four bus routes stop in the King George grounds. Nearest train station is 20 minutes' walk (or a short bus ride) away.

**Parking:**

Large on-site carpark for staff and visitors, charges apply.

# Current stroke services

**If you have a stroke at the moment, wherever you live, the current rehabilitation available means:**

- You'll spend more time in hospital than you need to, even when it is better for you to be at home
- You won't always have specialist stroke staff taking care of you
- Your recovery will take longer.

## If you live in Redbridge

- If you need inpatient rehabilitation you'll go to Beech ward at King George Hospital
- If you live in west Redbridge (Wanstead area) you can't have ESD, so you have to recover in an inpatient ward, which will mean you're in a hospital bed for longer
- If you can have ESD, you can't have the full range of therapies that should be on offer under ESD.

## If you live in Barking and Dagenham

- If you need inpatient rehabilitation you'll go to Grays Court
- You'll spend longer in an acute stroke unit because it takes longer to be admitted to Grays Court
- If you can have ESD, you can't have the full range of therapies that should be on offer under ESD.

## If you live in Havering

- If you need inpatient rehabilitation you'll go to Grays Court.


EST
BRENTWOOD
ROMFORD
QUEEN'S HOSPITAL
EWBURY PARK
HAVERING
GEORGE
OSPITAL
CHADWELL
HEATH
HORNCHURCH
UPMINSTER
BARKING AND
DAGENHAM
DAGENHAM
GRAYS COURT
RAINHAM
THURROCK

# Improving stroke rehabilitation services

Over the past year, we have been looking at how local stroke rehabilitation services could be improved, based on what clinicians and stakeholders told us, what was best practice, and what was happening locally. From this we developed a case for change, which sets out in detail what needs to change and why. As part of this we drew up a list of options for stroke rehabilitation services. To read about this in detail, visit our websites.

We held a workshop to discuss the options, the advantages, disadvantages and implications of each one and decided through a scoring process what was the best option. Details of this process and the evidence considered is on the stroke page on our websites.

The workshop involved doctors with an interest in stroke, representatives from all three councils, patient representatives, Healthwatch representatives, carer organisation representatives, stroke specialists and local NHS managers.

The group discussed the pros and cons of each option, using the following criteria:

**Clinical outcomes and safety**

- Does the option improve patient outcomes and patient safety?

**Patient/carers' experience**

- Does the option improve patient / carers' experience?

**Access to services**

- Can everyone use the services, wherever they live?

**Deliverability**

- Can the option be delivered without significant risk or disruption to business as usual?
- Is the option likely to deliver the benefits identified?

**Flexibility**

- Is the option able to respond to demand and future population growth?

Using these criteria, the group considered the following options:

**Option 1: Do nothing – services stay the same as they are now.**

The group decided that this option was not practical – stroke rehabilitation services need to change and can't stay as they are. The group agreed that the current service is unfair as the rehabilitation people receive depends on where they live and this shouldn't be the case.

**Option 2: A single separate ESD service and a single separate CRS service, covering all three boroughs.**

The group was of the opinion that while it was positive that all three boroughs would receive the same services, running ESD and CRS separately would mean that care would have to be handed from one team to another, which would mean patients would have to wait while this happened, leading to delays across stroke care.

**Option 3: A combined ESD and CRS service covering all three boroughs, offered by one provider, with one inpatient unit.**

Every participant in the group scored this as the best option. They decided this model of care would mean better, more joined up care which means patients would not have to wait for three working days (as they do at the moment) after leaving the HASU or ASU before they are seen by the ESD team.

The ESD and CRS services would be delivered by the same team which follows nationally-recognised best practice models that combine ESD and CRS functions.

**Where the inpatient stroke rehabilitation beds should be**

The group then looked at where the inpatient stroke rehabilitation service should be. The group decided it was important that a stroke inpatient unit should:

- be able to provide emergency medical cover (24/7)
- provide care to all BHR stroke patients
- be able to respond flexibly to changes in demand over time
- be 'reasonably accessible' to all BHR residents
- have good transport links and parking for disabled people.

Providing all inpatient rehabilitation in one place would mean that:

- care is provided by staff who specialise in caring for stroke patients, so patients would receive better care
- we could use staff much more efficiently and flexibly and develop their expertise
- relationships and communication with other parts of the NHS would improve, resulting in better care.

The two locations that could provide inpatient stroke rehabilitation were Grays Court and King George Hospital.

| **Option A: King George Hospital in Goodmayes** | **Option B: Grays Court in Dagenham** |
|---|---|
| Basing the inpatient unit at King George Hospital would mean that:<br>• Patients would have 24/7 emergency medical cover on site<br>• There are other services on the King George Hospital site that stroke patients can use<br>• It is easier for most families and carers to visit because transport links are better. | Basing the inpatient unit at Grays Court would mean that:<br>• Patients would not have 24/7 medical cover and would have to go to hospital by ambulance in an emergency<br>• Family and friends who rely on public transport and aren't able to walk far may struggle to visit easily<br>• Pressure on limited car parking would increase. |

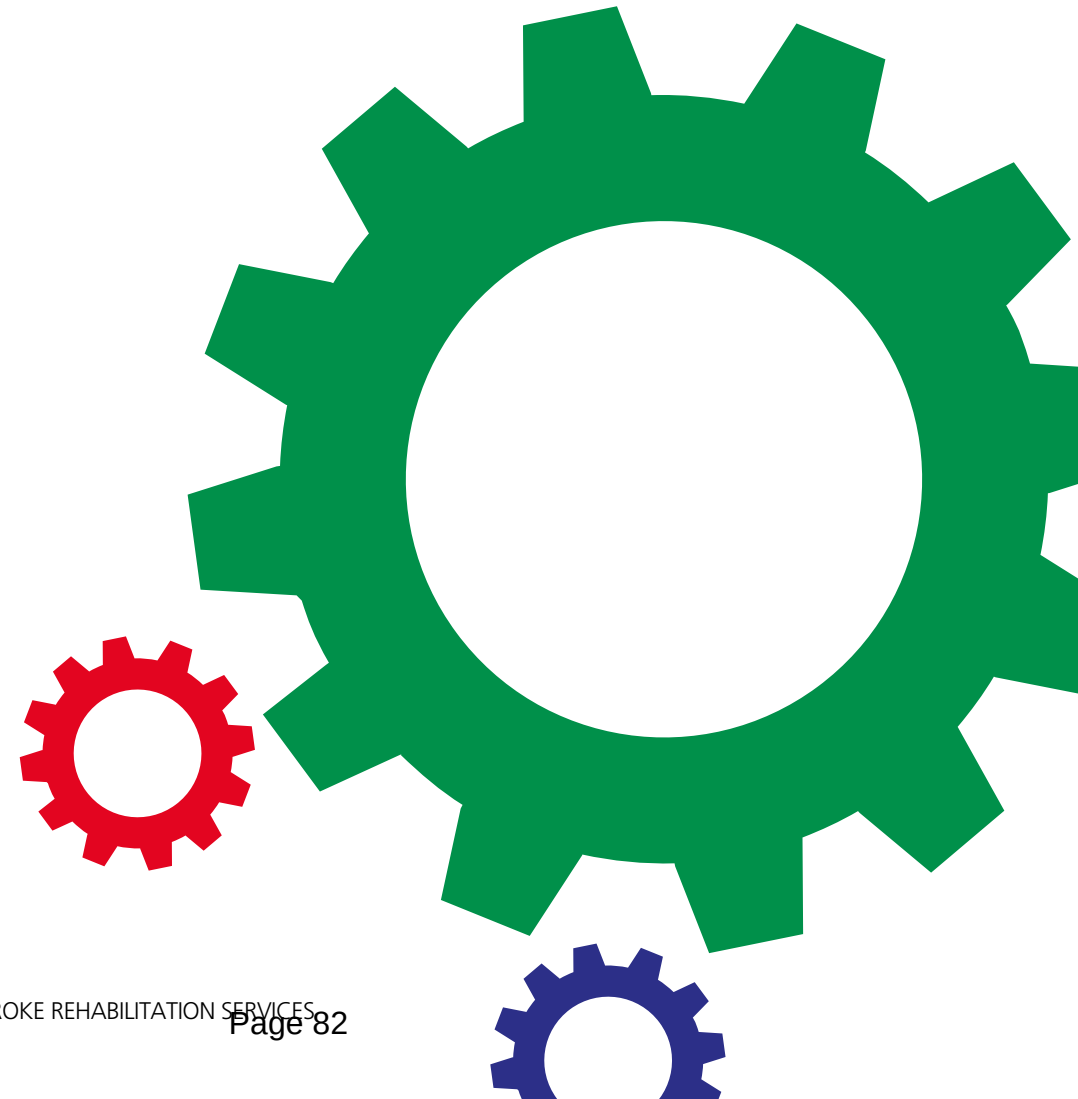
Following discussion, it was agreed that Option A: locate the inpatient unit at King George Hospital was the preferred option.

This means the preferred option (option 3A) is:

**A combined ESD and CRS service covering all three boroughs, offered by one provider, with one inpatient unit based at King George Hospital.**

Detail of the scoring processes and the evidence behind our thinking, including information on finances and the pre-consultation business case is on our websites.

**Note:** The scoring group only considered what was best for patients – they did not talk about money or how much any changes might cost. Separately, finance experts looked at how much each option would cost. It was agreed that any stroke rehabilitation service should cost no more than the current service, but the money we spend on stroke rehabilitation can be spent in a better way, so that people recover more quickly and fully.



# Why stroke services should change

We believe that by making changes to stroke rehabilitation services we can help people to recover better and more fully. The way stroke rehabilitation is provided currently means people don't always recover as fully or as quickly as they should.

What recovery means depends on the individual patient, but can be helping them to stay at home, rather than going into a care home, being able to speak without slurring or being able to do things that are important to them, such as baking a cake or going fishing.

At the moment, when it comes to receiving rehabilitation, stroke survivors face a 'postcode lottery' based on where they live or what hospital they've been in, and this shouldn't happen.

With more people expected to need stroke rehabilitation services in the future, we need to improve them now. This means moving towards a model of care, based on best practice and evidence, which involves:

- providing more rehabilitation in patients' own homes, so it can be tailored towards their individual circumstances
- offering Early Supported Discharge for up to six weeks (length depending on need) for all suitable stroke survivors, wherever they live, so they receive the rehabilitation and support they need in their own homes
- one provider to offer Early Supported Discharge (at the moment, two providers offer it) meaning more joined-up care for patients and less administration
- combining the provision of Early Supported Discharge and Community Rehabilitation Service, to make sure patients move seamlessly through the stroke rehabilitation pathway, avoiding unnecessary transfers and delays in care
- Having one specialist stroke rehabilitation inpatient unit at King George Hospital, which would mean patients would have better access to specialist therapy and nursing support.

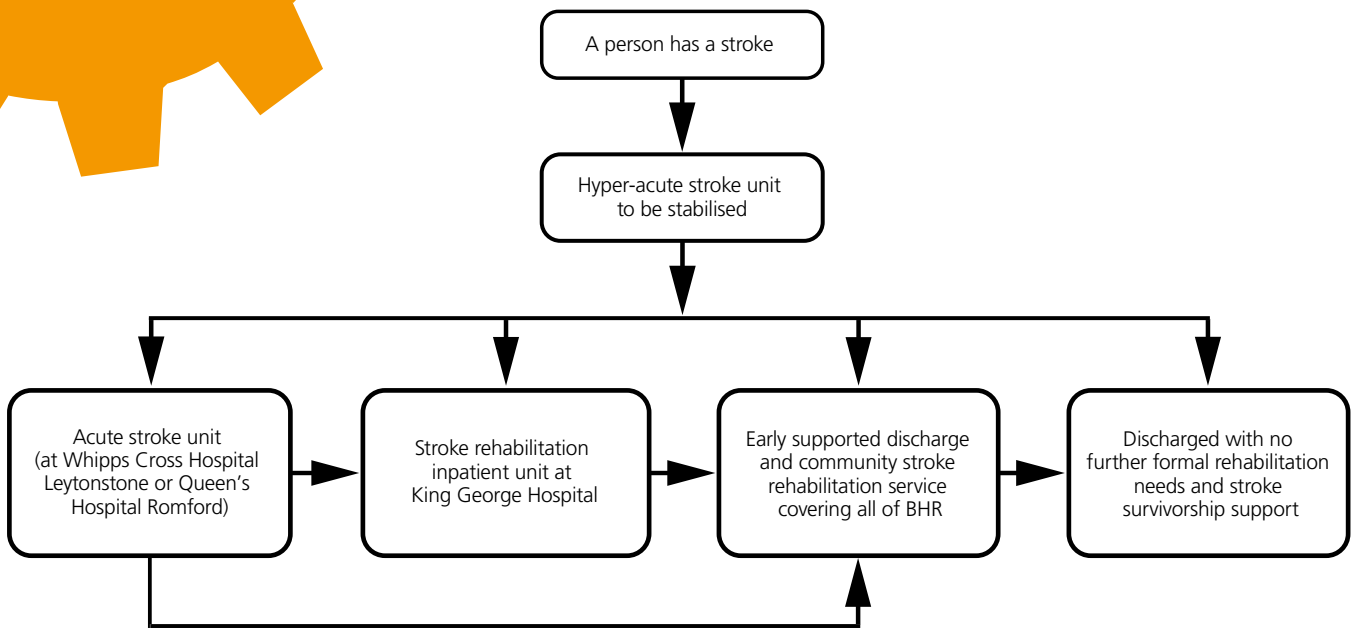
We want to make sure all stroke survivors:

- receive regular checks and assessments looking at how they are living with the effects of stroke and what support they need
- are referred to a disability employment adviser or vocational rehabilitation team if they want to go back to work after their stroke
- are assessed by a clinical psychologist if they need it
- receive six and 12 monthly reviews of their health and social care needs
- receive ongoing support to help their recovery.

Changing the way stroke rehabilitation services are delivered will mean stroke survivors will receive care from staff with the specialist stroke skills and can have speech and language therapy and psychological support.

They will have an improved quality of life, are less likely to have a long-term disability and will be able to go back to work or do other meaningful activity. They will spend less time waiting in a hospital bed for the right sort of care, and will receive rehabilitation services more quickly and go home sooner.

## The ideal stroke pathway




Scoring group members were very clear in their discussions that stroke rehabilitation services need to change – they can't continue as they are because people are not recovering as well or as quickly as they should. This is why it is so important that you tell us what you think of our proposals. If you don't agree with what we want to do, please tell us what you think we should do instead.

# Question and answers

**Q** Do local authorities and NHS providers support these proposals?

**A** Local authority representatives were in the scoring workshop and providers have been involved in discussions about what the stroke pathway should look like. We are asking all these partners what they think of our proposals as part of the consultation process.

**Q** If the preferred option was agreed, when would the changes happen?

**A** We need to take the time to make any changes properly, with minimum disruption to patients. We would need to have further discussions with Barking and Dagenham Council, which owns Grays Court, and BHRUT, which owns King George Hospital. We'd also need to look at how we could offer ESD and CRS across all three boroughs and what staff we would need.

**Q** Have you factored population changes into the planning?

**A** Yes. We always use the most up-to-date population information and projections to make sure we plan for current and future healthcare needs.

**Q** Isn't this just all about saving money?

**A** No. These proposed changes don't save us any money, but people will receive better care – which is more important to us.

**Q** Why just one stroke rehabilitation ward?

**A** The safest way to provide high quality stroke rehabilitation care is to have one stroke inpatient unit rather than a number of smaller units. One unit would mean we could use staff much more efficiently and flexibly and develop their expertise. A single stroke rehabilitation unit would be much better able to cope with fluctuations in demand. We would cut down on duplication of tasks, which would mean staff would have more time to spend with patients. Patients would have better access to specialist therapy and nursing support. The links with other parts of the NHS would be better too.

**Q** What would happen to Grays Court if the decision is made to centralise services?

**A** We do not own Grays Court – it belongs to Barking and Dagenham Council, so they would need to decide what to do with it. We would need to work with the council and other local stakeholders to help decide how best use the building. We'd also need to talk to Grays Court staff about the impact it might have on them and how to manage this.

**Q** Does King George Hospital have space for a stroke rehabilitation unit?

**A** Yes. We would need to talk to BHRUT (as owner of King George Hospital) about where this would be.

**Q** What about having a stroke rehabilitation inpatient unit on the St George's Hospital site in Hornchurch?

**A** Havering CCG is still working with the site's owners and NHS England to develop a new health centre on the site. That is still in the planning stage and so any new centre is some way off.

**Q** How does social care fit into this?

**A** We are asking social care teams what they think of our proposals as part of the consultation process. If we went ahead with the changes, social care would be arranged more quickly as there would be only one inpatient unit and care would be consistent wherever you live. There would only be one team to work with and so the relationship between the teams and ways of working together would improve.

**Q** How will the ESD/CRS work? When will it operate and who will staff it?

**A** If the preferred option is agreed, we'd need to work this out with the organisation that would provide ESD and CRS. The team would consist of occupational therapists, physiotherapists, speech and language therapists, rehabilitation nurses and therapy assistants and we'd want it to operate seven days a week, at times convenient to patients.

**Q** If you decide to centralise stroke rehabilitation beds at King George Hospital, how many beds will there be?

**A** We don't know this yet as we're still working it out. We currently have 32 stroke rehabilitation beds across two sites and there is space for all of these at King George Hospital. We would expect that the number of beds needed would reduce as more people use home-based services such as ESD.

To find out more about our work on stroke rehabilitation services visit our websites.

# What happens next?

When the consultation closes, we will read and consider all the responses we receive – we appreciate you taking the time to respond.

We will use what you tell us to write a report for the three CCGs' decision-making governing bodies to consider, alongside any other evidence and/or information available (for instance the equalities impact assessment) and they will make a decision about what to do.

We will put the dates of the CCG governing bodies' decision-making meetings on our websites. These are meetings held in public, so you can come along, and all the reports that governing body members read will be on our websites so you can read them too.

If you are responding on behalf of an organisation or you represent the public (as an MP, councillor or similar) your response may be made available for the public to look at. If you are responding in a personal capacity, we will not publish your name or response in full but we may use some of what you've said to show particular points of view.

If you let us know your contact details (by filling this in on the questionnaire), we can keep you up to date about any decisions we make.

**If you want to comment on our proposals, we must receive it by 5pm on Friday 1 April 2016.**

**Please send your completed questionnaire to: FREEPOST BHR CCGS (please write this in capital letters on the front of the envelope - no stamp is needed).**

## Equality impact assessment

We use equality impact assessments (EIAs) to identify the positive and negative impacts of a particular piece of work on equality and help us to identify actions which will build on the positive and mitigate the negative impacts. An EIA looking at the impact of potential changes to stroke rehabilitation services will be drafted during the consultation period, and will be on our websites. A final version will be published after the consultation has ended. If you would like a copy of either of these please let us know.

# Questionnaire

We want to know what you think about our proposals

## Tell us about yourself…

**Are you responding as …** (tick as many as apply)

- Someone who has had a stroke
- Someone who has experience of a friend or family member having a stroke
- A NHS staff member
- A carer
- A local resident
- Other
- Prefer not to say

**Are you?** (please tick)

- Male
- Female
- Other
- Prefer not to say

**What is the first half of your postcode?**

**Are you providing this response as a representative of a group?**

- Yes – what is the name of the group
- No

**Have you or someone you know used or worked in stroke rehabilitation services in any of the following areas: Barking and Dagenham, Havering, Redbridge?**

- Yes
- No

## Now we want to know what you think about our proposals to change stroke rehabilitation services…

**Rank the following inpatient (care in hospital) stroke rehabilitation services in order of how important they are to you (1 is the most important, 6 the least)**

- 24/7 medical cover
- Specialist stroke staff
- Easy to get to by public transport
- Easy to get to by car
- Rehabilitation facilities such as a gym
- Pleasant environment and surroundings

## Tell us what you think of the following statements…

**Inpatient stroke rehabilitation should be provided at one specialist rehabilitation unit**

- Strongly in favour
- in favour
- against
- strongly against
- no opinion

**If you are in favour of this, where do you think the specialist inpatient unit should be?**

- King George Hospital in Goodmayes
- Grays Court in Dagenham
- Somewhere else - please tell us where in the text box on the next page
- No opinion

**All stroke patients should have access to the same stroke rehabilitation services, regardless of where they live**

- Strongly in favour
- in favour
- against
- strongly against
- no opinion

**The local NHS should provide more stroke rehabilitation services in patients' homes, provided it is safe for them to be there**

Strongly in favour | in favour | against | strongly against | no opinion

**The local NHS should reduce the number of stroke beds if it can be shown that they are not used and are not needed.**

Strongly in favour | in favour | against | strongly against | no opinion

**Please tell us anything else about our stroke rehabilitation proposals that you think is it important for us to know**

Please write on another piece of paper and attach it to the questionnaire if you want to say more.

**Thank you for completing this questionnaire.**

# Monitoring questions

We would find it useful if you could tell us a bit about yourself so we can see what sorts of people are responding to this consultation and whether they think differently from other groups. That helps us to understand if the changes we want to make might have more of an impact on some groups of people than others. You don't have to give us your name if you don't want to and we will still take your views into account.

**Name** (optional)

**Would you like to be kept up to date with information about the NHS** (including this consultation?)

Yes | No

If yes, please give us your email or postal address

**Are you?**

Male | Female | Prefer not to say

**Do you have a disability?**

Yes | No | Prefer not to say

**How old are you?**

Under 16 | 16-25 | 26-40 | 41-65 | 66-74 | 75 – 79 | 80 or over | Prefer not to say

**What is your ethnic background?** (tick)

- Any White background
- Any mixed ethnic background
- Any Asian background
- Any Black background
- Any other ethnic group (please tell us what)
- Prefer not to say

**Which belief or religion, if any, do you most identify with?** (tick)

- Agnosticism
- Atheism
- Buddhism
- Christianity
- Hinduism
- Islam
- Judaism
- Sikhism
- Other
- Prefer not to say

This document is about changes we want to make to some health services in Barking and Dagenham, Havering and Redbridge. We want to know what you think about this. If you would like to know more, please contact us on haveyoursay@onel.nhs.uk or 020 3688 1615 and tell us what help you need. Let us know if you need this in large print, easy read or a different format or language.

# HEALTH AND WELLBEING BOARD

## 26 January 2016

| | |
|---|---|
| **Title: Learning Disability Partnership Board Strategic Delivery plan update** | |
| **Report of the Strategic Director for Service Development and Integration** | |
| **Open Report** | **For Information** |
| **Wards Affected: ALL** | **Key Decision: NO** |
| **Report Author:**<br><br>Karel Stevens-Lee<br>Joint Commissioning Manager, Learning Disabilities | **Contact Details:**<br><br>Tel: 020 8227 2476<br>Email: Karel.stevens-lee@lbbd.gov.uk |
| **Sponsor:**<br>Anne Bristow, Strategic Director for Service Development and Integration | |

**Summary:**

This is a report which seeks to give assurance to the Health and Wellbeing Board (HWBB) on the workplan that is being delivered by the Learning Disability Partnership Board (LDPB). In order that progress on the work-plan can be monitored and the HWBB can be assured on the delivery of this work, the Partnership Board has created a delivery plan.

The delivery plan covers the following areas, reflecting national and local agendas in relation to learning disability and autism:

- Learning Disability Self Assessment Framework (LSDAF);
- Autism Strategy;
- The Winterbourne View Concordat and the Transforming Care agenda;
- Challenging Behaviour plan;
- Carers Strategy.

This report summarises the work that has been undertaken to date to deliver against the delivery plan. It will enable the HWBB to note achievements made, review areas or services which require further improvement, and ensure the actions agreed to progress any improvements are implemented.

There are currently 40 actions within the delivery plan attached at Appendix 1. Of these, 28 actions are on track to be delivered (rated as green on the attached). This report highlights the 11 actions that are rated as amber (where progress has been slow) and one action that is rated as red.

There is one red rated action highlighting significant concerns and interventions are being

made by partners on the LDPB to ensure that progress improves as quickly as possible. The red rated action is:

- Ensuring people with a learning disability are receiving health checks.

GPs are responsible for ensuring health checks and health action plans are carried out. Discussions have begun to address the issues, with remedial actions being put in place and detailed in the report below. It is recommended that the HWBB gives due consideration to these actions and discusses any further actions that can be taken.

It is proposed that the HWBB will receive a further update on the LDPB delivery plan in six months time. The LDPB will also escalate any exceptional issues which require attention, or investment, by the HWBB via the sub-group reports to Health and Wellbeing Board meetings.

The delivery plan is attached at Appendix 1.

**Recommendation(s)**

Members of the Board are recommended to:

- Comment upon the progress that has been made in implementing the delivery plan.
- Discuss and agree the proposed actions to be taken forward to maintain or improve services for people with learning disabilities and autism.
- Agree actions to improve current performance around health checks and health action plans.
- Advise as to whether the Delivery Plan adopted by the LDPB provides assurance to the Board on the delivery of the LDPB workplan, and whether this approach should be replicated by the other sub-groups.

**Reason(s)**

The Learning Disability Partnership Board is a sub-group of the Health and Wellbeing Board. The HWBB tasked each sub-group to be responsible for reporting and implementing actions relating to national and local priorities, as well as sections of the Health and Wellbeing Strategy delivery plan that relates to its service area. This report provides assurance from the Learning Disability Partnership Board (LDPB) that the actions delegated to the LDPB from the HWBB are being delivered.

The Delivery Plan and Outcomes Framework of the Health and Wellbeing Strategy delegates the following actions to the LDPB. These have been incorporated into the delivery plan attached, although these are also covered in the Learning Disability Self Assessment (LDSAF) and the Autism Self Assessment (ASAF):

- Completion of health checks and health action plans;
- Stable and appropriate accommodation for people with a learning disability;
- People with a learning disability in paid employment;
- Greater acceptance and diagnosis of adults with autism.

## 1. Introduction

**1.1** This report is the first of a new style of assurance report from HWBB sub-groups that aims to give assurance to the Board that workplans delegated to the Board's sub-groups are being delivered.

**1.2** The Learning Disability Partnership Board (LDPB) meets on a bi-monthly basis and includes representatives from organisations who work across the local health and social care economy, from both the voluntary and statutory sectors.

**1.3** The LDPB has three representative groups that support it – a **Service User Forum**, a **Provider Forum** and a **Carers Forum**. These groups discuss and comment upon items that go to the LDPB, and escalate issues facing people with learning disabilities and autism to the Board. A representative from each of the representative groups sits on the LDPB and attends each of the meetings. There are two service user representatives on the LDPB.

**1.4** The delivery plan at Appendix 1 has been created to track and monitor the progress being made against key national and local agendas for people with learning disabilities and autism, including:

- Learning Disability Self Assessment Framework (LSDAF);
- Autism Strategy;
- The Winterbourne View Concordat and the Transforming Care agenda;
- Challenging Behaviour plan;
- Carers Strategy.

**1.5** The delivery plan will be discussed at each LDPB meeting and updates to the plan are coordinated by the Integrated Commissioning Manager for learning disabilities. In future, the LDPB will escalate any exceptional issues which require attention or investment by the HWBB via the sub-group reports to Health and Wellbeing Board meetings.

**1.6** The main areas of activity will be discussed and summarised below. In particular, the report highlights any areas which are currently rated as amber or red. An amber rating would indicate slower progress than expected on delivering the outcome required. A red rating would highlight a significant under performance with a possibility of not delivering the outcome within the specified target date.

## 2. Learning Disability Self-Assessment Framework (LDSAF)

**2.1** The Joint Health and Social Care Learning Disability Self-Assessment Framework (LDSAF) began in 2007 as a guide for health and local authorities to recognise the overall needs, experience and wishes of people with a learning disability and their carers. The LDSAF is overseen nationally by NHS England and ADASS (Association of Directors of Adult Social Services).

**2.2** The aim of this framework is to provide a single, consistent way of identifying the challenges in caring for the needs of people with learning disabilities, and documenting the extent to which the shared goals of providing care are met

locally. The LDSAF is used to identify the priorities, levers and opportunities to improve care and tackle health and social care inequalities.

**2.3** Each year authorities are tasked with carrying out a self-assessment on how it meets a set of criteria outlined within the LDSAF for both children and adults. This year's assessment covered the period 1 April 2013 – 31 March 2014 and was completed in early 2015. The Integrated Commissioning Manager for Learning Disabilities led on the collation of the data for the LDSAF with health and social care colleagues from the CCG, Children's Services, Community Learning Disability Team Practitioners, Transport services, Leisure and Arts, Youth Offending, Probation services, as well as service users, carers and providers.

**2.4** Each qualitative measure assessed was rated as fully met, partially met or unmet, represented as red, amber or green as detailed in the national guidance. Each service area agreed the rating of how they meet the needs of people with a learning disability and agreed to actions stating how they would maintain or improve these measures. These actions were then developed into a Borough-wide action plan which has been incorporated into the delivery plan at Appendix 1.

**2.5** The Health and Wellbeing Board received the LDSAF on 19 May 2015 and agreed to the action plan accompanying the self-assessment. The original report and action plan can be found here: http://moderngov.barking-dagenham.gov.uk/documents/s90347/LDSAF%20HWBB%20-%20Report.pdf.

**2.6** It should be noted that there is no requirement to complete an LDSAF for 2014/15 and the Association of Directors of Adult Social Services (ADASS) have stated that they will be reviewing the position in April 2016. However, we will continue to monitor our LDSAF actions within the delivery plan to maintain and improve our performance in services for people with learning disabilities.

## 3. Update to the LDSAF

**3.1** Most indicators from the LDSAF are achieving within the agreed implementation plan. However, there is one key area at a red rating, indicating that progress has been significantly slow with little chance of achieving its target. There are also two key areas rated as amber indicating progress has been slower than anticipated. These areas are:

| | |
|---|---|
| **Health checks** | **R** |
| **Screening programmes** | **A** |
| **Offender health and the Criminal justice system** | **A** |

**Health Checks – RED RATING**

**3.2** People with learning disabilities have poorer health than the general population and have a shorter life expectancy compared to the general population. Mental illness, chronic health problems, epilepsy and physical and sensory problems are more common amongst this group than they are within the general population.

**3.3** To help address these health inequalities GPs are commissioned to offer an Annual Health Check to people with a learning disability (i.e. once every financial year). GPs are required to undertake this in line with the Cardiff Health Check[1].

**3.4** In addition each annual Health Check should result in a Health Action Plan setting out the steps to be taken to address any issues identified by the GP.

**3.5** To further highlight the importance of robust health checks and health action plans, Walthamstow Coroner's Court published a report in March 2015. The report detailed events leading up to the death of a service user in a neighbouring London Borough. One of the contributing failures was the inadequacy of thorough health checks. The LDPB reviewed the report and used its' recommendations to support the Borough's learning. The report emphasised the crucial importance of Barking and Dagenham ensuring that appropriate systems and support are in place to support people with a learning disability accessing appropriate health care.

**3.6** Robust health checks and health action plans are therefore important indicators that people with a learning disability living in the borough are accessing the health care services that they need.

**3.7** In previous years, the Annual Health Checks were validated by the Community Learning Disability Team (CLDT) before full payments were approved. The NHS contracts with GPs no longer require a validation of health checks as a condition of payment. This year's figures are showing a significant reduction in the number of health checks recorded as being carried out by GPs. With the reduction in the number of health checks being carried out there has been a corresponding reduction in the number of Health Action Plans (HAPs).

**3.8** ADASS and NHS England suggest the following RAG ratings for completed health checks for primary medical services (Directed Enhanced Service) directives 2015, which came into force on 1st April 2015. The directives include a learning disability heath check scheme. The scheme is in place to encourage primary medical services contractors to identify registered patients aged 14 plus who are known to Social Care and have a learning disability:

- **Green**: 80% or more of people with a learning disability are on the GP DES Register and have had an annual health check.
- **Amber**: Between 41% and 79% of people with a learning disability are on the GP DES Register and have had an annual health check.
- **Red**: Fewer than 40% of people with a learning disability are on the GP DES Register and have had an annual health check.

**3.9** The current figures available via Health Analytics state that 25% of LBBD residents with a learning disability who are logged onto the GP DES Register have had an Annual Health Check this year since 1 April 2015. This equates to 197 people. To achieve the 80% rate described above, 630 people would require a health check to be completed. It should be noted that this figure is provisional and further validation of the data is being undertaken. This is therefore a red rating and has been categorised as such on the delivery plan attached at Appendix 1.

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[1] The Cardiff Health Check is the recommended health checklist for people with learning disabilities to be used by GPs.

**3.10** Similarly, ADASS and NHS England suggest the following RAG ratings for Health Action Plans:

- **Green**: 70% or more of Annual Health Checks generate a health action plan.
- **Amber**: 50% - 69% of Annual Health Checks generate a health action plan.
- **Red**: Fewer than 50% of Annual Health Checks generate a health action plan.

**3.11** More than 90 percent of people registered with the CLDT have a Health Action Plan. Work is currently underway, however, to calculate the proportion of GP Annual Health Checks that have this year resulted in an amendment (as per the SAF RAG Rating guidelines).

**REMEDIAL ACTIONS**

**3.12** The quality of health checks from GPs in the borough needs to be consistent and follow the guidelines as set out in the Cardiff Health Check. The low numbers of recorded health checks and health action plans has been shared with senior officers within the CCG and the Clinical Director with a lead for primary care improvement. Further work is needed to understand where the problem lies and ensure that there are an effective set of actions to address the issue quickly.

**3.13** The following actions have been identified which will be built upon and implemented from January 2016 onwards:

- Joint Commissioner, CLDT Lead Nurse and the Practice Improvement lead will attend the GP forums, the Practice Nurse forums and the Practice Managers forums. The Practice Improvement Lead will confirm when the scheduled meetings are taking place during early 2016. The focus will be on raising awareness of the issues and understanding support needed from CLDT.

- Discussion of issue and action plan at Primary Care Development Group on 19th January. The action plan will be supported by the Joint Commissioner, Practice Improvement Leads, CLDT Lead Nurse, Health Facilitation and the Clinical Director for primary care improvement. The plan will identify any additional training needed and a programme for providing this.

- Via a project management approach the CLDT will support the GPs to undertake the required Annual Health Checks and subsequent updates to Health Action Plans. The Health Facilitation team within the CLDT have provided additional resources of a scale 6 administrator to co-ordinate and monitor the number of health checks and health action plans completed by GPs on a weekly basis. The administrator will take the lead in reviewing the register and validating the data held by the CLDT and the GPs. It is expected this process will be completed by early February 2016.

- The CLDT Lead nurse and a member of the health Facilitation team will attend each GP surgery individually and agree the most appropriate support and actions that need to be implemented at a local practice level. There are

39 GP surgeries this will programme will be implemented over a 6 months period.

- The CLDT Lead Nurse, the Joint Commissioner and a member of the Health Facilitation team will initially attend the Integrated Care meetings. The meetings are held every 6 weeks and include representation from both heath and social care practitioners. There will be a new expectation introduced to the meetings where GPs will bring to the meetings a list of all patients with planned health checks in the coming 6 weeks. This will ensure the CLDT are aware of the health assessments and plan and provide support where needed to GPs. Once the process is established a member of the Health Facilitation team will continue to attend the Integrated Care meetings.

- The CLDT will monitor and encourage health checks and health action plans when completing their annual, social care reviews.

**3.14** CLDT has also begun to work with providers and service users on the need for, and process of, a health check. This will empower service users to expect a health check routinely when visiting their GP. The Integrated Commissioning Manager (Learning Disabilities) has also reminded Borough Providers through the provider sub-group forum of the role that they play in supporting service users when visiting the GP. This expectation is also detailed in the Learning Disability Supported Living contracts' Outcomes Framework in which providers are asked to evidence how they support service users to have Health Checks, Health Action Plans and hospital passports.

**3.15** The Integration and Commissioning team are in the process of standardising the outcomes and key performance indicators for accommodation based services. The team are undertaking a Quality Assurance programme to assess and validate all providers that have not had their services evaluated through a competitive tender exercise. This will include ensuring that provider services contribute to supporting service users to stay healthy.

**3.16** Performance in heath checks and health action plans will be continuously monitored by the LDPB over the coming months. The Joint Commissioner and the CLDT will meet every 6 weeks to monitor the implementations agreed. A progress update will be brought to the HWBB in 6 months time in order that the Board can be assured that performance in this area has improved.

**Screening Programmes – AMBER RATING**

**3.17** There is a national cancer screening programme which is included within the LDSAF. This includes:

- National breast screening - The NHS Breast Screening Programme invites all women aged between 50 and 70 for screening every 3 years. In England, the screening programme is currently extending the age range to include women from 47 to 73 years old.

- National cervical screening - NHS cervical screening programme is available to women aged 25 to 64 in England. All eligible women who are registered with a GP automatically receive an invitation by mail. Women aged 25 to 49

receive invitations every 3 years. Women aged 50 to 64 receive invitations every 5 years.

- Bowel cancer screening – The screening programmes send a bowel cancer testing kit (FOB testing) every 2 years to people eligible to take part. In England, men and women aged between 60 and 74 years old take part.

**3.18** The data for these indicators is captured by a national data source and this data is not yet available. Our local data is yet to be validated and maybe subject to change. Early local indicators are showing that breast and cervical screening performance is in line with expected performance. However, local indicators are showing that performance may be below average for bowel cancer screening for people with learning disabilities.

**3.19** The Board may wish to consider this in terms of its earlier discussion on how to improve cancer outcomes in the Borough.

**REMEDIAL ACTIONS**

**3.20** Cancer screening programmes remain a priority for the CCG. In order to raise the awareness and outcomes for Cancer screening specifically for people with a learning disability, a number of actions are proposed as follows:

- The CLDT will work with GPs to ensure that cancer screening is included within the patients health check. Any diagnosis identified should be recorded on the patients file and the CLDT should also be made aware of the outcome of any positive cancer screening outcomes in order that this is included in health action plans and the team can work closely with individuals.

- Joint Commissioner to work with BHRUT LD lead and Macmillan GPs/Cancer UK Facilitator to understand specific issues around people with learning disabilities participating in screening and to develop an action plan to address this. This will include:

    - Working with GPs through the Cancer programme and LD health checks work to raise awareness of screening.

    - Wider awareness raising with carers, service users and LD providers on the process and importance of screening.

    - Working with screening providers to ensure appropriate information and appointment times are provided for people with LD.

**Offender health and the criminal justice system – AMBER RATING**

**3.21** The LDSAF states that commissioners must have a working relationship with specialist prison health commissioners to ensure that there is good information about the health needs of people in local prisons and the wider criminal justice system. Barking and Dagenham does not have a local prison, so there have been limited opportunities to engage with prison services. However there has been improved engagement with Community Safety, probation and the local police force. The recent Learning Disability week had a themed event working with the police to

raise awareness of the needs of people with a learning disability in keeping safe and the type of support the police offer to individuals with learning disabilities when they are called in response to criminal activity as either a victim or an offender.

**REMEDIAL ACTIONS**

**3.22** The local authority is developing the borough's Crime and Disorder Strategic Assessment which will be used by the Community Safety Partnership to identify what the current and emerging priorities are for the people living, working and visiting Barking and Dagenham. Officers from CLDT and Commissioning are involved in developing the Strategic Assessment. There have been some improvements in engaging with the criminal justice system but further inclusion remains a target for achievement.

**3.23** The LDPB has tasked the service user and carer sub-groups to consider ways to engage with front-line police officers to raise the awareness of learning disabilities to Police Officers and other community safety professionals.

**3.24** The CLDT and the Joint Commissioning Manager will work with the Group Manager for Community Safety and Integrated Offender Management, to ensure the authority is tracking the number of people with a learning disability who are managed through the Multi-Agency Public Protection Arrangements (MAPPA).

**3.25** The Group Manager for Community Safety and Integrated Offender Management, as well as colleagues from Probation, will also be invited to attend the LDPB meetings in an advisory capacity from January 2016.

## 4. Autism Strategy implementation plan

**4.1** The Government's first Adults Autism Strategy was launched in 2010. It detailed the duties and developments that local authorities and CCGs should implement for Adults with Autism. These were:

- improved training of frontline professionals in Autism;
- the recommendation to develop local Autism teams;
- actions for better planning and commissioning of services, including involving people with Autism and their parents/carers;
- actions for improving access to diagnosis and post-diagnostic support;
- leadership structures at national, regional and local levels for delivery;
- proposals for reviewing the strategy to make sure that it is working.

**4.2** The Council, alongside its partners, is required to produce a local plan which sets out the Borough's approach to delivering the national strategy and commissioning local services.

**4.3** Following the production of the Borough's first Autism Strategy in 2011, the Health and Wellbeing Board received the second iteration of the Barking and Dagenham Adult Autism Strategy in December 2014. The Strategy was developed in conjunction with professionals, local voluntary groups, as well as individuals with

Autism and their carers. The full report and the Adult Autism Strategy can be found here: http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MId=7555&Ver=4.

**4.4** The Adult Autism Strategy was structured around nine different priorities with an accompanying action plan stating how these priorities would be delivered. The priorities were based on what service users, carers and professionals told us were priorities for adults with autistic spectrum disorders and for the services that currently exist in the Borough. The priorities were:

- There is a clear and effective diagnostic pathway for Autism with information and advice on the support that is available.
- There is good quality care and support for adults with Autism.
- Adults with Autism are effectively supported with their housing needs.
- Adults with Autism are effectively supported to access employment, training and skills.
- There are lots of opportunities to take part in meaningful activities, during the day, in the evenings and at weekends.
- Young people with autistic spectrum disorders who 'transition' to adult services are appropriately supported and encounter a smooth transition.
- Adults with Autism are involved in the design, planning and operation of services.
- Adults with Autism feel safe from harm and abuse at home and in the local community.
- All health and social care staff, including those commissioned to provide services, are aware of Autism and are appropriately trained to identify, assess and support those with Autism.

**4.5** Running concurrent to the development of the Council's Autism strategy was the submission of a national annual Autism Self Assessment Framework (ASAF). The ASAF was conducted in a questionnaire style and our submission was greatly facilitated by the work that had been undertaken to update the Adult Autism Strategy. Alongside the LDSAF, the ASAF was presented to the Health and Wellbeing Board in May 2015. The report from that meeting can be found here: http://moderngov.barking-dagenham.gov.uk/documents/s90347/LDSAF%20HWBB%20-%20Report.pdf

**4.6** There was no requirement for local authorities to develop an improvement plan. However the Adult Autism Strategy collectively captures all of the priorities detailed in the ASAF.

**Update to the Autism Strategy**

**4.7** The Integrated Commissioning Manager for Learning Disabilities has worked with colleagues from across the health and social care economy to take forward the actions identified in the Adult Autism Strategy. The below are areas in which it has been identified that progress has been slow or not progressing in taking the Adult Autism Strategy forward. These have been flagged as amber on the learning disability delivery plan at Appendix 1.

| | |
|---|---|
| **Housing needs** | **A** |
| **Diagnostic pathway** | **A** |
| **Accurate reporting on the social care database** | **A** |

**Housing Needs – AMBER RATING**

**4.8** Historically autism has been included within the grouping of learning disability services. The government's strategy on autism gives a clear message that services can no longer assume the needs of people with autism are met under overarching services. The Council is developing its Independent Living Strategy; this will detail how the Council will meet the housing and support needs of adults with autism and also engage with ageing carers around the housing and support needs of their adult children with autism. The previous target date for completion was March 2015. This target date was not been met due to staff resourcing issues. The revised target date is now April 2016. The LDPB have received regular updates from the Group Manager of Housing Strategy and a task and finish group, specifically looking at housing for people with learning disabilities and autism, has now been put together. The strategic objectives of the Independent Living Strategy are currently being drafted and consultation on these will begin in February 2016.

**REMEDIAL ACTIONS**

**4.9** The LDPB and its subgroups will continue to monitor the implementation of the Independent Living Strategy to ensure it includes the needs of people with autism. This will be particularly challenging as there is not sufficient housing in the borough to meet the needs of all the vulnerable groups. To mitigate the sole reliance on the council's Housing department, Adult Social Care is also exploring options of working with Providers and Private Investors to create additional housing solutions for people with learning disabilities and autism.

**Diagnostic Pathway – AMBER RATING**

**4.10** A key driver of the success of the Autism strategy is access to information through diagnosis and assessment. The agreement within the Autism Strategy was for an autism diagnostic pathway to be provided by NELFT, including its' implementation and publication.

**REMEDIAL ACTIONS**

**4.11** NELFT has set up a Diagnostic Pilot Pathway across the four NELFT London Boroughs. This pathway was developed and agreed by the Trust / CCG to provide a

diagnostic service. The local authority is working with NELFT to ensure the autism diagnostic pathway service is implemented and is accessible and publicised to service users, including publicity on the Council's Care and Support Hub. Officers from NELFT have been invited to the February 2016 Partnership Board meeting to present the pathway and how it will be accessed and publicised to service users, carers and professionals.

**Accurate recording on the Social Care Service User Database – AMBER RATING**

**4.12** The diagnosis of autism has at times been recorded with the overall diagnosis of learning disabilities. In order to truly focus on meeting the needs of people with autism, the strategy highlights the need to ensure autism is recorded on service user's records when autism is diagnosed as the primary need.

**REMEDIAL ACTIONS**

**4.13** The CLDT will ensure when autism is diagnosed as the primary need it is recorded as such on the Social Care service users database (AIS). This will improve our records and ensure service users and enable the authority to plan better on meeting the needs of people with autism.

## 5. Other updates

**5.1** The rest of this report will focus on providing the Health and Wellbeing Board with an update on the work that has been undertaken regarding other national and local agendas and the progress of actions on the Delivery Plan in these areas.

## 6. Transforming Care: The Winterbourne View Concordat

**6.1** Following the Panorama programme on Winterbourne View Hospital, the government produced a report and concordat that were to be implemented nationwide called 'Transforming Care: A National response to Winterbourne View Hospital (December 2012)'. The report clearly stated that local authorities and health services should identify those patients within a hospital setting with a learning disability who no longer require this level of care intervention and whose needs could be more appropriately met within a community setting, preferably in a location close to their family. In particular, it sets out that local authorities and Clinical Commissioning Groups (CCGs) work together to ensure that vulnerable people, particularly those with learning disabilities and Autism, receive safe, appropriate, high quality care. It states '*the presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people.'*

**6.2** The actions, as set out in the Concordat accompanying the review, report a commitment by CCGs and local authorities to work in partnership to:

- Reduce the number of people who are residing inappropriately in specialist learning disabilities and Autism hospitals and services;
- Reduce the length of stay in these services (where appropriate); and,
- Improve the quality of care in those services.

**6.3** The Transforming Care report set out some particular actions for CCGs to complete in order to support the commitments of the concordat. These were:

- The development of registers of all people with a learning disability or Autism in NHS funded care;
- Maintenance of the register;
- A comprehensive review of all placements for individuals identified as being resident within Assessment and Treatment units (ATU).

**Actions around the Winterbourne View Cohort**

**6.4** One of the key recommendations in the Winterbourne View Concordat was the development and maintenance of a register for all patients receiving treatment in a specialist hospital. The patients on the register are referred to locally as the Winterbourne Cohort. Maintaining the register is the responsibility of the CCGs.

**6.5** The Barking and Dagenham register began in 1st April 2013 with six people on the register. Since then there have been 8 new admissions, taking the total number of people who have been on the register to 14.

**6.6** The annual cohort of admissions breakdown is:

- **April 2013 – 2014 = 6 (Start of the register)**
- **April 2014 – 2015 = 4**
- **April 2015 – 2016 = 4**

**6.7** The total number of discharges since the register began is 10. The cohort breakdown is:

- **April 2013 – 2014 = 3**
- **April 2014 – 2015 = 4**
- **April 2015 – 2016 = 3**.

**6.8** At the time of writing this report there are 4 service users on the register. The breakdown of their annual admission dates is:

- **April 2013 – 2014 = 3**
- **April 2015 – 2016 = 1**.

**6.9** The four individuals on the register are in Assessment and Treatment Units (ATUs). Two service users within the April 2013-14 cohort are still receiving active treatment and are not ready for discharge. One individual was reviewed at the end of September 2015 (with the next review due in February 2016) and it was agreed that a discharge was not appropriate because the individual exhibited intense challenging behaviour that it was felt was best supported in the setting in which the individual currently resides. The second individual was reviewed in July 2015 and December 2015. The individual is a Ministry of Justice patient and was moved to a smaller ATU in December. The patient is scheduled to have a care and treatment review in February 2016.

**6.10** One service user within the April 2013-14 cohort was reviewed in late November 2015 and is working towards a discharge within the next 3 months and a detailed

discharge plan is in place which has been agreed by the service user, family carers, care management and clinical advisors.

**6.11** The patient within the April 2015-16 cohort was admitted in mid December 2015 and is currently being assessed prior to having an active treatment plan.

**6.12** The authority is reviewing each service user's progress in a number of ways. These include:

- Setting up and chairing six monthly Care and Treatment Reviews (CTRs) attended by the service user, family carers, advocates, care management and the full medical team including independent clinical advisors and a lay advocate.
- Attending all case reviews such as Care Programme Approach (CPA) and mental health tribunals.
- Regular visits to see the patient to observe progress and treatment being offered.

**6.13** The past 12 months has seen the CCG and the Council focussed on reducing the number of patients that are in Assessment and Treatment Units (ATU). This has been achieved by the CCG and the Council working together to agree those patients within a hospital setting with a learning disability who no longer require this level of care intervention and whose needs could be more appropriately met within a community setting, preferably in a location close to their family. The number of Barking and Dagenham service users (4) is slightly lower than the London average of 4.8.

**6.14** The challenge for successful discharge are that patients are not re-admitted back into hospital for treatment for the same or similar reasons that led to their first admission. To date the number of Barking and Dagenham re-admissions is 0 (zero), the London average for re-admissions is currently 28%.

**6.15** NHS England has set London CCGs a regional target to have a 13% reduction of patients on the register at 1st April 2015 by 31 March 2016. London CCGs are tasked to contribute to this target. At 1 April 2015 the number of patients on the B&D register was 7; there are now 4 patients on the register, a reduction of 57% within the first 6 months of the year and thereby already exceeding the national target. A further discharge is planned to take place before 31st March 2016. Achieving the additional discharge would further increase the Barking and Dagenham discharge reduction rate. This reduction has been achieved by:

- Working closely with Current Providers, potential new Providers, Service users, Advocates, Carers, Integrated Care Management team and Commissioners to ensure the most appropriate placement and process is agreed that will lead to a stable discharge outcome.
- Careful consideration is taken to identify potential Providers that have the required experience and resources to develop bespoke packages.
- Ensuring all agreed discharge transition plans reflect a timetable suited to each individual service user.
- Liaising with Commissioners from other Local authorities and CCGs to agree joint funded packages of care and support as part of the discharge plan.

**6.16** Whilst progress has been made towards achieving the objectives of the Concordat, the challenges that the CCG and the local authority face are:

- Preventing unnecessary admission and re-admission into ATU services.
- Identifying Providers with the expertise to develop be-spoke packages.

The following outlines the work that is being done to meet these challenges.

**6.17** **Preventing unnecessary admission and re-admissions**: To date the authority has not had any patient re-admitted following discharge. It is felt that this has been achieved by:

- Ensuring the patient has made significant and stable improvements whilst receiving care and treatment before recommending a discharge;
- Taking the time to identify the most appropriate Provider and environment to meet the needs of the patient;
- Allowing sufficient time for a transition into the new service;
- Collaborating well with all the relevant stakeholders.

**6.18** **Gate-keeping to admissions**: To add further resilience to Preventing Unnecessary Admissions (PUA) into ATU services, LBBD and B&DCCG are currently considering how to implement a gate keeping process to ATUs. The gate-keeping process will include:

- Inclusive Meetings held at the provider setting
- Ensuring family involvement & meaningful input
- Experts by Experience being involved at the earliest opportunity
- Flexible & Creative approaches to funding care packages
- Extra staff being commissioned at short notice to prevent placement breakdown
- Learning from CTR's being used to change practice/thinking
- Where the principles of Positive Behavioural Support were being deployed
- Where Localities had effective ways of monitoring and tracking people at risk of admission.

**6.19** '**At Risk of admission' Register:** Further work in preventing and minimising admission is the development of an "at risk" register. The introduction of a risk register is to identify individuals at risk of admission. This will enable commissioners to track individuals, identify existing gaps in current service provision and design the required services in partnership with relevant stakeholders. Working with NHS England each CCG and local authority will develop and hold a register of those "at risk" of admission. Providers, community teams and other organisations (as appropriate) will be involved in the development of the register. Although in its early stages, some of the identifiable risks or triggers that will assist the authority to be proactive in offering timely support are: (please note that this list is not exhaustive list)

- Significant life events and/ or change such as bereavement or abuse.
- Unstable / untreated mental illness
- Previous history of admission(s).
- Presenting significant behavioural challenges.
- Being supported in an unstable environment or by a changing staff team.

- Not being previously known to learning disability services.
- Being homeless
- Being in contact with the Criminal Justice System.
- Presenting 'in crisis' at Accident & Emergency Departments.
- Having no family carers/advocates.
- Having drug and alcohol addiction problems.
- Having no effectively planned transition from Child to Adult learning disability services.
- Being placed in specialist '52-week' residential schools or out of area specialist providers
- Having recently been discharged from long stay hospital beds.
- Having a family history of significant mental health challenges
- Having a history of safeguarding challenges.

**6.20** The development and maintenance of the risk register will require the on-going support of health and social care services, in partnership with service users, carers, Providers, Housing Services and other stakeholders. It is planned to commence the development of the "at risk" register in January 2016. This action has been included in the LDPB delivery plan.

**Building the Right Support**

**6.21** Another phase of the Transformation Care Programme is for the CCG to lead on developing community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.

**6.22** In October 2015, NHS England announced a national plan called *'Building the Right Support'*. The programme is expected to achieve a closure of 40-65 % closure of hospitals within the next 4 years. Much of the priorities for Barking and Dagenham will be centred on the "Building the Right Support" Programme. Barking and Dagenham will form part of a Transforming Care Partnership (TCP) with the other east London CCGs.

**6.23** Transforming Care Partnerships will be supported to work alongside people who have experience of using these services, as well as their families/carers, clinicians, providers and other stakeholders to formulate and implement joint transformation plans; closing some inpatient provision and shifting investment into support in the community**.** They will bring commissioners together at a scale larger than most CCGs and many local authorities, with their geographical footprint based on:

- Building where possible on existing collaborative commissioning arrangements (e.g. joint purchasing arrangements amongst CCGs, joint commissioning arrangements between CCGs and local authorities).

- Local health economies of services for people with a learning disability and/or autism (e.g. patient flows, the provider landscape, and relationships between commissioners and providers). Where, for instance, a number of CCGs tend to use the same hospital provider for inpatient services it makes sense for those CCGs to implement change collaboratively.

- Commissioning at sufficient scale to manage risk, develop commissioning expertise and commission strategically for a relatively small number of individuals whose packages of care can be very expensive.

**6.24** The final TCP membership has not yet been agreed. The work of TCP will commence in January 2016 and it is expected to run until 2019. The key commission intentions of the TCP are:

- Reduced reliance on inpatient services (closing hospital services and strengthening support in the community).
- Improved quality of life for people in inpatient and community settings.
- Improved quality of care for people in inpatient and community settings.

## 7. Addressing Behaviour that Challenges Services: Challenging Behaviour Plan

**7.1** Additionally, in responding to preventing or minimising admission, the local authority is implementing the strategic commitments made to the Health and Wellbeing Board in March 2014 on *"Addressing Behaviour that Challenges services*", the Borough's Challenging Behaviour Plan. The key actions relating to this plan are:

- Developing local services that have the expertise to support behaviour that challenges.
- Developing services that offer service users and carers a respite during short term crisis.
- Working regionally to develop provisions that are feasible and sustainable across the neighbouring borough boundaries.
- Sharing good practice across the region and nationally.

**7.2** The following actions have been achieved in the first phase of the Challenging Behaviour Plan:

- Improved integration with health and social care. Many service users who display behaviour that challenges often have a combination of health and social care support needs, joint assessments and joint funding solutions have been a successful outcome to meeting the needs of the service user.
- Raising awareness understanding, and knowledge of good practice in supporting service users who have challenging needs. This has included encouraging Providers through the Providers forum to implement Positive Behaviour Support as a core training element of their induction programme for staff.
- Supporting Providers to implement the Safeguarding reporting and Deprivation of Liberty Safeguard (DoLS) in a transparent, non risk aversive approach that leads to service improvements.
- Reshaping the Community Learning Disability team to include specialists in behaviour that challenges and ensure these specialists offer training and crisis intervention.

- Utilising the Fulfilling Lives programme to work with existing providers/specify in the supported living tender the need to move people who have attended day services for a long time and who wish to move on to find mainstream opportunities.

**Next Steps – Challenging Behaviour Plan**

**7.3** The next phase of the Challenging Behaviour Plan will take place over the next 5 years. The programme of work will require a long term commitment from all partners in order to see a sustainable change in how service users that have behaviour that challenge are supported by the borough. These actions have been captured in the LDPB delivery plan.

**7.4** An ongoing challenge is the **availability of housing** which can be tailored to ensure that services for individuals with challenging behaviour can be delivered. This will include developing links with landlords and the Housing department. This will be incorporated into the Independent Living Strategy and monitored through the LDPB meetings.

**7.5** It has been identified there is a need to develop a **service specification** that meets the need of service users who display challenging behaviour. It is recognised that there is a national and regional problem regarding the lack of providers with the expertise to develop bespoke packages and sustain support to people with challenging and complex needs. Working within the collaboration of the neighbouring boroughs across North East London preliminary work has began to develop a framework of "expert Providers" that would be accessible to the authority. It is planned to have the framework in operation by April 2017.

**7.6** Barking and Dagenham are also part of a working group that is led by the Tizard Centre within Kent University. The Tizard Centre is recognised as one of the world's leading research and study centres for learning disability. The completion of the service specification will assist the council to commission good providers that are clear on the expectations of commissioned services designed for challenging behaviour services, and ensure providers have the skills and resources to achieve the outcomes.

**7.7** Barking and Dagenham are **working closely with all the regional authorities overseen by NHS England**. This joined up approach has led to the a number of positive outcomes:

- Sharing of information about good quality providers.
- Sharing of safeguarding concerns across the region and therefore minimising the risk of another Winterbourne View type of incident.
- Sharing the task of sourcing suitable providers, and therefore creating economies of scale and financially viable models that would not have been sustainable in isolation by a single borough.

**7.8** The lack of good local services has led to many service users being offered a placement out of the borough, this happens in both children and adults services. Once the service users are settled in their new community it is often difficult to support service users to return to Barking and Dagenham, as occasionally they

are now settled in their community and do not wish to return or at times there are legal requirements restricting a return to the borough.

**7.9** In order to minimise the number of out of borough placements that are agreed in the first instance the Council will need to work with providers and landlords to develop services in our locality, and ensure closer working between services for adults and those for children and young people.

## 8. Carers Strategy

8.1 The Care Act puts in statute for the first time, the needs of carers and their right to be recognised for the work that they do. The Care Act introduces significant and welcome measures to improve the rights of adult carers. These measures include:

- A duty on local authorities to promote the physical, mental and emotional wellbeing of carers and their participation in work, education and training;
- A duty on local authorities to provide information, advice and access to a range of preventative services which reduce carers' need for direct support;
- New assessments which put carers on an equal footing with the person they care for;
- Giving carers, for the first time, a clear right to receive services, via a direct payment if they choose;
- A national eligibility threshold, bringing greater clarity around entitlement for carers and those they care for;
- Processes in place to ease the transition between child and adult services.

6.2 In 2014/15 the local authority and the CCG worked with Carers UK, stakeholders and carers to develop the Borough's Carers' Strategy, *Let's Care for Carers: A Carers' Strategy for Barking and Dagenham 2015-18*. The strategy was agreed by the Health and Wellbeing Board in February 2015 and recognises the importance of the contribution made by carers to the safe and sustainable delivery of care in the Borough. The Strategy also reflects the changes made by the Care Act 2014.

6.3 Where actions in the Carers Strategy are relevant to carers of individuals with learning disabilities, these actions have been incorporated into the delivery plan attached and will be monitored regularly at LDPB meetings.

6.4 Completed actions from the Carers Strategy so far have included:

- Consultation with the LDPB and the Carers Forum sub-group to develop the new service specification for the Carers' Hub.
- The inclusion of learning disability provider services on the Carers Strategy Group.
- The inclusion of carers as a key part of the Carers Hub tender evaluation.

## 9. Mandatory Implications

### 9.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment has a strong learning disability analysis and the detail contained in this report aligns well with the strategic recommendations of the Joint Strategic Needs Assessment. It should be noted, 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.

### 9.2 Health and Wellbeing Strategy

The report describes performance against priorities outlined in the strategy on service improvement that need to be provided now and in the future to enhance the lives of people with a learning disability.

### 9.3 Integration

The Learning Disability Partnership Board is a multi-agency Board with representation from the local authority, the CCG, NELFT, BHRUT and other partners across the health and social care economy and the voluntary and community sector. The Board also has representation from service users, carers and Providers of learning disability services. The Integrated Commissioning Manager for Learning Disabilities is also a joint appointment between the Council and the CCG.

### 9.4 Financial Implications

Implications completed by: Carl Tomlinson, Group Finance Manager

There are no direct financial implications arising from this report. The delivery plan would mainly be managed within existing funds available through the Council base budgets and the Better Care Fund.

### 9.5 Legal Implications

Implications completed by: Dawn Pelle, Adult Care Lawyer

There are no legal implications for the following reasons:

- First the Action plan is being developed with regard to all the relevant policies, the Care Act 2014, the associated regulations and guidance;
- The required actions as directed by the Winterbourne Concordat has been implemented;
- There is to be a Carer's strategy implemented and developed especially for those carers of LD/Autism Spectrum Disorders service users;
- There is recognition of the actions that have been met, those that need improvement and those for which the authority is in the red zone.

## 10. Background Papers

Adult Autism Strategy, presented at the Health and Wellbeing Board on 9 December 2014: http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MID=7555

Review of Learning Disability and Autism Self Assessment Frameworks, presented at the Health and Wellbeing Board on 12 May 2015: http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MID=8156#AI55438

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## Learning Disability Partnership Board Delivery Action Plan

| Number | Overarching Strategy | Secondary Strategy | Priority | Area of Focus | Success Measure | Responsible Partner | RAG | Date Due | Date Comp'd | Update | Closed |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | LD SAF | HWBB Delivery Plan<br><br>Walthamstow Coroner's Report | Finding and managing long term health conditions, obesity, diabetes, cardiovascular disease and epilepsy | Joint Commissioning Manager and CCG to liaise with GP surgeries to ensure all PWLD have had all necessary health checks and have a treatment plan in place. Health check take-up and treatment plans to be monitored at the Clinical Quarterly review meetings. | Compare treatment and outcomes for all four conditions (obesity, diabetes, cardiovascular disease and epilepsy) between people with learning disabilities and others in the borough and at a local GP level. | Joint Commissioning Manager<br><br>CCG Practice Improvement Lead | | Mar-16 | | During the current period of 01/04/15 -31/03/16 there have been 25% completed health action plans. Remedial actions in place include:<br>• Joint Commissioner, CLDT representative and the Practice Improvement lead will attend the GP forums, the Practice Nurse forums and the Practice Managers forums, with the Practice Manager forum taking place on 12th January. The focus will be on raising awareness of the issues, understanding support needed from CLDT and developing actions to address at practice level.<br>• Discussion of issue and action plan at Primary Care Development Group on 19th January. The action plan will be supported by the Joint Commissioner, Practice Improvement Leads, CLDT, Health Facilitation and the Clinical Director for primary care improvement. The plan will identify any additional training needed and a programme for providing this.<br>The health facilitation team within the Community Learning Disabilities Team (CLDT) will monitor the number of health checks and health action plans completed by GPs on a weekly basis. Additionally, the CLDT team will monitor and encourage health checks and health action plans when completing their annual reviews. | |
| 2 | LD SAF | HWBB Delivery Plan<br><br>Walthamstow Coroner's Report | Specific health improvement targets (Health Action Plans) are generated at the time of the Annual Health Checks in primary care | Health Action Plan (HAP) take-up could be further improved by the CCG Practice Improvement lead liaising with GP surgeries to ensure all PWLD have HAPs in place. This will be monitored at the Clinical Quarterly review meetings.<br><br>CLDT will assist GPs on completing HAP for users with complex care needs. | 70% or more of Annual Health Checks generate specific health improvement targets | Joint Commissioning Manager<br><br>CCG Practice Improvement Lead | TBC | Mar-16 | | CLDT and Joint Commissioning Manager are validating numbers of health checks and are implementing an action plan to ensure that performance in this area is satisfactory.<br><br>Whilst working with GPs the Joint Commissioning Manager and the Practice Improvement Lead will:<br>Review practice level data<br>Identify the practice engagement strategy<br>Understand practice issues to resolve the situation. | |
| 3 | Autism Strategy | | Access to info through diagnosis and assessment | NELFT published timescales about diagnosis pathway | Monitoring of timescales through service | NELFT | | Dec-15 | | NELFT Diagnostic Pathway is not being publicised. NELFT have been invited to the February 2016 Partnership Board meeting to present the pathway and how it will be accessed and publicised to service users, carers and professionals. | |
| 4 | Autism Strategy | | Access to info through diagnosis and assessment | Ensure autism is recorded on case management | Data used to effectively report on ASD | All Health/Social Care Staff | | Mar-16 | | Autism is listed as an option on case recording for primary diagnosis. The numbers being recorded are still low. The CLDT will ensure when Autism is diagnosed as the primary need it is recorded as such on the Social Care service users database (AIS). This will improve our records and ensure service users and enable the authority to plan better on meeting the needs of people with Autism. Baseline to be established. | |
| 5 | Autism Strategy | | Access to info through diagnosis and assessment | Service description/attributes on Care and Support hub | Easy read plages about referral to diagnosis | NELFT | | Mar-16 | | The Care and Support Hub will include information about the diagnosis pathway once the pathway has been implemented and publicised - see 'NELFT published timescales about diagnosis pathway'. | |
| 6 | LD SAF | | National Cancer Screening Programmes (bowel, breast and cervical) for people with learning disabilities | CCG Practice Improvement Lead to liaise with GP surgeries to ensure PWLD have a cancer screening where required.<br><br>This will be monitored at the Clinical Quarterly review meetings | Screening takes place for the same proportion (+ or – 5%) of eligible people with learning disabilities as the general population (23%). | Joint Commissioning Manager<br><br>CCG Practice Improvement Lead | | Mar-16 | | IHAL will collate this data however, ourlocal data which is not validated and maybe subject to change is showing;<br><br>National breast screening % completed 29%<br><br>National cervical screening % completed 23%<br><br>Bowel Cancer screening % completed - no data, but initial information is showing that this may be below average.<br><br>• Joint Commissioner to work with BHRUT LD lead and Macmillan GPs/Cancer UK Facilitator to understand specific issues around people with learning disabilities participating in screening and to develop an action plan to address this. This will include:<br>o Working with GPs through the Cancer programme and LD health checks work to raise awareness of screening<br>o Wider awareness raising with carers, service users and LD providers on the process and importance of screening<br>o Working with screening providers to ensure appropriate information and appointment times are provided for people with LD.<br>The CLDT will also work with GPs and colleagues around ensuring that screening programmes are encouraged as part of health checks and are recorded in health action plans. | |

| Number | Overarching Strategy | Secondary Strategy | Priority | Area of Focus | Success Measure | Responsible Partner | RAG | Date Due | Date Comp'd | Update | Closed |
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| **7** | **LD SAF** | | Offender health and the Criminal Justice System | The Learning Disability Partnership Board to facilitate the continued improvement in the working relationship between Health and Social Care and Offender and Probation services, including:<br>• LD Week to include a theme on keeping safe, inviting along community safety partners to input and take part.<br>• Invite the Group Manager, Community Safety and Integrated Offender Management, and Probation and Offender services to attend the LDPB as advisory members.<br>• The LDPB to hold a themed meeting on the criminal justice system and keeping safe in 2015/16. | Local commissioners have a working relationship with regional, specialist prison health commissioners<br>There is good information about the health needs of people with LD in local prisons and wider criminal justice system and a clear plan about how such needs are to be met<br>Prisoners and young offenders with LD have had an annual health check which generates a health action plan, or are scheduled to have one in the coming 6 months. | Interim Group Manager - Community Safety and Offender Management | | Mar-16 | | The borough does not have a local prison or young offenders institute and therefore unable to meet the full criteria. However during the Borough's LD week in July 2015 crime and keeping safe was a featured focus and event. The local police service took part and interacted with service users and explained how their response team works to a reported crime incident.<br><br>The Borough held a strategic assessment workshop looking at Crime & Disorder. Learning disability services were represented in the workshop. Continued joint working will build on raising learning disabilities awareness within the Offender and Criminal Justice System and ensuring that learning disabilities is included in the Crime and Disorder Strategic Assessment.<br><br>Commissioners and Care managers participate and contribute to hearings and appeals for patients with learning disabilities detained within the criminal justice system by the Ministry of Justice.<br><br>Plans are in place with supported living schemes for offenders to complete their community service/volunteering at the supported living schemes. This is in progress.<br><br>GM Community Safety and Integrated Offender Management and Probation to be invited to attend the LDPB meetings in advisory role. working with the GM GM Community Safety and Integrated Offender Management and Probation to ensure we are tracking the number of people with a learning disability managed through the Multi-agency public protection arrangements (MAPPA). | |
| **8** | **LD SAF** | HWBB Delivery Plan<br><br>Walthamstow Coroner's Report | Annual health checks and annual health check registers | CLDT Team and Joint Commissioning Manager to work with providers of learning disability services to advocate and support users to have health checks. This will include relationship building between the local GP surgeries and provider organisations and ensuring that staff are aware of what the health checks are and when they need to be completed by. | All PWLD have an annual health check and GPs have a check register | Joint Commissioning Manager<br><br>CCG Practice Improvement Lead<br>CLDT Manager | | Mar-16 | | The Heath Facilitators team (members of CLDT) have begun training Providers to better understand the Health Check process. This is an ongoing process. This will enable the providers to better support and advocate for service users during health checks with GPs. Please also see commentary above under health action plans and health checks. | |
| **9** | **Autism Strategy** | | Supporting housing needs | LBBD housing to indicate timescales for Independent Living Strategy. | Stakeholder events and final strategy | GM Housing Strategy | | Apr-16 | | The Learning Disability Housing sub-group has been set up and has met to agree initial objectives for an Independent Living Strategy.The subgroup includes representation of autism and ASD. Regular updates are provided to each Learning Disability Partnership Board. The strategic objectives of the Independent Living Strategy are currently being drafted and consultation on these will begin in February 2016 | |
| **10** | **Autism Strategy** | | Supporting housing needs | Work with ageing carers about housing needs | Establish base line data ageing carers | GM Intensive Support/GM Housing Strategy | | Apr-16 | | See above commentary | |
| **11** | **Autism Strategy** | | Access to info through diagnosis and assessment | Nelft to Monitor timescales of referral to diagnosis | report to LDPB 90% case marked | NELFT | | Apr-16 | | Further discussions to be had once implementation and publicity of diagnostic pathway is discussed - see 'NELFT published timescales about diagnosis pathway'. | |
| **12** | **Autism Strategy** | | Access to info through diagnosis and assessment | Public health to use data to improve JSNA on ASD | ensure data is effectively used to report | Public Health | | Apr-16 | | Most recent JSNA has included updated information regarding autism and ASD. Once diagnostic pathway is implemented and publicised, this data can be used to inform JSNA. | |
| **13** | **Autism Strategy** | | Delivering Good Quality Care and Support | Review of services for people with high functioning ASD | Report to LDPB about service gaps | LD Joint Commissioner | | Jan-16 | | The current provision of services is delivered to a good quality. People with high functioning ASD are encouraged to access mainstream services. Further work on raising awareness of employers and mental health service would be beneficial. To discuss at Mental Health Strategy sessions as Mental Health Strategy is developed. Suggested that this is reviewed in January 2016 in line with the development of the Strategy. | |
| **44** | **Challenging Behaviour plan** | Winterbourne View<br><br>Transforming Care Agenda | Longer term commitments | Establish an 'at risk' register for individuals whom may be at risk of crisis and need crisis support | | LD Joint Commissioner | | Jan-16 | | Integrated Commissioning Manager has initiated discussions with the CLDT around the estabishment of the 'at risk' register | |
| **58** | **Challenging Behaviour plan** | Winterbourne View<br><br>Transforming Care Agenda | Longer term commitments | Establish a gate keeping process for the assessment and treatment unit in the Borough | | LD Joint Commissioner | | Jan-16 | | Work is underway with BHR CCGs and NELFT to establish this gateway. | |

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| **59** | **LD SAF** | | Learning disability services contract compliance | The local authority and the CCG will continue to review contracts over a scheduled year.<br><br>The outcomes of service reviews are reported on the monthly "call over" report to Senior Managers. Progress on the supported living contracts are also regularly given at the LDPB. | Evidence of 100% of health and social care commissioned services for people with learning disability: 1) have had full scheduled annual contract reviews; 2) demonstrate a diverse range of indicators and outcomes supporting quality assurance and including un announced visits. Evidence that the number regularly reviewed is reported at executive board level in both health and social care. | Joint Commissioning Manager, Learning Disabilities | | Feb-16 | On-going | The Integration and Commissioning team quality assure all contracts through a programme of on-going scheduled reviews. There are a range of performance indicators that are reported and validated by officers.<br><br>Inspection visits carried out are both planned and unannounced.<br><br>Any service that is not performing within the contracts expectations are instructed to develop an improvement plan.<br><br>Monthly reporting is included in the senior managers "call over" document. | |
| **60** | **LD SAF** | | Monitor assurances | This indicator is maintained. BHRUT has a Learning Disability Action plan, which is monitored internally at the BHRUT LD Committee, Quality and Safety Committee, Safeguarding Adults Committee and exceptions raised to Trust Board. | Commissioners review and monitor returns and review actual evidence used by Foundation Trusts in agreeing ratings. Evidence that commissioners are aware of and working with non-Foundation Trusts in their progress towards monitor compliance. | Learning Disability Liasion Nurse | | Feb-16 | On-going | BHRUT are working within the Guidelines and Audit Implementation Network (GAIN) guidelines. This is also reflected in the Learning Disabilty action plan and the LD Six Lines of Enquiry action plan maintained by BHRUT. | |
| **61** | **LD SAF** | | Individual health and social care package reviews | CLDT will prioritise reviews over the next year to ensure all reviews are carried out for people with learning disabilities. This will be monitored through the LDPB performance framework on a quarterly basis. | Evidence of 100% of all care packages including personal budgets reviewed within the 12 months are covered by this self-assessment. | Group Manager Intensive Support | | Mar-16 | | The Community Learning Disability Team are working through the reviews of all care packages. The updated FACE V7 assessment is now more comprehensive and Care Act 2014 compliant. | |
| **62** | **LD SAF** | Carers Strategy | Carer satisfaction rating. To be answered by family carers | Implementation of the Carers' Strategy 2015 and changes to commissioned carers' services.<br><br>LA and CCG and providers to ensure questionnaires, surveys reflects a satisfaction rating. | Most carers are satisfied that their needs were being met. | Integrated Commissioning Manager responsible for carers' services.<br><br>Joint Commissioning Manager, Learning Disabilities | | Mar-16 | | A Carers Strategy was approved by the Health & Well Being Board in March 2015. The Commissioning Manager responsible for carers' services is leading a series of workshops with a wide range of stakeholders including carers of learning disability service users and providers of Learning Disability carers support services.<br><br>The Workshops will ensure the implementation of the strategy reflects the needs of the Learning Disabilites community. Prelimary workshops have indentified the need to distinguish the support needs of older and younger carers with learning disabilites service users. The new Carers' Hub will ensure services reflect Learning Disability carers needs. This should commence around April 2016. | |
| **63** | **Challenging Behaviour plan** | | Commissioning activity and service redesign | Joint Commissioning Plans to include: the need to address culture and environment change; the explicit requirement to commission by outcomes; provider staff up-skilling through specification and service development via the procurement process recognition that the availability of appropriate training courses and approaches and providers is limited and that fragmented approaches will not deliver and acknowledgement that specialist services that require significant training and experience have a cost implication. consideration of whether growth via transition could provide opportunities to develop specialist services. | | LD Joint Commissioner | | Mar-16 | | A service specification is being devloped this will include explicit outcomes and the level of skill required by the workforce. This is being developed at a Cross-Borough level. Suggested that review takes place in March 2016. | |

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| **78** | **Challenging Behaviour plan** | | Build commitment, understanding, and knowledge of good practice | Develop links with landlords and the Housing department to access properties in which tailored services can be delivered, ensuring tenancy rights and stability for those whose behaviour presents challenges. Housing to work with Commissioning to ensure that individuals can live in general needs housing with commissioned packages of support. | | Joint Commissioning Manager | | Mar-16 | | This is an on-going process that will also be captured in the developing Independent Living Strategy for individuals with learning disabilities and behaviour that challenges. Review at February LDPB meeting. | |
| **79** | **Autism Strategy** | | Supporting housing needs | Support from Tenancy support service for ASD | Establish base line data ageing carers | GM Housing Strategy | | Apr-16 | | The Learning Disability Housing sub-group has been set up and has met to agree initial objectives for an Independent Living Strategy.The subgroup includes representation of autism and ASD. Regular updates are provided to each Learning Disability Partnership Board. The strategic objectives of the Independent Living Strategy are currently being drafted and consultation on these will begin in February 2016 | |
| **80** | **Challenging Behaviour plan** | | Commissioning activity and service redesign | Further refine the working protocols to support the pathway between services (Mental Health and Learning Disability, Children to Adult – the latter is likely to be included as part of work on the Children and Families Bill); these protocols to be monitored and to include processes for prompt dispute resolution. | | LD Joint Commissioner | | Apr-16 | | The Local Authority is developing its Mental Health Strategy. This will adress any areas of dual diagnosis. Suggested that this is reviewed in April 2016. | |
| **81** | **Autism Strategy** | | Making all our services accessible (inc training) | CCG to encourage GP's/staff to undertake training | Establish Base line | CCG Commission lead | | Apr-16 | | The Joint Commissioner will work with the CLDT and the Health Practice Lead to encourage further training for GP practices around autism. Joint Commissioner to also establish baseline and target figures for training. | |
| **82** | **Autism Strategy** | | Access to employment, training and skills | Ensure that autism can be declared non-discrimatory | Establish baseline data | GM Employment/Skills | | Apr-16 | | Work to commence with employment and skills | |
| **83** | **Autism Strategy** | | Access to employment, training and skills | Sufficient info on Care and Support hub about jobs | Info and Advice Strategy Inc ASD | GM Learning Disabilities | | Apr-16 | | The Care and Support Hub contains information regarding support into employment and services that are available. Work to commence with employment and skills about publicising job opportunities for adults with autism. | |
| **84** | **Autism Strategy** | | Access to meaningful activities | Ensure people with ASD have personal budgets | 10% increase in people with ASD with personal budget | GM Intensive Support | | Apr-16 | | This is ongoing - linked to recording issue. | |
| **85** | **Autism Strategy** | | Access to meaningful activities | Peope with ASD right to independent advocacy | Monitor uptake of advocacy people with ASD | Joint Commissioning Manager | | Apr-16 | | Advocacy service currently out to tender - autism has been highlighted in the tender as a specialist area of experise that the advocates will need to have. | |

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| **86** | **Autism Strategy** | | Access to meaningful activities | Information on Support organisations | Monitor updates to care and support hub | Joint Commissioning Manager | | Apr-16 | | The Care and Support Hub continues to be updated with services and information relating to autism and ASD. | |
| **87** | **Autism Strategy** | | Access to meaningful activities | Ensure that independent advocacy options are publicised | Establish Baseline Data | GM Integration/Commiss | | Apr-16 | | The new Advocacy contracts will ensure Advocates have accredited training for people with autism and define autism as a specialist requirement in data recording. Suggested this is reviewed in April 2016 with the launch of the new Advocacy Hub. | |
| **88** | **Challenging Behaviour plan** | | Longer term commitments | Identifying need coming through and considering the feasibility of commissioning a service which collectively provides, through a block contract, respite, short breaks, crisis intervention and 'cool off', a small specialist, medium term, supported housing service, training and outreach services to carers in their homes. This service could be a combination of block and personal budget funded services. The feasibility of any such service needs to take into account the likely costs of eligible individuals presenting to Adults' services over the next few years. Combining all these elements into one service would maximise its flexibility and create the greatest economies of scale | | LD Joint Commissioner | | Apr-16 | Ongoing | The next phase of the Challenging Behaviour Plan will take place over the next 5 years. The programme of work will require a long term commitment from all partners in order to see a sustainable change in how service users that have behaviour that challenge are supported by the borough.The Local Authourity has already awarded a contract for Supported Living that will re-model the block contractual arrangements. The Local authority is continually reviewing and working with stakeholders on a range of services to meet the varying needs of service users within these schemes.<br><br>Suggest a new date of April 2016 to review impact of this action. | |
| **89** | **Challenging Behaviour plan** | | Longer term commitments | Making any appropriate service commissioned by the borough available to carers of children whose behaviour presents challenges so that early intervention work can help to prevent the establishment of behaviours that challenge and crisis | | LD Joint Commissioner | | Apr-16 | Ongoing | On-going work will take place with Adults and Children services.There is a lack of good local services has led to many service users been offered a placement out of the borough, this happens in both children and adults services. Once the service users are settled in their new community it is often difficult to support service users to return to Barking and Dagenham, as occasionally they are now settled in their community and do not wish to return or at times there are legal requirement restricting a return to the borough. In order to minimise the number of out of borough placements that are agreed in the first instance the council will need to work with providers and landlords to develop service in our locality, and work more closely with Children Services.<br><br>Suggest a new date of April 2016 to review impact of this action. | |
| **90** | **Challenging Behaviour plan** | | Longer term commitments | Ensuring that travel training organisations, services which seek employment for individuals, PAs and micro-providers are included in specialist training to be able to work with those whose behaviour challenges | | LD Joint Commissioner | | Apr-16 | Ongoing | PAs are included in this specialist training. Supported living providers are trained in positive behavioural techniques. Ongoing monitoring of this work provided. Suggest a new date of April 2016 to review impact of this action. | |
| **91** | **Challenging Behaviour plan** | Winterbourne View<br><br>Transforming Care Agenda | Longer term commitments | Establish a service specification to meet the needs of individuals with challenging behaviour | | LD Joint Commissioner | | Apr-16 | | Barking and Dagenham are working with LB of Newham and the Tizard Centre to develop specifications for providers who can work with individuals with challenging behaviour. This will be reviewed in April 2016. | |
| **92** | **Autism Strategy** | | Safeguarding people and their families with ASD | Safe Space Scheme to include ASD | Baseline data collection | LDPB | | Jun-16 | | This scheme was in place but requires relaunching in 2016 - suggested that this is relaunched and reviewed in June 2016. | |

| Number | Overarching Strategy | Secondary Strategy | Priority | Area of Focus | Success Measure | Responsible Partner | RAG | Date Due | Date Comp'd | Update | Closed |
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| **93** | **Carers Strategy** | | Carers are identified at the earliest opportunity and offered support to prevent, reduce or delay their needs and the needs of their cared for | Develop more focused information and advice offer to support carers | Publish information on assessment, eligibility, services available, personal budgets, through Care & Support Hub<br>Refresh Care & Support Hub to have clearer 'one-stop' carers' information | GM Integration and Commissioning | | Nov-16 | | Integrated Commissioning Manager (ICM) for Carers' Services has been working with the ICM for Learning Disabilities and the LD Carers Forum to develop the specification for the new information and advice hub for carers. The LD Carers Forum provided some useful feedback which has been built into the specification. An LD Carer will also take part in the evaluation process for the tender, which will be a speed dating event.<br>The Care and Support Hub has been updated following the changes from the Care Act. The new information and advice hub for carers will link through to the Care and Support Hub and will work with the team to ensure the Care and Support Hub continues to be developed and updated.<br>The next step for the Care and Support Hub is to review the information relating specifically to services for people with learning disabilities. | |
| **94** | **Carers Strategy** | | Carers are identified at the earliest opportunity and offered support to prevent, reduce or delay their needs and the needs of their cared for | Activities to develop the market in support for carers, including diverse carer groups, widened access and different models of support | Consultation activity to develop carers section of revised Market Position Statement<br>MPS revision published<br>Develop innovation grant programme and invite bids, based on emerging gaps in provision | GM Integration and Commissioning | | Nov-16 | | The ICM for carers' services is regularly attending the LD Carers Forum and the ICM for learning disabilities is a member of the Carers Strategy Group. As this market development work progresses, both groups will discuss new models of support, particularly peer support models. | |
| **95** | **Carers Strategy** | | Carers are identified at the earliest opportunity and offered support to prevent, reduce or delay their needs and the needs of their cared for | Specific service commissioning initially carers' breaks and respite | Make available personalised breaks through Direct Payments; simplify information and access<br>Review access to respite to follow up on issues identified in consultation process | GM Integration and Commissioning | | Jan-17 | | This work is due to be reviewed in early 2016. Initial conversations have begun with the ICM for learning disabilities and the Group Manager for Intensive Support around carers' breaks and respite options and linkages with personal budgets. | |
| **96** | **Carers Strategy** | | Carers are identified at the earliest opportunity and offered support to prevent, reduce or delay their needs and the needs of their cared for | Widen options for carer support in crisis | Review service availability and priorities<br>Develop commissioning intentions including the development of an Emergency Planning Scheme with existing out-of-hours and emergency providers<br>Revised commissioning steps finalised through governance | GM Integration and Commissioning<br><br>CCG Chief Operating Officer | | Jan-17 | | The new information and advice service for carers will require the new provider to ensure that all carers have In Case of Emergency Plans which are shared with social care and health professionals. Initial discussions have taken place as to how this can be integrated into the Adult Social Care database. Further work needs to be done in 2016 around emergency providers and support specifically for LD carers. | |
| **97** | **Carers Strategy** | | Carers are supported when their caring role is coming to an end and to have a life after caring | Through development of more focused 'peer support' offer, provide opportunity to maintain engagement in social care system | Convene group to develop proposals, including LBBD, Carers of B&D<br>Develop proposals and plan for delivering, including commissioning intentions if necessary | GM Integration and Commissioning | | Jan-17 | | Initial conversations have taken place with the Carers Strategy Group around peer support models and 'gaps' in the peer support market. A grants programme will be set up in 2016 to take this forward and facilitate the start-up of new peer support groups in the Borough.<br>The End of Life Coordinator has also attended the LD Carers Forum to discuss end-of-life planning. Plans are in place with GPs to increase end of life care planning for learning disabilities which will be developed in 2016. | |

# HEALTH AND WELLBEING BOARD

## 26 January 2016

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| **Title:** | Market Position Statement Update 2015 |

**Report of the Cabinet Member for Adult Social Care and Health**

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| **Open Report** | **For Information** |
| **Wards Affected:** All | **Key Decision:** No |
| **Report Author:**<br>Monica Needs, Market Development Manager | **Contact Details:**<br>Tel: 020 8227 2936<br>Monica.Needs@lbbd.gov.uk |

**Sponsor:**
Councillor Worby, Cabinet Member for Adult Social Care and Health

**Summary:**

Barking and Dagenham published a Market Position Statement entitled "The Business of Care" in July 2014 to facilitate the development of the social care market in Barking and Dagenham and provide relevant timely information to providers looking to operate in the market locally.

The Care Act 2014 places a new duty on local authorities around market shaping. Section 5, part 1 of the Care Act (2014): the new duty to promote the efficient and effective operation of a "vibrant and responsive market of service providers". One of the key mechanisms identified for supporting market shaping is the development and implementation of a Market Position Statement or similar document.

This report presents the update to Barking and Dagenham's Market Position Statement, which was published in July 2014.The update reflects the implications of the Care Act 2014, the increased pressures on local authority budgets and significant other local developments, such as the personal assistant market.

The report also outlines the process for a new Market Position Statement to be developed in 2016, to reflect both the changing demand and market for adult social care in Barking and Dagenham and the findings of the Growth Commission.

The key messages that the update gives to providers in the social care market are with regard to the following:

- The focus on prevention for all partners
- Considering at every point the provision of information and advice in a digital age
- The role of carers and advocacy in the community
- The reconfiguring of provision in line with the Care Act 2014
- The changes to social care budgets and the additional pressures being faced

locally

**Recommendation(s)**

The Health and Wellbeing Board is recommended to:

- Note the Market Position Statement Update
- Raise any comment and recommendations that they have on the proposed new Market Position Statement.

**Reason(s)**

The development of a Market Position Statement is the basis of an on-going 'conversation' with social care providers about the quality and future development of social care services. It is the Council's way of supporting providers to develop people focused, quality and sustainable services for the local adult social care market.
The Market Position Statement supports the Borough's vision of: 'One borough; one community; London's growth opportunity' and particularly the priorities of "growing the borough" and "enabling social responsibility". Social Care in Barking and Dagenham is a significant part of the economy and supporting providers to provide effective services provides local employment opportunities in addition to providing personalised responsive services. One of the principles underpinning the development of a Market Position Statement for Barking and Dagenham is that of giving service users meaningful choice and control over the care and support that they receive. The Borough is committed to working with the local community to help create a Borough that supports wellbeing, promotes independence and encourages residents to lead active lifestyles as far as they possibly can. The Market Position Statement facilitates the development of services for residents with and adult social care need and outlines the types of provider we would like to see in the local market.

## The Business of Care: An Adult Social Care Market Position Statement for Barking and Dagenham

### 1. Introduction and Background

1.1 Market Position Statements in adult social care are one of the key ways in which local authorities can support the development of the local market and demonstrate that they are fulfilling their Care Act duties with regard to market shaping.

1.2 The Market Position Statement for Barking and Dagenham was developed in 2013-14. Barking and Dagenham's Market Position Statement is a tool to support existing providers, those who do not currently work in the authority and new start-ups by:

- giving information about the direction of travel, in order to enable effective business planning and better investment decisions
- responding to opportunities around personalisation
- reducing the risk of wasting resources on poorly targeted initiatives.

1.3 The process for the development of the Market Position Statement in Barking and Dagenham included input from a wide range of service providers of different size and type, to find out what information would be useful in shaping their services for the future. Provider forums targeted different client groups and consultations were held with residents and service users at market events and workshops. Feedback was gained from a range of service providers and key stakeholders both within and external to the council.

1.4 The Market Position Statement was agreed in April 2014 and then launched on July 15 2014. The launch event was attended by 54 providers providing a range of services. The document can be found on the Barking and Dagenham Care and Support Hub website here: http://careandsupport.lbbd.gov.uk/kb5/barkingdagenham/asch/advice.page?id=Mp_qJPtFLEw

1.5 Since the launch a Market Management peer review in October 2014 commented on the usefulness of the Market Position Statement and both providers and other local authorities have commented on the effectiveness of Barking and Dagenham's Market Position Statement.

1.6 The Market Position Statement has been used in dialogue with providers through forums and other interactions over the last year.

## 2 Market Position Statement Future Development

2.1 The context within which the Market Position Statement has been written in Barking and Dagenham is rapidly changing. With the One Community vision, changing demographics, reducing local authority budgets, the future growth of the borough, as being reported on by the Growth Commission and the current programme of work around the future shape of the Council and its role within the borough and community it is felt that there is a need for a new Market Position Statement in 2016 to reflect this.

2.2 In more detail the key developments that will impact on the Market Position Statement and the context in which it is written are:

### The Growth Commission and Economic Development

2.3 Barking and Dagenham Council in July 2015 have agreed an ambitious focus: to transform the Borough into 'London's Growth Opportunity' in order to improve the social and economic outcome, and maximise opportunities now and in the future. Underlying this is a recognition and belief that London needs an affordable, attractive place to grow at scale and Barking and Dagenham has the potential to do this.

2.4 The Growth Commission is independent of the Council and is due to report in February 2016 and the findings will make recommendations to the Council and its partners.

2.5 One key element of growth in the borough is with regard to health and social care. According to the Business Register & Employment Survey 2014 there are 1600

jobs in residential and community based social care for older and disabled people alone. This is 3.2% of the employment. If we add to this the wider health and social care workforce both in the statutory sector and in partner and provider agencies this is a significant workforce and as we move forward in growing the borough the role of health and social care economy is a key consideration.

2.6 Alongside the size of the workforce the development of Care City as a driver for innovation and change in the health and social care field is of note. Care City's potential role across the three boroughs with regard to research, innovation and education will be important in the next season and a submission to be an NHS test bed for innovation has been made.

**Ambition 2020**

2.7 The Council continues to face a significant challenge with regard to its financial resources and estimates a funding gap of £63million by 2020. Ambition 2020 is a transformation programme set up to determine the best way to spend the remaining funding the Council will have available following funding cuts. .

2.8 Within the Adult Social Care market specifically the new requirement with regard to the national living wage and the pension's liabilities will place significant additional pressures on an already reducing budget. Following the provisional Local Government finance settlement, there are some ways in which these pressures may be alleviated and these include the ability for the Council to charge an additional 2% Council tax as a precept ring fenced for Adult Social Care and additional funding given via the Better Care Fund (BCF) in the later years of this government.

2.9 Within this context the Council is seeking to look at what can be achieved for and what will have the biggest impact on residents within a significantly reduced resource. The Ambition 2020 programme work identifies the key initiatives through to 2020 that will help the borough to meet its future challenges.

2.10 The findings of the Growth Commission and Ambition 2020 will shape the role of the Council and its partners through to 2020 and beyond and will inform the nature of the Adult Social Care market locally going forward.

2.11 It is therefore recommended that the development of a new Market Position Statement begins in April 2016 to reflect these changes for publication in the autumn.

2.12 The process for developing the new Market Position Statement will include: Stakeholder engagement, statutory partners and providers, the review of current data sets, focus groups with people and the review of market facilitation and development in other areas.

## 3 Market Position Statement Update – January 2016

3.1 However with the implementation of the Care Act in April 2015 there was a need to update the current Market Position Statement to reflect more clearly how the new duties impact on providers and the market locally and the developments that have taken place locally in the last 18 months. The Care Act 2014 is the most important

piece of adult social care legislation and guidance for a generation.

3.2 The approach taken has been to produce an update for the current Market Position Statement for early 2016. The update is in two sections. The first looks at the developing the adult social care system and the environment within which this is set and the second contains updates for each of the category specific sections that are included in the current Market Position Statement e.g. older people and learning disability.

3.3 Section one of the update covers a number of issues that have either impacted the context nationally or locally in the last 18 months or need clarifying with the implementation of the Care Act 2014. This includes an updated context and introduction and specific sections on the following:

- Prevention
- Information and Advice
- Carers
- Advocacy
- Personal Assistants

Whilst many of these areas were covered within the existing Market Position Statement it is helpful to provide additional clarity particularly in light of the development of the Prevention Approach, the Information and Advice plan, the Carers Strategy and the changes to the provision of advocacy in 2015.

3.4 Working with providers to understand the implications of the significant changes highlighted above will be ongoing in the next year.

3.5 In addition a technical update has been provided on each of the current client sections of the Market Position Statement to reflect any changes that have occurred since publication in July 2014.

3.6 In summary the key messages from the update to providers are:

- The increased pressure on social care budgets in light of national and local changes.
- The adoption of the Prevention Approach by the Health and Wellbeing Board in May 2015 has led to developing dialogue around the nature of service provision and how providers can work with clients to adopt strength based approach to their lives.
- There is an increased focus on preventing, reducing and delaying the need for adult social care and, in line with the prevention approach; this should be considered at every opportunity.
- In the digital age the delivery of good quality information and advice in accessible ways becomes increasingly significant as residents access information differently. There is a key role for stakeholders and providers in the market to signpost to appropriate resources,
- Providers and partners need to recognise carers and support them in their caring role whether through signposting or direct support.
- Providers in the market should consider where they can attract additional resource to support wider agendas in the borough.
- There will be significant developments in the next year in the following service areas: Carers, Mental Health and Advocacy,

## 4 Mandatory Implications

### 4.1 Joint Strategic Needs Assessment

The Market Position Statement is a statement to providers about the nature of the adult social care market in Barking & Dagenham and, as such, complements the identification of need and the priorities for future action described in the JSNA. The data in the Market Position Statement is, in part drawn from, and used to provide information to the JSNA. This is a cyclical process.

### 4.2 Health and Wellbeing Strategy

The commitments set out in the Health & Wellbeing Strategy are consistent with and reflected in the development of a Market Position Statement which looks to the market or the provision of services across the adult social care market. The two documents therefore complement each.

### 4.3 Integration

Integration is a theme that occurs in a number of places in the Market Position Statement, and the document reaffirms the Council's commitment to work with partners in the development of integrated services and improving the experience of local residents in accessing health and social care services.

### 4.4 Financial Implications- completed by Carl Tomlinson, Group Finance Manager

This report provides an update on the Market Position Statement and there are no direct financial implications arising from the report. However, given increasing financial pressure within adult social care and reductions in local authority funding, further analysis would be required to understand the implications of the provisional Local Authority Finance Settlement 2016-2020 and outcomes of the Ambition 2020 programme as contributing towards managing these pressures

### 4.5 Legal Implications-completed by Chris Pickering, Principle Solicitor

The Market Position Update is for noting and there are no legal implications.

**List of Appendices:**

Appendix 1: The Business of Care Interim Update - January 2016

Appendix 2: The Business of Care in Barking and Dagenham: Adult Social Care Market Position Statement – London Borough of Barking and Dagenham 2014 to 2016
http://careandsupport.lbbd.gov.uk/kb5/barkingdagenham/asch/advice.page?id=Mp_qJPtFLEw

# The Business of Care in Barking and Dagenham

## Adult Social Care Market Position Statement 2014 to 2016

## Interim update: January 2016:

**[To be read in conjunction with the Market Position Statement 2014 to 2016]**

## London Borough of Barking and Dagenham

## Contents

## Part 1: Developing the social care system



## Part 2: Developing social care for the different client groups update

# Part 1: Developing the Social Care System

# 1 Introduction and Context

**Over the past eighteen months there have been a number of significant changes in the way adult social care and support is delivered. This document provides an interim update to The Business of Care, Barking and Dagenham's Market Position Statement 2014 to 2016. It sets out some of the key national and local changes, and looks in more detail at a number of key areas for commissioning and the provider market.**

The Market Position Statement is a vital tool in driving market development and supporting providers to create local service provision that is responsive to the needs of our residents and delivers positive outcomes by ensuring that:

- care needs are prevented from becoming more serious
- people can easily get the information they need to make good decisions about their own care and support
- there is a wide range of high quality providers to choose from

The Market Position Statement[1] published in 2014 can be viewed on the Council's website. The Market Position Statement and this interim update should be read in conjunction. The update seeks not to repeat information, but simply clarify any significant developments that have taken place both in terms of policy and relevant data/context. If the item you are looking for is not included in the update please refer to the original Market Position Statement.

## National context

The context for the Business of Care in Barking and Dagenham has changed significantly in the last 18 months.

The current climate for Local Government is the most challenging it has been for a number of years. The budget pressures require significant remodeling both across authorities and, particularly in this context, within the adult social market. The funding gap in Barking and Dagenham to 2020 following the Comprehensive Spending Review is £70 million. The introduction of a national living wage and the pension liabilities from April 2016 will add additional cost pressures within the local care market.

[1] http://search3.openobjects.com/mediamanager/barking/asch/files/ad6814-lbbdmarkstatpages_web_final_1.pdf

### Care Act 2014

The Care Act 2014 became operational on 1 April 2015 and is the most important piece of adult social care legislation and guidance for a generation. It focuses on prevention, wellbeing and personalisation, introducing new rights for carers, a new assessment approach and national eligibility criteria for care and support.

The Care Act has direct implications for the Council's role in developing and shaping the local care and support market. It places a duty on the local authority to ensure quality, diversity and sustainability in the market through its commissioning activities and its interactions with providers.

The interim update below includes updates on specific duties under the Care Act 2014 to help providers understand its relevance and implications for the Adult Social Care Market in Barking and Dagenham.

## Local context

### The borough's vision: One borough; One community; London's growth opportunity

To achieve its vision, the Council is focused on its priorities of:

- Encouraging civic pride
- Enabling social responsibility
- Growing the borough

In line with the overarching vision the Council is now seeking to respond to the changing environment both within the borough itself and the authority.

### Ambition 2020 and the Growth Commission

By 2020 the Council will need to have reduced its budget by £70 million to £110 million. The Ambition 2020[2] programme will lead a radical rethink of the role of the Local Authority and services and functions provided by the Council and its partners in order to save the £70 million that is required to balance the books.

Clearly one of the key areas to look at in redesigning services and working with partners is within the adult social care. Within the Adult Social Care market specifically the new requirement with regard to the national living wage and the pensions liabilities will place significant additional pressures on an already reducing budget. The introduction of the ability to raise the Council tax by 2% would net Barking and Dagenham approximately £900,000, which is significantly lower than the funding gap that has been created.

However, the borough has huge growth opportunity[3] with the ambition of creating 35,000 new homes and 10,000 new jobs over the next 15 years. This is an ideal opportunity for businesses to work alongside the Council and create a "place" that

[2] https://chrisnaylorlbbd.wordpress.com/2015/07/14/ambition-2020-and-the-growth-commission/

[3] https://www.lbbd.gov.uk/wp-content/uploads/2015/04/Londons-growth-opportunity-brochure.pdf

delivers the aspirations of the community. As part of the process Barking and Dagenham Council has set up a Growth Commission made up of leading experts in order to provide an independent, evidence-based view of what is needed to support economic growth and social development in Barking & Dagenham. The Growth Commission is due to report in the spring of 2016.

A key element of growth in the borough will be health and social care related services. According to the Business Register & Employment Survey 2014 there are 1600 jobs in residential and community based social care for older and disabled people alone, representing 3.2% of total employment in the borough. If we factor in the wider health and social care workforce in the statutory sector and in partner and provider agencies this is a significant workforce. Therefore the health and social care economy will play an important role in the economic growth of the borough in the future.

The role of an effectively trained workforce for adult social care is significant. Links to Care City and other training opportunities will be key for the market and for changes in the way services may be delivered.

The Market Position Statement is a good starting point for providers from all sectors to work with the Council and deliver Ambition 2020 through collaborative working, introducing new ways of delivering adult social care functions to modernise delivery of care and support provision in line with the legal framework of the Care Act 2014. Whilst this in an interim update, a new Market Position Statement will be published in the autumn of 2016 that will fully reflect Ambition 2020 and the Growth Commission.

### Health and Wellbeing Strategy

The Statement also seeks to reflect key points from other drivers, such as the Health and Wellbeing Strategy[4], which was refreshed in May 2015.

This seeks to work with partners to deliver integrated care and support to ensure all residents have the best possible opportunity of:

- Staying well
- Living well
- Ageing well

The key outcomes from the delivery of the Strategy from 2015-2016 are to:

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

The four strategic aims are:

[4] http://moderngov.barking-dagenham.gov.uk/documents/s90333/JHWS%20Refresh%202015%20V3.pdf

- Prevention: Supporting local people to make lifestyle choices that will positively impact their lives
- Protection: Protecting local people from threats to their health and wellbeing
- Improvement and Integration of services
- Personalisation: Ensuring people have choice and control over the care and support they receive regardless of setting

For further details on the Health and Wellbeing Board and the Strategy please see the existing Market Position Statement (Page 5)

### Role of Social Care in London – Care City development

Barking and Dagenham Council, NELFT and University College London partners are working together on the Care City[5] brand to focus the agenda on those areas where partnership working is uniquely placed to accelerate progress for the benefit of the communities across Barking and Dagenham, Havering, Redbridge and Waltham Forest. .

Care City's vision focuses on healthy ageing and social regeneration structured around the following strategic priorities:

- Innovation: To stimulate continuous improvement and innovation across the local health and social care system
- Research: To advance the application of cutting-edge research into practice by bringing research closer to local people, and facilitating new models of research
- Education: To increase resilience across the system's workforce by inspiring new entrants from within our local community, creating opportunities at all career stages, and evolving our workforce model

Care City will aim to bring together health and social care professionals with researchers, education providers, technology experts, small and medium companies and social entrepreneurs to develop the workforce and healthcare products of the future. It will also aim to create local employment for local people and will be a centre where research is conducted into frailty and long term health conditions.

[5] http://www.nelft.nhs.uk/about-us-partnership-working

# 2 Prevention

## What we want for our residents

We want a community where residents take responsibility for their health and wellbeing and understand how to maintain this throughout the stages of life. Therefore an understanding of what helps to prevent, reduce or delay deterioration in health and wellbeing is essential.

Prevention is at the very heart of our approach to One Community and the Care Act 2014. It is a principle that cuts across all health and wellbeing activity and as such we have sought to embed this in the refreshed Health and Wellbeing Strategy as well as agreeing a Prevention Approach for the borough at the Health and Wellbeing Board in May 2015. It is about individuals and communities being proactive at the earliest opportunity rather than waiting for a crisis before responding to need.

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

## Good prevention practice

Good prevention is about facilitating individuals taking responsibility for their own lives, health and wellbeing. It is not a one off task, but an ongoing approach to life.

Where service providers across the piece are involved it starts at the point of initial contact and continues at all stages throughout life and changing circumstances.

Effective and early intervention at any point may **prevent**, **reduce** and **delay** more complex health or social care needs. It enhances the quality of life as well as saving resources and costs in the longer term. A preventative approach is at the heart of assessment and service provision, and is closely allied to positive wellbeing.

## Prevention in Barking and Dagenham

In line with the One Community vision and the priority around "enabling social Responsibility" and to implement the Care Act 2014 the Council and its partners have developed a local prevention framework[6]. It applies the 'prevent, delay and reduce' ethos to adults as:

- People who do not have any current needs for care and support, but may have in the near future
- Adults with care and support needs, whether their needs are eligible or met by the local authority or not

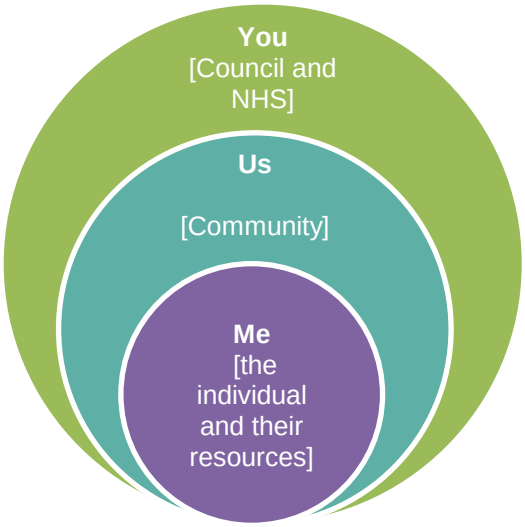
[6] https://search3.openobjects.com/mediamanager/barking/asch/files/prevention_-_a_local_framework.pdf

- Carers, including those who may be about to take on a caring role or who do not currently have any needs for support, and those whose support needs may not be being met by the Council or other organisation

The borough's prevention framework has three stages: the 'Me', 'Us' and 'You' (Figure 1):

- The approach starts with the individual ('Me': the person who may have care needs). This means considering what the individual already has and what is potentially available to support their health and wellbeing. The framework reinforces the role of the individual, encouraging people to do as much as they can for themselves.
- The second stage recognises that prevention is a job for the community ('Us'). Community underpins social responsibility and creates not only personal but community service development. Where the individual cannot do any more to help themselves, the community is the next stage.
- The final stage ('You') is about statutory agencies such as the NHS, Council, employment agencies, and so on. This tends to target specific population groups or people with high levels of need which cannot be met by the individuals themselves or by communities.

Figure 1: Barking and Dagenham's Prevention Framework




## Future Approach

This approach will inform our work with providers and partners going forward as we seek to embed the prevention approach in our work and commissioning cycles as well as supporting providers to implement the approach.

Public Health and the Council as a whole are reviewing the potential for further joined up targeted activity and resources to support preventative commissioning.

Much of the funding for prevention work in the borough is externally funded by grants from independent funders and we recognise the importance of this funding and will seek to work with providers wherever possible to support such initiatives for the

residents of the borough.

## Examples of local prevention services

The Ageing Well programme is for borough residents aged 60 years and over and in September 2015 had a membership of 1981. The programme is funded through a combination of the Public Health grant and income generation, with an annual membership fee of £52. Membership provides access to a range of activities at over 16 venues across the Borough, ranging from Darts to Tai-Chi and entitles members access to swimming, the fitness suite, studio classes and racket activities at the Borough's Leisure Centre's, Monday to Friday (9.00am-5.00pm) and all weekend.

Details of the activities can be found at http://www.gettingactive.co.uk/wp-content/uploads/2015/05/Ageing-Well-Programme-2015-2016.pdf

The Better Care Fund is supporting a range of initiatives, including:

- Falls prevention for over 75s at particular risk of falling
- The Handyperson Scheme, which is being delivered by Harmony House, offering a practical solution in people's homes to fix trip hazards, reducing risks and improving wellbeing
- Prevention mapping with the clinical commissioning group to improve links between services, increasing the understanding and awareness of the contribution of universal services across professionals and providers.

Community Resources for Change run a Community Hub at Castle Point in Dagenham. This is a "vibrant hub" run mainly by volunteers where local people can get to know each other, take part in a wide range of activities and give something back to their community. People become isolated for lots of different reasons, like losing a job, health issues or just a change in life circumstances. By getting involved in the Community Hub people can develop friendship, realise how valuable they are and grow in confidence.

As people start to connect, the Hub helps them discover how they can contribute to change in the community by giving their time, energy and skills to different projects. Many people move on to new opportunities, saying their connections with the Hub have made a significant difference in their journey.

## Good prevention is supported by information and advice

Good information and advice enables individuals and communities to make well informed choices regarding the support, services and opportunities available to them and helps our campaign to 'prevent, reduce and delay' the need for statutory services. The Council wishes to ensure that it is delivering high quality, impartial information and advice, contributing to prevention and preventative practices and supporting the health and wellbeing of its population.

Section 3 below on information and advice outlines the approach being taken and the services that support this.

## Opportunities

There are a range of ways providers can support the implementation of the "Prevention Approach" in Barking and Dagenham. The Council will continue to seek a joined up approach to preventative services, linking into appropriate projects locally, regionally and nationally, and seeking external funding where this is available

Some potential opportunities for providers would be:

- Services that are funded externally through independent funders that help to build "resourceful communities" and encourage social interaction and responsibility
- Opportunities that will help to reduce isolation
- Services that are targeted at reducing falls in the older population

## Providers we would like to see in the market

Every social care provider will need to who understand how their services contribute to preventing, reducing or delaying the need for further services through every stage from the beginning of need to End of Life. As such, we would like to see:

- Providers who, understand the impact of data and can use the data their services generate to help them and us to attract additional funding.
- Those who are outcomes-focused and wish to provide expert and innovative personalised care and prevention planning
- Providers who recognise the importance of preventing loneliness and isolation and encourage social responsibility.
- Those who are aware of how they fit into the spectrum of care and prevention and are able to work jointly and interdependently

# 3 Information and Advice

### What we want for our residents

We want people to be active citizens; able to live a meaningful life and make positive contributions to the community they are part of. The availability of appropriate, timely and accessible information and advice is key to enabling residents be active citizens.

From April 2015 the Care Act placed a statutory duty on councils to provide information and advice to the whole population that is both accessible and proportionate.

> *"Providing accurate and timely information and advice is 'fundamental to enabling people, carers and families to take control of, and make well-informed choices about their care and support and how they fund it…. It is also vital in preventing or delaying people's need for care and support.'"*

### Information and Advice in Barking and Dagenham

The Council has, with partners, developed a clear vision and set of priorities to ensure that information and advice is being delivered with due regard to the Care Act 2014 by:

> *Delivering high quality, impartial information and advice supporting health and wellbeing*

To achieve this, the Council will:

- Ensure there is a comprehensive range of information and advice about care and support available locally
- Ensure all digital and face to face information and advice is accurate, up to date, easy to understand and consistent with other sources of information
- Offer tailored information and advice about care and support (in a variety of formats) whenever possible to help individuals understand their range of options
- Work with key information and advice providers from all sectors to improve the co-ordination of information and advice locally
- Develop and promote the Care and Support Hub as the borough's web based local directory
- Transform information and advice provision in line with the Council's 'digital by design' approach to ensure quick, efficient and localised signposting

The Council, with its partners has taken a three-pronged approach to providing information and advice for residents. This approach seeks to facilitate digital and online services as the first port of call as a more convenient and timely way of accessing services. Where face to face support is provided, particularly with regard to advice, this is delivered at a number of locations:

**BanD Together Routemaster**

The Council has worked with an innovative partnership, CommunityConnect, to develop an online resource around information and signposting in Barking and Dagenham residents.

BanD Together Routemaster provides individuals and practitioners with a single tool that takes account of multiple or complex needs to identify appropriate local services across all sectors. It asks residents a series of questions and gives them personalised relevant advice and details of organisations which can provide support. This signposts them into early intervention services and provides a diagnostic tool for complex cases in a cost effective way, reducing the demand on stretched frontline advice services.

It is available at: www.BanDTogether.co.uk.

**Care and Support Hub**

For people to make informed choices they need good quality information and advice about services, support and opportunities available to borough residents. The Council's Care and Support Hub[7] provides an accessible, interactive and engaging way to find out about care and support. This is an essential resource for residents and anyone looking to or already providing services locally.

The Hub includes a directory of services to help people choose what to spend their budget on, with links to the latest Care Quality Commission (CQC) inspections. The directory is an opportunity for service providers to promote their offer. Providers can be included by clicking on the '*Register here*' section on the Hub's home page.

To help people choose the right person to support them, the Hub also has a Personal Assistant Finder[8]. This allows those seeking to employ someone to view the Council's register of accredited personal assistants, look at their profiles and find someone who matches their requirements and personal preferences.

There will always be a number of residents wanting to purchase services directly from providers who will choose not look to the Council for information and advice. Therefore some providers will market their services directly without going through the Council.

**Face to face information and advice**

Face to face advice for all residents is provided by Barking and Dagenham Citizen's Advice Bureau and DABD through a commissioned contract with the Council. The service provides open access to residents 6 days a week from various locations, including children's centres, across the borough.

7 http://careandsupport.lbbd.gov.uk/kb5/barkingdagenham/asch/home.page

8 http://careandsupport.lbbd.gov.uk/kb5/barkingdagenham/asch/pa_home.page

If residents have a disability, additional focused advice is provided by DABD.

In addition Barking and Dagenham CAB, with external funding, coordinates an Advice Plus network which seeks to support the development of the quality and provision of advice in the borough.

## Future Approach

### Growing a digital borough

As can be seen in the section above the Council is committed to delivering more public services online and making online options easier and more accessible for everyone to use, while recognising the need for reasonable adjustments under the Equality Act 2010. This is because, to be sustainable in the long term, digital self-service options must be the first point of call for residents accessing public services. The Council's *Digital by Design* programme will develop means to switch users from face-to-face contact and encourage uptake of online services. This approach is integral to delivering information and advice.

Providers need to consider online solutions and adapt their service delivery to meet the need and expectation of the rapid digital change. We need to deliver services that are modern, inexpensive and efficient, and in a way that is inclusive of all our residents.

In Barking and Dagenham, the recent Freedom Pass renewal programme showed that around 62% of our over 65s renewed online. Earlier this year, 82% of the one million people who registered to vote used the online service, around one third of them via a smartphone or tablet.

## Opportunities

There are a range of ways providers can support the provision of information and advice in Barking and Dagenham. The Council will seek to ensure that residents have access to appropriate, timely and accurate information and advice. This will require coordination and cooperation across the Council and its partners, including providers.  Some potential opportunities for providers would be:

- Services that are funded externally through independent funders that help to build "resourceful communities" and encourage access to information and advice to enable social responsibility
- Opportunities that will help to residents to access the "right" information and advice
- Information and Advice to specific communities, e.g. Carers, people with behavior that challenges etc.

## Providers we would like to see in the market

- Every social Care provider will need to who understand how their services provide signposting, information and advice to people using their services so that they are effectively informed and therefore empowered to make appropriate decisions with regard to their health and wellbeing.
- Providers who understand the impact of data and can use the data their services generate to help them and us to attract additional funding.
- We would like to see providers who recognise the importance of information and advice in accessing wider services and opportunities for the people they are working with.
- Providers who consider online solutions and adapt their service delivery to meet the need and expectation of the rapid digital change.
- Providers who effectively maintain their information on the Care and Support Hub and other digital platforms in order to facilitate access to up to date information for residents.

# 4 Carers

## What we want for our residents

We want to create a community where carers feel recognised, supported and valued in their caring role. We want to support carers to stay active and healthy so that they can continue to support the people they care for as well as accessing support for themselves. The Care Act recognises the important work done by carers and makes provision for them to have an assessment of their own support needs.

Carers are an integral part of the social care economy, providing an estimated equivalent of £352.5 million of paid care in the borough per year[9]. Carers come from all walks of life and we know that some do not even identify themselves as carers. We know that carers want to be part of the decisions made about the people they care for. We also know that some carers continue to work and others would like to return to employment or education.

The Care Act 2014 introduced significant and welcome measures to improve the rights of adult carers. These measures include:

- A duty on local authorities to promote the physical, mental and emotional wellbeing of carers and their participation in work, education and training;
- Clearer information, advice and access to a range of preventative services which reduce carers' need for direct support;
- New assessments which put carers on an equal footing with the person they care for;
- A national eligibility threshold, bringing greater clarity around entitlement for carers and those they care for;
- Giving eligible carers, for the first time, a clear right to receive services, via a direct payment if they choose;
- Processes in place to ease the transition between child and adult services.

In the Business of Care, Barking and Dagenham's Market Position Statement 2014 to 2016, Carers were indentified throughout the document. This addendum and future market position statements will have a specific section on carers in line with the Care Act 2014.

## Looking back

Around 16,200 people in Barking and Dagenham identify themselves as carers (Census 2011). Carers of Barking and Dagenham works with 2,600 registered local carers. This suggests there are a large number of carers not receiving services. Nationally it is estimated that 1 in 9 people in the workforce are caring for someone

[9] Valuing Carers (Carers UK and University of Leeds, 2011) – calculation is based on a methodology that uses an official estimate of cost per hour of providing home care to an adult

who is ill frail or has a disability. It is important to maintain the health and wellbeing of carers and support them to access or maintain employment opportunities.

In 2014/15 there were 551 carers' assessments or reviews carried out by the Council's social care teams and third sector partners.

Carers provide a significant number of hours of support for service users in the borough with older carers providing more hours of care as shown in the Figure 2.

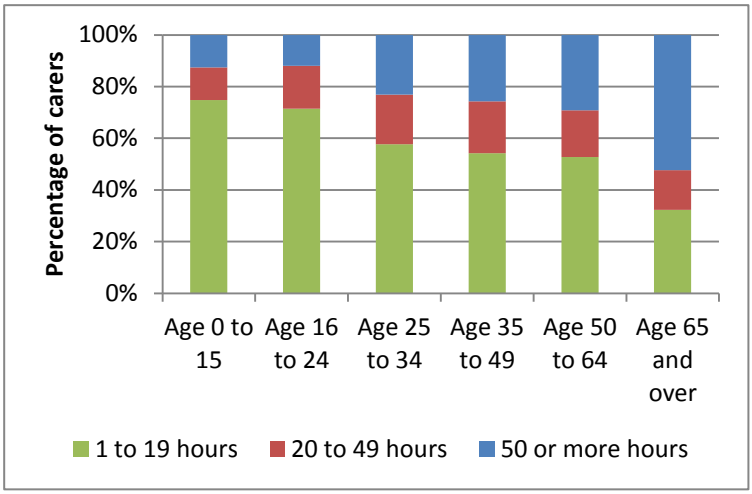



Figure 2: Number of caring hours by age group

Carers of Barking and Dagenham[10] provide support to carers in the borough. In 2014/15, 1262 carers accessed support; overall 19% of whom were men and 81% were women. This data shows that men are under- represented when it comes to accessing the support service, although there is some evidence to indicate that women register and male partners access support via their partners.

The number of carers from Black, Asian and Minority Ethnic (BAME) communities is significant at 34% (2014/15). This needs to be reflected in the support services provided.

### Carers in Barking and Dagenham

Following the commissioning of local research and investigation by Carers UK in 2014 the Council, Clinical Commissioning Group and Carers of Barking and Dagenham have worked in partnership to develop the Let's Care for Carers: A Carers' Strategy for Barking and Dagenham 2015-18[11] to be:

> *A carer-conscious community, working to create innovative and sustainable support for carers, where carers are viewed as 'everybody's business' and feel valued.*

It has seven priority areas:

1. Carers are identified at the earliest opportunity and offered support to prevent, reduce or delay their needs and the needs of the person they care for
2. Carers are provided with personalised, integrated support that is tailored to their assessed needs
3. Carers are consulted in the care provided to their loved ones, treated with respect and dignity with recognition of their skills and knowledge

10 http://www.carers.org/local-service/barking

11 https://search3.openobjects.com/mediamanager/barking/asch/files/carers_strategy_v4.pdf

4. Carers are supported to maintain good physical and mental wellbeing
5. Carers are supported to improve individual social and economic wellbeing, reduce social isolation and fulfill their potential in life
6. Carers are supported to cope with changes and emergencies and plan for the future
7. Carers are supported when their caring role is coming to an end and to have a life after caring

With the implementation of the Care Act 2014 it was anticipated that the number of carers assessments carried out by social workers would increase. This has not yet been the case. In 2014-15, 282 carers assessments were completed. In the first six months of 2015-16, 62 carers' assessments have been completed.

### Looking forward

Through the mechanism of the Better Care Fund, the Council and CCG are implementing a range of services in line with the Carers strategy. The first of these, in line with our information and advice duty under the Care Act 2014, is the tendering for a Carers Hub.

The Hub for Carers will provide a single point for information advice, signposting, screening and referral for assessment. The Hub also supports the effective coordination of the offer across universal services and specialist services. The commission for the Hub for Carers will be awarded in February 2016, to be in operation for April 2016.

Following on from the establishment of the Carers Hub there will be a number of initiatives that will provide opportunities for innovation and development in the provision of services with and for carers.

### Future

In the future we expect the number of carers to increase as young carers transition to adulthood. There is a projected growth in the overall population of Barking and Dagenham of 22.7%, suggesting there will be an even greater number of unpaid carers in the borough.

### Opportunities

There are a range of ways providers can support the provision of carer's services in Barking and Dagenham. The Council will seek to ensure that carers are enabled to support themselves and through a range of mechanisms and receive services that are tailored to their personal circumstances. This will require coordination and cooperation across the Council and its partners, including providers. Some potential opportunities for providers would be:

- Services that are funded externally through independent funders that help to build "resourceful communities" and encourage access to information and advice to enable social responsibility
- Opportunities that will help to develop self sustaining carers peer support

networks across specific communities, e.g. men, specific ethnic groups etc
- The development of volunteer based services to support carers such as befriending schemes or respite services.
- Innovative ways of supporting young carers reaching adulthood.

## Providers we would like to see in the market

- Every social care provider proactively considering the needs of carers and referring to appropriate services such as the Carers Hub. In addition providers should be able to respond in a crisis and alert the Council when necessary.
- Providers who understand the impact of data and can use the data their services generate to help them and us to attract additional funding.
- We would like to see providers who recognise the importance of information and advice for carers in accessing wider services and opportunities for the people they are working with.
- Providers who consider online solutions and opportunities, such as carers chat rooms, and adapt their service delivery to meet the need and expectation of the rapid digital change.
- Providers who support carers to maximise their opportunities in a personalized way.

# 5 Advocacy

### What we want for our residents

We want people who need support to understand information, express their needs and wishes, secure their rights, represent their interests and obtain the care and support they need to have access to the right advocate where necessary.

The aim of advocates is to ensure people from vulnerable groups are empowered to speak up and be heard so that they are included and afforded the equality of opportunity (as others) and that their human rights are protected.

### Advocacy in Barking and Dagenham

The Council has statutory advocacy duties can be summarised as the following:

**Mental Health Advocacy**

The Mental Capacity Act 2005 (MCA) and the Mental Health Act 2007 (MHA) introduced statutory obligations in England and Wales to provide advocacy services in certain circumstances. These can be summarised as:

**Independent Mental Health Advocacy (IMHA)** - IMHAs are specialist advocates who are trained to work within the framework of the Mental Health Act to provide an additional safeguard for patients who are subject to the Act (who have been detained). IMHA support also includes providing information and exploring options for individuals. IMHA work will take place in the community or in hospital. IMHAs are available for anyone over the age of 18.

**Independent Mental Capacity Advocacy (IMCA)** - IMCAs provide specialist independent advocacy to people (aged over 16) covered by the Mental Capacity Act 2005 who have no one able to support or represent them, and who lack the capacity to make a decision **and/or have problems communicating, possibly because of dementia, a brain injury, a learning disability or mental health needs**.

**Deprivation of Liberty Safeguards (DoLS)** - DoLS is one element of a wider IMCA Service and is intended to protect individuals who have been deprived of their liberty to serve their best interest. The Council may request advocacy support on receipt of a DoLS application. The purpose of a DoLS is to ensure that a person's liberty is only restricted correctly and safely. The Law Commission are currently consulting on proposals to revise the DoLS regime, and proposals in this paper would be adaptable to their recommendations as they currently stand.

**Individual Advocacy under the Care Act 2014**

Local authorities must now involve people in decisions made about them and their care and support. No matter how complex a person's needs, local authorities are required to help people express their wishes and feelings, support them in weighing

up their options, and assist them in making their own decisions. An independent advocate can help someone to do this.

Individual advocacy must be considered from the very first point of contact with the local authority and at any subsequent stage of the assessment, planning, care review, safeguarding enquiry or safeguarding adult review.

The criteria for the provision of independent advocacy is set out in the Care Act. It is required if the individual has substantial difficulty in:

- Understanding relevant information
- Retaining information
- Using or weighing the information as part of engaging
- Communicating their views, wishes and feelings.

**Independent NHS Complaints Advocacy**

Independent NHS Complaints Advocacy supports patients, service users, residents, their family, carer or representative with a complaint or grievance related to any aspect of healthcare as described in the Health and Social Care Act 2012. This includes that which falls under the remit of the Health Service Ombudsman, such as complaints about poor treatment or service provided through health services in England

### Looking back – existing advocacy support

In 2014/15 advocates were used to support the following people under the following categories

| | |
|---|---|
| IMHA | 73 |
| IMCA | 98 |
| DoLs | 47 |
| NCAS | 43 |
| Specialist and Care Act | 51 (Q1, 2015/16) 200-250 forecast 2015/16 |
| Care Act | 30) (Q1, 2015/16) 120-160 forecast 2015/16 |
| Total | (461-511) |

The provision of the advocacy (until March 2016) is being supported by the following:

- Specialist Advocacy Framework providing Independent Care Act Advocacy (ICA) and 'specialist', non-statutory advocacy

  A framework of providers including Royal Mencap[12], DABD[13] (Disablement Association of Barking and Dagenham) and VoiceAbility[14] provide short term, professional (paid), issue based advocacy for people with a social care need who are in crisis This includes people with learning disabilities, mental health,

[12] https://www.mencap.org.uk/our-services/personal-support-services/advocacy

[13] http://www.dabd.org.uk/our-services/advocacy

[14] http://www.Voiceability.org/in_your_area/london/barking_dagenham_and_havering

dementia, autism and older people. The framework aims to ensure that people have more choice and control over the advocacy support they receive and that the provider is specialist in their area of need. The borough's user led organisation, the Independent Living Agency (ILA), helps people choose who they want to use for advocacy. Each organisation has its own specialist knowledge and service offer.

- Mental Health Advocacy

  This service provides statutory advocacy with regard to IMCA,IMHA and DoLS and is provided by VoiceAbility.

- NHS Complaints Advocacy Service (NCAS)

  This service is to support people around Independent NHS Complaints Advocacy and provided, as part of a Pan-London contract with 26 boroughs by VoiceAbility.

The majority of service users who access these advocacy services are people with learning disabilities, older people with dementia, people who have acquired a brain injury or people with mental health problems, as well as people with a temporarily reduced mental capacity due to alcohol or drug abuse, illness or trauma.

### Looking forward

With the implementation of the Care Act 2014 it is anticipated that there will be a progressive increase in demand over the next few years. It is also anticipated that the demand for The IMCA/IMHA/DoLS services will remain at current levels moving forward. The anticipation is that there will be more than 400 referrals across the two statutory acts in 2016/17.

Rather than having two contracts for mental health and specialist advocacy going forward the Health and Wellbeing Board agreed in October 2015 to tender for one coordinated service. One advocacy service will lead to a more outcome-focused service, enabling one advocate to support an individual throughout their care and support journey, whether this is subject to the Care Act, Mental Capacity Act or Mental Health Act without any reduction in specialisms.

A single advocacy service (proposed to be called the 'Advocacy Centre') is being tendered for April 2016. The intention is that this will be a web based service that will receive all referrals for advocacy, provide a seamless advocacy service for the borough with one advocate supporting the needs of an individual and ensure that appropriately trained advocates are available. One particular focus of the provision will be signpost to other services in the Borough and encourage informal and self-advocacy.

This service will not be commissioned for non statutory advocacy but will be expected to service to efficiently signpost to other services in the Borough. The provider would also respond to self referrals by encouraging informal and self advocacy and supporting elements around prevention and capacity building to

build, shape and develop the local advocacy market in the Borough. The successful Provider will:

- **Develop and support 'appropriate persons'** (family member, interpreter, friend, carer etc) to provide advocacy support through support and training.
- **Work with local organisations**, such as our colleges and Care City, to establish advocacy training centres in the Borough and ensure, where possible, that advocates are recruited from Barking and Dagenham and the local area.

### Opportunities

There are a range of ways providers can support the provision of advocacy services in Barking and Dagenham. The new advocacy provider from April 2016 will be seeking to support the development of the market. Some potential opportunities for providers would be:

- Services that are funded externally through independent funders that help to build "resourceful communities" and encourage access to information and advice to enable social responsibility
- Opportunities that will help to develop appropriate adults (family member, interpreter, friend, carer etc) to provide advocacy support
- The development of locally trained advocates to increase the professional workforce.

### Providers we would like to see in the market

- Every social care provider proactively considering the needs for advocacy at the initial point of contact and referring to appropriate services such as the Advocacy Centre. In addition providers should be able to respond in a crisis
- Providers with specific specialisms where the core contract may not be able to meet the need.
- Providers with trained advocates who can be called on in cases of urgent need,
- Those with IMCA, IMHA and Care Act qualifications able to operate in different settings offering a seamless service for the individual depending on their point in the pathway
- Those who can build capacity self-promote and market their services to individuals and referrers alike.

# 6 Personal Assistants

### What we want for our residents

We want people to be active citizens; able to live a meaningful life and make positive contributions to the community they are part of. The availability of a pool of appropriately trained personal assistants is key to enabling residents be active citizens.

Personalised care enables people to meet their individual needs. It allows them to maintain independence and achieve personal outcomes. Personal budgets are an important means of delivering this, and direct payments enable individuals to employ their own PAs if they choose to. The expectation is that more people will be using PAs as the number of direct payments increases.

Barking and Dagenham have been proactively developing the PA market as part of a policy decision to facilitate choice and control for people with adult social care budgets. We have been successful in encouraging the take up of the personal assistant model particularly with older people

The Care Act requires councils to make sure that people who use their direct payments to employ PAs meet their legal responsibilities and act as good employers. Councils face a challenge to provide timely access to the right information, advice and support for this to happen. The expectation is that the local authority will provide:

- Clear advice for direct payment recipients on becoming an employer
- Specialist support and advice to enable direct payment users to meet all of the responsibilities associated with employing people including tax, national insurance obligations, health and safety, and pension obligations
- Information on how to access disclosure and barring service checks where possible
- Signposting to other sources of advice and resources including Skills for Care Workforce Development Fund and local direct payment support services

A Personal Assistant (PA) supports people with their everyday life. This can include:

- help with shopping and household tasks
- personal care such as bathing and getting dressed
- supporting people to access community resources such as libraries, community activities and leisure facilities
- helping people to work and maintain their independence

Whatever service is required, the PA enables their service user to maintain choice and control.

## Personal Assistants in Barking and Dagenham

### Looking back

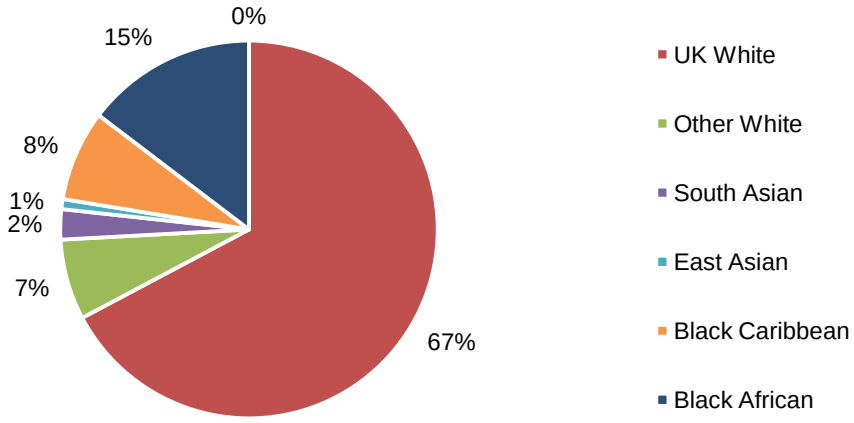
The Council has been proactively developing the PA market locally since December 2012 to provide people who have a personal budget with the option of a personal assistant.

2014/15 was a year in which the number of personal assistants (PAs) in Barking and Dagenham grew substantially. Over 2014/15 the council has worked to build up the PA market in the Borough and we now have over 150 PAs on our PA register as of December 2015.

The Council has a list of accredited Personal Assistants (PAs) on its Personal Assistant Register[15], located within the Care and Support Hub. All PAs accredited by the London Borough of Barking and Dagenham must go through a number of checks, including a Disclosure and Barring Service (DBS) check. PAs must also sign up to a Code of Conduct to ensure that they meet the required standard of care including promotion of rights and independence, confidentiality, safeguarding and risk.

Figure 3 below provides the ethnic breakdown of Pas on the Council's register in June 2015.

**Accredited PAs: Ethnic profile**




PAs provide differing levels and types of care depending on the needs of the service user. The current gender breakdown of PAs on the register shows that the vast majority of PAs are women, with seven men in total.

Not all PAs are on this register. This may be for a number of reasons, for example, they may have chosen not to be on the register, or they may not be seeking additional employment, or they may not meet the required accreditation criteria. However, they still provide services to residents of the borough.

15 http://careandsupport.lbbd.gov.uk/kb5/barkingdagenham/asch/pa_home.page

## Looking Forward

Skills for Care's report, Supporting individual employers and their personal assistant[16] report (March 2015), draws on the findings of the POET survey 2014 and the ADASS personalisation survey report 2014. It acknowledges that progress has been made in supporting PAs and their employers. It identifies a number of gaps in provision including:

- availability of effective PA registers
- access to general advice and guidance
- learning and development opportunities for PAs and their employers
- local quality assurance for PAs
- sustainable peer support

In Barking and Dagenham we are seeking to continue to develop the PA market as viable options for people with a social care budget. It is also anticipated that demand will continue to increase due to the social care information we have:

- There are a large number of people under 65 living with long term conditions needing care and support
- In the next 20 years the number of older people 85+ is likely to grow increasing the need to enable this group to plan for their care and support
- There are a high proportion of young people with learning disabilities whose transition needs must be planned for

## Personal Assistants we would like to see in the market

From the information we have above there are some specific gaps in the PA market locally that we would like to see addressed:

- Those who are reflective of the local community, for example, from Black, Asian and Minority Ethnic (BAME) communities
- More male PAs
- Younger PAs
- Those with specialist experience of working with specific client groups.

16 http://www.skillsforcare.org.uk/Document-library/Employing-your-own-care-and-support/Report-Supporting-individual-employers-and-their-PAs.pdf

# Part 2: Developing social care for the different client groups update

# 7 Older People Addendum

**This should be read in conjunction with the older people's section of the Business of Care in Barking and Dagenham pages 15-19**

## Older People

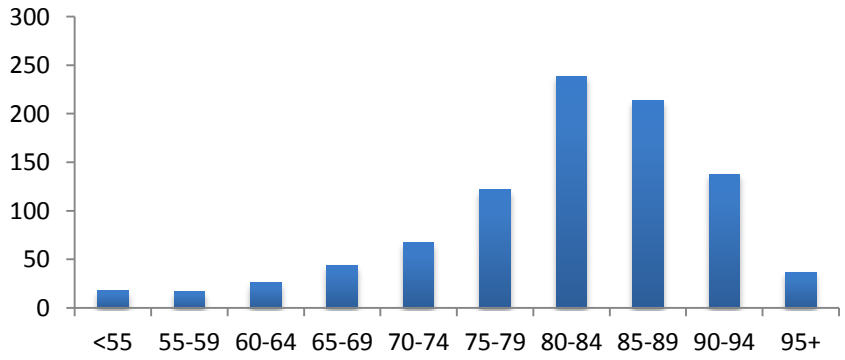
The demand for adult social care services continues to increase, even though the numbers of older people, who are the largest client group, are reducing. Increasingly services users are choosing self-directed support, through the provision of direct payments for their care, supported by a Personal Assistant.
Older people continue to be the largest adult social care client group within Barking and Dagenham. Throughout 2013/14 56% 17 of all adult social care expenditure was spent on services for older people. This is slightly above the England average of 51%.

## Dementia

According to the NHS Dementia Calculator the number of people estimated to be living in the borough with dementia has risen to 1,324, 184 of which are living in a residential care setting. Barking and Dagenham currently has a dementia diagnosis rate of 63.93%, compared to the London average of 65.79%. Despite falling slightly short of the London rate this is still a massive increase compared to the 2010/11 financial year when the borough's rate was 37.55%.

Figure 4 below shows that dementia continues to affect more people in the age groups between 75 and 94.18

**Figure 4:**Age breakdown of clients with diagnosis of dementia




17 HSCIC expenditure report 2013/14
18 The NHS Dementia Calculator

The number of people living with dementia is on an increasing trajectory both nationally and locally, the number of people with dementia in Barking and Dagenham is predicted to increase to 1,842[19] by the year 2030.

## Residential Care

We are continuing to help older people to remain independent in their own homes for as long possible. As a result of this throughout 2014/15 when comparing the number of older people entering a care home with the number of people leaving the net figure was a reduction of 9 places over the year. The Council's average monthly spend on care home placements for an older person is approximately £435,825. The average length of stay in a care home has also reduced in recent years. In 2011-12 the average length of stay was reported to be 2.67 years. A recent piece of work undertaken shows that this average has fallen to approximately 1.5 years. This reduction is also linked to the fact that people are remaining in their own home for longer than any time before, resulting in the average age of admission into a care home is increasing.

We are currently working closely with residential and nursing homes in the borough to establish the true cost of providing these services. The results of this piece of work will form the basis of the prices paid for this type of care moving forwards.

## Care and support in the home

We are currently undertaking a tender exercise to establish a list of providers for both our Homecare and Crisis Intervention services.

Over 90 organisations expressed an interest in the tender, with 41 submitting an application. As a result of the tender between 10 to 15 providers will be selected and contracted to provide these services. The sheer numbers of applicants is a clear indication that the provision of Homecare and Crisis Intervention service available in the borough outweighs the current need the Council has.

Over the last year the average weekly hours delivered by homecare agencies continued to decrease to just under 4,350. In correlation the number of older people using a direct payment has increased over the same period.

## Joint Assessment and Discharge Service

In June 2014, Barking and Dagenham in partnership with Redbridge and Havering launched a Joint Assessment and Discharge team. In the six months following the team's implementation there was a 35% reduction in Delayed Transfers of Care (attributable to social care) reported. The team have also helped to reduce the time between a patient (requiring social care support) being ready for discharge and their actual discharge.

[19] The Projecting Older People Population Information System (POPPI).

# 8 Learning Disability Addendum

**This should be read in conjunction with the Learning disability section of the Business of Care in Barking and Dagenham pages 20-23**

Learning disability services in Barking & Dagenham remains one of the highest area of Adult Social care spend. It is also a service that supports many of the boroughs most vulnerable and complex need of care and support. The borough is focused on ensuring learning disabilities services are safe, offer good outcomes and offer value for money.

There have been a number of developments over the past year:

## Working with our partners

We are working with Barking and Dagenham Clinical Commissioning Group ensuring people with a learning disability receive an integrated health and social care provision. The effects of this are single or joint assessment, quicker decisions on joint packages and a focus on outcomes that enhance the wellbeing of the individual.

## Personalisation

Personalisation has often being a challenge to implement within learning disability services. However the authority remains committed to ensuring services reflect person centred approaches and outcomes.

## Supported Living

The supported living services underwent a competitive tender exercise and awarded 3 contracts to provide accommodation based supported living services. The contracts were awarded with intent to transform the service from a traditional authority commissioned single provider; to a model that offers a combination of a provider offering the core essential shared services with each service users designing their own network of personalised providers to meet their needs.

Assessments are taking place and service users are being supported to develop their support plans.

## Day Opportunities

Day resources are for many service users and families' part of the support package. Service users with appropriate educational, social, vocational or a respite services ensures that people remain at home within the family unit. The borough has provided the traditional model of day service at the Maples Day centre for a number of years. The Health and Wellbeing Board agreed the de-commissioning of the Maples Day resource, and the centre closed in October 2015. Whilst this has been challenging it is the much needed catalyst to support the review of re-modeling of some of the other day provision that is currently commissioned.
A project group has been tasked with the re-modeling of day services and the

following steps were taken for all service users accessing Maples or the Osborne Trust:

- A re-assessment which is compliant with the new Care Act eligibility criteria
- All services users that are eligible have receive an Individual Budget and supported to develop a personalised support plan to access day provision
- Two workshops were held with service users and carers to introduce a range of options for people, from leisure and sports activities to volunteering and routes into employment where appropriate.

The re-modeling and transformation of services has created an opportunity for new providers to develop and offers services. Community Catalysts; a Social Enterprise and Community Interest company provides imaginative solutions to help micro organisations to assist them develop services that are required. The Micro-enterprise Coordinator also acted as the liaison between the local authority and service users to ensure the provision being offered is integrated into the council's care and support hub and general awareness of the micro providers are publicised.

# 9 Autism Addendum

**This should be read in conjunction with the autism section of the Business of Care in Barking and Dagenham pages 24-25**

People with autism can have a wide variety of support needs and any one individual with autism can have areas where they function well and other areas where they may need support. The term ‘autistic spectrum’ is used to reflect this variation.

The Council carried out a self assessment of how it delivers autism services and follows the Government’s Autism Strategy ‘Fulfilling and Rewarding Lives’, which aspires to: ‘ensure that adults with autism are able to lead fulfilling and rewarding lives within a society that accepts and understands them. A three year strategy was published in December 2014 with nine agreed priorities. These were:

- Priority One: Access to relevant information and support through diagnosis and knowing what support is available.
- Priority Two: Delivering good quality care and support.
- Priority Three: Supporting housing needs.
- Priority Four: Access to employment, training and skills (including volunteering and work placements).
- Priority Five: Access to meaningful activities, during the day, in the evenings and at weekends.
- Priority Six: Transition planning.
- Priority Seven: Involvement in service planning.
- Priority Eight: Safeguarding people with autistic spectrum disorders and their families.
- Priority Nine: Making all of our services accessible (including ensuring staff are trained)

The authority will be developing autism services that meet the priorities. Therefore there are opportunities for providers who would be interested in developing services in these areas.

The key to ensuring people with autism receive the appropriate support and service is Priority 1 having a diagnosis and ensuring the appropriate pathway is offered. The authority has commissioned the diagnostic pathway for autism from North East London Foundation Trust (NELFT). This will ensure people with on the autistic spectrum get a diagnosis and access support if they need it.

The authority is working towards bridging the gaps between learning disability and mental health services to ensure adults with autism receive the appropriate service.

Historically Autism has been included within the grouping of learning disability services. The government’s strategy on Autism gives a clear message that services can no longer assume the needs of people with Autism are met under overarching services. The Council is developing its Independent Living Strategy; this will detail how the council will meet the housing and support needs of adults with Autism.

# 10 Supporting Challenging needs Addendum

**This should be read in conjunction with the behavior that challenges section of the Business of Care in Barking and Dagenham pages 26-27**

In responding to preventing or minimising admissions for people  the local authority is implementing the strategic commitments made to the Health & Wellbeing Board in March 2014 on *"Addressing Behaviour that Challenges services*", the Borough's Challenging Behaviour Plan. The key actions relating to this plan are:

- Developing local services that have the expertise to support behaviour that challenges.
- Developing services that offer service users and carers a respite during short term crisis.
- Working regionally to develop provisions that are feasible and sustainable across the neighbouring borough boundaries.
- Sharing good practice across the region and nationally.

The following actions have been achieved in the first phase of the Challenging Behaviour Plan:

- Improved integration with health and social care. Many service users that display behaviour that challenges often have a combination of health and social care support needs, joint assessments and joint funding solutions have been a successful outcome to meeting the needs of the service user.
- Raising awareness understanding, and knowledge of good practice in supporting service users that have challenging needs. This has been through encouraging Providers through the Providers forum to implement Positive Behaviour support as a core training element of their induction programme for staff.
- Supporting Providers to implement the Safeguarding reporting and Deprivation of Liberty Safeguard (DoLS) in a transparent, non risk aversive approach that leads to service improvements.
- Reshaping the Community Learning Disability team to include specialists in behaviour that challenges and ensure these specialists offer training and crisis intervention.
- Utilising the Fulfilling Lives programme to work with existing providers/specify in the supported living tender the need to move people who have attended day services for a long time and who wish to move on to find mainstream opportunities.

**Next Steps – Challenging Behaviour Plan**

The next phase of the Challenging Behaviour Plan will take place over the next 5 years. The programme of work will require a long term commitment from all partners in order to see a sustainable change in how service users that have behaviour that challenge are supported by the borough.
An ongoing challenge is the **availability of housing** which can be tailored to ensure that services for individuals with challenging behaviour can be delivered. This will include developing links with landlords and the Housing department. This will be incorporated into the Independent Living Strategy that is being developed.

It has been identified there is a need to develop a **service specification** that meets the need of service users that display challenging behaviour. It is recognised that there is a lack of providers with the expertise to develop bespoke packages and sustain support to people with challenging and complex needs. We will be working with colleagues across North East London to develop a framework of "expert Providers" that would be accessible to the authority.

Additionally, it has been highlighted that the challenge for CCGs will be developing a selection criteria and service specification for providers that is robust enough to meet the needs of people with challenging and complex needs. The London Borough of Newham is leading this development. Barking and Dagenham have representation on the development of the framework through the Learning Disabilities Lead Networks Group. It is planned to have the framework in operation by April 2017.

Barking and Dagenham are also part of a working group that is led by the Tizard Centre within Kent University. The Tizard Centre is recognised as one of the world's leading research and study centres for learning disability. The completion of the service specification will assist the council to commission good providers that are clear on the expectations of commissioned services designed for challenging behaviour services, and ensure providers have the skills and resources to achieve the outcomes.

Barking and Dagenham are **working closely with all the regional authorities overseen by NHS England**. This joined up approach has led to a number of positive outcomes:

- Sharing of information about good quality providers.
- Sharing of safeguarding concerns across the region and therefore minimising the risk of another Winterbourne View type of incident.
- Sharing the task of sourcing suitable providers, and therefore creating economies of scale and financially viable models that would not have been sustainable in isolation by a single borough.

The lack of good local services has led to many service users being offered a placement out of the borough; this happens in both children and adults services. Once the service users are settled in their new community it is often difficult to support service users to return to Barking and Dagenham, as occasionally they are now settled in their community and do not wish to return or at times there are legal

requirement restricting a return to the borough.

In order to minimise the number of out of borough placements that are agreed in the first instance the council will need to work with providers and landlords to develop service in our locality, and work more closely with Children services.

# 11 Mental Health Addendum

**This should be read in conjunction with the mental health section of the Business of Care in Barking and Dagenham pages 28-31**

## Mental Health Review

There are significant inequalities between mental health and physical health –often referred to as 'parity of esteem'. These inequalities include preventable premature deaths, lower treatment rates for mental health conditions and an underfunding of mental healthcare relative to the scale and impact of mental health problems. The Royal College of Psychiatrists has proposed one of the simplest and most influential definitions of 'parity of esteem': "Valuing mental health equally with physical health".

A number of government initiatives have been introduced in an attempt to reduce this deficit. The first one being No health without mental health, a cross government mental health outcomes strategy launched in 2011, is underpinned by the Government's three main guiding principles of freedom, fairness and responsibility. Following on from this the government published Closing the Gap in February 2014. Closing the Gap challenges health and social care economies to go further and faster to transform the support and care available to people with mental health problems and is the concept of 'parity of esteem' between mental health and physical health services. Most recently the NHS released their Five Year Forward Plan[20] setting out how the health service needs to change in order to promote wellbeing and prevent ill-health. The plan includes the five year ambitions for mental health which states that over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together. In addition to the above the Council's Better Care Fund submission includes a stream covering mental health outside of hospital.

In light of the above the delivery model mental health social care is currently undergoing a full review. The Mental Health Sub Group of the Health and Wellbeing board has been leading on this process and three events were scheduled in the autumn of 2015. The themes of the three events were "My Life", "My Home & Family" and "My Care", and covered all aspects of mental health service delivery in the borough from stigma to packages of care. A final scoping meeting will take place in January 2016 where the process for developing a new Mental Health Strategy will be agreed. The new strategy will shape the future delivery of mental health services in the borough.

[20] https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/5yfv-exec-sum/

# 12 Physical and sensory disabilities Addendum

**This should be read in conjunction with the Physical and sensory disability section of the Business of Care in Barking and Dagenham pages 32**

## Physical disabilities

### Spend and activity

In 2014/15 313 clients with physical disabilities aged 18-64 were in receipt of direct payments. For those aged 65 or above, 675 people were in receipt of a direct payment who had physical disabilities.

From November 2014 there were 5310 working age people claiming Disability Living Allowance (DLA) in the borough. Arthritis made up the largest proportion of claims at 13.6%. London Borough of Barking and Dagenham is one of only 4 Boroughs in London where more than 15% of the population live with a long-term, limiting health condition (others being: Newham, Hackney and Islington).

Figure 5 shows the number of people with a physical disability who were known to Adult Social Care in 2014/15. The graph is split into the following categories:

- Nursing care
- Residential care
- Community (those individuals, who receive support in the community via a direct payment, managed personal budget or commissioned service)

| Primary Support Reason | Nursing | Residential | Community TOTAL |
|---|---|---|---|
| Physical disabilities (aged 18 - 64) | 17 | 10 | 520 |
| Physical disabilities (aged 65+) | 198 | 250 | 1680 |

### Support at Home

Since 2012, adaptations for older and disabled people who live in owner-occupied and privately rented accommodation have been provided via two Council schemes - Disabled Facilities Grants (DFG) and the Adaptation Grant Scheme. The former is governed by the Department of Communities and Local Government (DCLG) guidance and is intended to provide disabled people with access to essential facilities within their homes and access to the exterior of their property. This is for both adults and children. The latter is a preventative, direct payment scheme based on a self assessment for over 18s.

For our Adaption Grant Scheme, approximately £300,000 was paid out for 90 adaptations such as stair lifts, bathing equipment and downstairs toilets.

The Borough does not pay for adaptations costing under £50 and residents are signposted to suppliers who can provide small adaptations of this nature.

People also use a personal budget to purchase other forms of support such as a personal assistant to help with certain tasks.

There is a great deal of pressure on both the DFG and the Adaptation Grant Scheme in Barking and Dagenham. Between 2012 and 2014 there was an increase of 150 referrals to the DFG which has resulted in a significant budget pressure and an additional £150,000 of funding from the Council to this service on top of money from the DCLG. The Borough is predicting a continued increase in pressure on these services due to demographic change and increases in long-term conditions. Please see the Borough's JSNA for a further analysis.

### Day Opportunities

The Adult Social Care Survey for 2014/15 pointed to two key areas of improvement for Barking and Dagenham:

40% of people with physical disabilities said that they found it easy or very easy to find information and advice about support, services or benefits. This is a low figure and down from last year when it was 48%.

37% of people with physical disabilities said that they felt that they have as much contact as they want with people they like. This is the same figure as last year.

The survey and further consultation has revealed that there are limited social activities available for people with a physical impairment in the borough.

Additionally, the survey points to the need for the Borough to improve its information and advice provision for people with physical disabilities. The Borough commissions Disabled Go, an online access guide for the Borough providing information on around 1,000 venues across Barking and Dagenham. We will work with Disabled Go to ensure that they are better integrated into our Care and Support Hub website.

### Sensory disabilities

### Who needs support?

Figure 6 indicates that there are relatively few people receiving a social care service in the community for a sensory impairment (either a hearing, visual or dual impairment). The numbers increase slightly with age. A large proportion of people who experience sight and hearing loss are older, but this is often not the primary area of need recorded.

| Primary Support Reason<br><br>for those aged 18 to 64 | Nursing | Residential | Community TOTAL |
|---|---|---|---|
| Sensory Support: Support for Visual Impairment | 0 | 0 | 17 |
| Sensory Support: Support for Hearing Impairment | 0 | 0 | 2 |
| Sensory Support: Support for Dual Impairment | 0 | 1 | 0 |

| Primary Support Reason<br><br>for those aged 65 and over | Nursing | Residential | Community TOTAL |
|---|---|---|---|
| Sensory Support: Support for Visual Impairment | 2 | 2 | 19 |
| Sensory Support: Support for Hearing Impairment | 1 | 0 | 6 |
| Sensory Support: Support for Dual Impairment | 0 | 1 | 4 |

## Services

A multi-agency Vision Strategy Group has been set up to provide strategic direction on how the Borough as a whole comes together to work on eye care and vision issues for our residents. The Council chairs the group, but it is also attended by local Optical Committee representatives, local voluntary sector organisations, our Community Learning Disability Team and carer representatives.

The Borough was also instrumental in setting up and supporting East London Vision (ELVis). ELVis is a user-led organisation designed to provide an effective and efficient way of ensuring that vision impaired people living in East London get the support and services they need. It is an umbrella organisation with voluntary sector, user led representation in each of the east London Boroughs, including Barking and Dagenham. ELVis is an excellent resource for providers and providers can contact ELVis for support and advice in setting up services for vision impaired people. Details can be found at: http://www.eastlondonvision.org.uk/

## Future

The Council's Health and Adult Services Select Committee are also undertaking a scrutiny review of sight loss and the associated services available to support residents. The recommendations from the review will be published in autumn 2015. It is thought that the recommendations will focus on the importance of sight tests and the use of correct eye wear.

## Opportunities

More user-led organisations and models of peer support for people with physical and sensory impairments.

# 13 Drug and Alcohol Addendum

**This should be read in conjunction with the drugs and alcohol section of the Business of Care in Barking and Dagenham pages 36-39**

In line with the National Drug Strategy, Barking and Dagenham would like to see services and support who focus on preventing drug use in the community and supporting people to recover from drug and alcohol dependence.
Substance misuse can be a problem for anyone; no matter if they are old or young, have a disability or a mental health problem

For example use of alcohol amongst older people appears to be increasing and causing related health problems. We would like all service providers in Barking and Dagenham to be aware of emerging substance misuse issues and be adaptable to deal with changes in the drug and alcohol market. There are a few updates from publication in July 1014.

### The Prescribing Service

The prescribing service has been newly re-designed and re-commissioned.

The new services will work primarily with all adult residents of Barking & Dagenham who are affected by drugs, including prescription and over-the-counter medications.

The Prescribing Service will provide a range of drug treatment services and interventions which consist of specialist prescribing, rapid prescribing, G.P shared care.  The Prescribing Service will also provide wound care and blood borne virus services along with advice, information and training to carers, partners, families and other professionals.

### The Recovery Management Service

The Recovery Management Service has been newly re-designed and re-commissioned.

The Recovery Management Service provides Open Access which includes the Criminal Justice Services, who will take on the care-coordination of an individual's recovery journey from point of entry to the service to treatment exit and will facilitate referrals to other services in Barking and Dagenham including the prescribing service and the structured day programme.

The service's offers a mix of evening and core office hours to service users to maximise uptake of the service, including those who are working or have childcare need. The delivery will take place at a variety of settings and satellites anywhere in the borough based on need.

The new model will provide robust recovery interventions throughout an individual's

treatment.  An individual's recovery plan will also incorporate non substance misuse related interventions and support in order to build full recovery capital.  This may include basic health screenings (including tuberculosis and dental), family liaison, housing, benefits and education, training and employment.

Enabling the individual to stop using drugs will reduce acquisitive crime in the borough connected with drug misuse, ensure that the health and wellbeing of local residents improves by enabling them to return to employment, training or education, securing stable accommodation and thereby reducing the wider harm to individuals and communities.

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# HEALTH AND WELLBEING BOARD

## 26 January 2016

| **Title: Health and Wellbeing Performance Report – Quarter 2 (2015/16)** | |
|---|---|
| **Report of the Director of Public Health** | |
| **Open Report** | **For Decision** |
| **Wards Affected: ALL** | **Key Decision: NO** |
| **Report Author:**<br>Danielle Lawrence, Public Health Analyst<br>Dr Fiona Wright, Consultant in Public Health | **Contact Details:**<br>Tel: 020 8227 5943<br>Email: danielle.lawrence@lbbd.gov.uk |
| **Sponsor:**<br>Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham | |

**Summary:**

The quarter 2 performance report provides an update on health and wellbeing in Barking and Dagenham. It reviews performance for the quarter, highlighting areas that have improved, and areas that require improvement. The report is broken down into the following sub-headings:

1. Performance Summary
2. Background / Introduction
3. Primary Care
4. Secondary Care
5. Mental Health
6. Adult Social Care
7. Children's Care
8. Public Health

**Recommendation(s)**

Members of the Board are recommended to:

- Review the overarching dashboard, and raise any questions with lead officers, lead agencies or the chairs of subgroups as Board members see fit.
- Note the detail provided on specific indicators, and to raise any questions on remedial actions or actions being taken to sustain good performance.
- Note the areas where new data is available and the implications of this data; specifically, the immunisation uptake, under 18 conception rate, chlamydia screening, smoking quitters, NHS Health Check, permanent admissions of older people to residential and nursing care homes, delayed transfers of care, A&E attendance and Care Quality Commission inspections.

**Reason(s)**

The dashboard indicators were chosen to represent the wide remit of the Board, whilst remaining a manageable number of indicators. It is, therefore, important that Board members use this opportunity to review key areas of Board business and confirm that effective delivery of services and programmes is taking place. Subgroups are undertaking

further monitoring across the wider range of indicators in the Health and Wellbeing Outcomes Framework. When areas of concern arise outside of the indicators ordinarily reported to the Board, these will be escalated as necessary.

# 1. Performance Summary

**Section 1 is a summary. Further information and detail on the actions implemented to improve performance can be found in the main report.**

**Primary Care**

Please see **section 3** for detailed information.

1.1. The Barking and Dagenham, Havering and Redbridge (BHR) Accountable Care Partnership proposal has been submitted to NHS England. There is a separate report elsewhere on the agenda.

1.2. Four out of six of the general practices inspected by the Care Quality Commission (CQC) in Q2 received a rating of 'good'. The remaining two were Dr MF Haq's Practice, which was rated 'inadequate', and Dr Niranjan's Practice, which was rated 'requires improvement'. Action plans are in place to make the improvements required.

**Secondary Care**

Please see **section 4** for detailed information.

1.3. A&E performance deteriorated this quarter, as did delayed transfers of care (DTOC). However, improvements continue to be made at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) following its CQC rating of 'requires improvement' earlier this year. In addition, the BHR System Resilience Group (SRG) successfully bid to become a Vanguard site.

1.4. The London Ambulance Service (LAS) received a CQC rating of 'inadequate' and has been placed into special measures. The leadership have already taken steps to address the areas of concern highlighted.

**Mental Health**

Please see **section 5** for detailed information.

1.5. The number of children and young people accessing Child and Adolescent Mental Health Services (CAMHS) decreased in Q2; however, waiting times for emergency assessment were consistently good throughout the quarter. Improving access to psychological therapies (IAPT) performance did not meet the target during Q1 (most recent data available). To address this, the mental health service provider is working to improve performance.

**Adult Social Care**

Please see **section 6** for detailed information.

1.6. There was a slight increase in DTOC from hospital in Q2. The number of permanent admissions to residential and nursing care homes also increased this

quarter. An action plan is in place to improve performance.

1.7. Of the four providers inspected by the CQC this quarter, three received a 'good' rating; however, Lynwood Social Care Organisation was rated 'inadequate'. A CQC action plan is in place for improvements, and Quality Assurance is closely monitoring and supporting the provider to meet the CQC action plan requirements.

**Children's Care**
Please see **section 7** for detailed information.

1.8. The percentage uptake of Measles, Mumps and Rubella booster immunisation (MMR2) and Diphtheria, Tetanus and Pertussis and Polio booster immunisation (DTaP/IPV) was above the London average, but below the national average, and did not meet the target. The NHS England action plan continues to be implemented to improve performance.

1.9. The percentage of looked after children with an up to date health check decreased this quarter. A performance improvement action plan has been demonstrated.

**Public Health**
Please see **section 8** for detailed information.

1.10. The number of four week quitters in the borough this quarter did not meet the target. Public Health continues to implement a project plan to improve smoking cessation performance in the borough. A service review has also commenced.

1.11. Although there was an increase in the number of positive chlamydia screening results in Q2, this fell just short of the quarterly target. There was also an improvement in the Q2 2014 (most recent data available) conception rate for women aged under 18 years. In contrast, there was a decrease in cervical screening coverage in 2014/15 (most recent data available).

1.12. Action plans to improve performance in these indicators continue to be implemented.

1.13. In 2014, there was a 15% decrease in the rate of new cases of tuberculosis among London residents (most recent data available). Early detection and treatment remains a priority in reducing the rate of new cases in London.

## 2. Background / Introduction

2.1. The Health & Wellbeing Board has a wide remit, and it is therefore important to ensure that the Board has an overview across this breadth of activity.

2.2. The indicators chosen include those which show performance of the whole health and social care system, and include selected indicators from the Systems Resilience Group's dashboard.

2.3. The indicators contained within the report have been rated according to their performance; red indicates poor performance, green indicates good performance and amber shows that performance is similar to expected levels. The indicators are measured against targets, and national and regional averages.

2.4. **A dashboard summary of performance in Q2 (July – September 2015) against the indicators selected for the Board can be found in Appendix A.** The most recently available data is presented. For some indicators data is only reviewed annually. For others there are gaps due to time lag or limitations in data availability.

2.5. The following indicators have not reported on because there is no new data available. These indicators are:

- Childhood obesity
- Breast screening
- Injuries due to falls in persons aged 65 and over
- Emergency readmissions within 30 days of discharge from hospital, and
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions.

2.6. At the last report Barking and Dagenham was performing below national average on all of these indicators, with the exception of injuries due to falls in persons aged 65 and over.

## 3. Primary Care

**Primary Care Transformation**

3.1. The Primary Care Transformation Board is developing a vision statement which captures the person centred approach primary care will take once transformation is complete, and which the three boroughs will devise collaboratively. A scheme was piloted at Rydal Practice, Redbridge, and this was received positively, such that the pilot has now been extended to include 11 practices from BHR.

3.2. **BHR are continuing to deliver on the Strategic Commissioning Framework** by focusing on the ten key objectives set out in the document: primarily by achieving improvement in the health and wellbeing of all people through a stronger, collaborative focus on health promotion, the prevention of ill health and supporting self-care, as well as closing health inequality gaps.
A primary care strategy for each borough is in development. The draft strategies will be presented to local Health and Wellbeing Boards. In addition, a Primary Care Dashboard has been developed so that performance against several key performance indicators can be monitored by the Board.

3.3. **The BHR Accountable Care Partnership proposal was submitted to NHS England** to begin the development of a business case which aims to demonstrate whether a partnership could deliver improved care over the next 3-5 years. A process is currently being developed which will include an engagement and communication strategy for Clinical Directors and local GPs.

3.4. The recent signing of a London Health and Care Devolution deal means the BHR

Devolution Pilot can proceed. **The business case for the development of an Accountable Care Partnership is to be completed by Summer 2016** and will try to ensure that health and care are more closely integrated and patient pathways are redesigned with a focus on intervening early and managing the chronically ill.

**CQC Inspections**

3.5. An overview of General Practice CQC inspection reports published during the second quarter of 2015/16 can be found in Appendix B. During this period 6 reports were published on local organisations. Of the **6 GPs inspected, 4 met the requirement for an overall rating of 'good'**. The remaining **2 GPs were rated 'requires improvement' and 'inadequate'**.

3.6. **Dr MF Haq's Practice, Abbey Medical Centre, rated 'inadequate'.** During their inspection, the CQC found several areas of concern including the absence of systems and processes to keep patients safe and a lack of clarity surrounding the reporting of incidents. They also found evidence of division and a lack of communication between clinical and non-clinical staff which hindered progress on improving patient outcomes. As a result, the provider has been placed into special measures. An action plan is in place to ensure the practice makes the required improvements. Please see Appendix B for further information.

3.7. **Dr Niranjan's Practice rated 'requires improvement'.** During their inspection the CQC found that safety was not a sufficient priority, there was little evidence of learning from events or actions implemented to improve safety and some leadership policies were out of date. The practice must now make improvements in the areas of concern highlighted. Please see Appendix B for further information. An action plan is in place to make the improvements required.

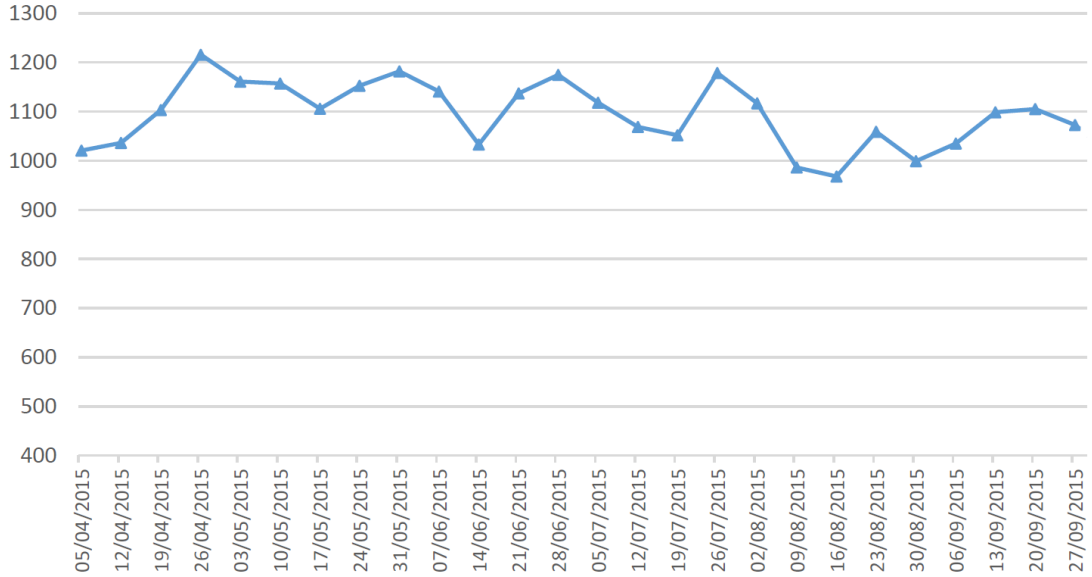
## 4. Secondary Care

**Urgent Care**

4.1. **A&E performance for patients waiting less than four hours from arrival to admission, transfer or discharge fell below the national standard this quarter.** The Trust's overall performance began the quarter at 95.9% in July, fell to 90.3% in August, and performance continued to fall below the national standard of 95% in September, with no weeks achieving the standard.

4.2. **BHR Clinical Commissioning Groups (CCGs) non-elective admissions at BHRUT increased** by 344 (8.8%), from 3,899 in July to 4,243 in September. NHS Barking and Dagenham CCG had an increase of 9 (0.1%) from 1,159 in July to 1,168 in September. In comparison with September 2014, September 2015 non-elective admissions were 9.8% higher (there were 1,064 non-elective admissions in September 2014).

**Figure 1: BHRUT Non-Elective Admissions**




4.3. In order to address this, BHRUT have started to track patients to identify where the demand is coming from, as it is felt the figures for utilisation of GP appointments and A&E attendances are increasing, raising questions around the demand in the system. The Adastra data system will help identify whether the cohort of patients utilising the GP appointments are the same that are attending A&E or are, in fact, a new cohort of patients.

4.4. **Overall, DTOC performance deteriorated between July and September, but remained within target.** The lower DTOC threshold target is 20, and the upper threshold limit is 40. At the start of the quarter the weekly average was 12.8. This decreased to 12.3 in August, before increasing to 13.0 in September.

4.5. In October 2015, for incomplete pathways (instances where the treatment pathway has not yet finished), NHS Barking and Dagenham CCG (as a commissioner) had 93.8% of referral to treatment (RTT) periods within 18 weeks of referral. This is higher than both the London (92.6%) and national (92.3%) averages. BHRUT, as a provider, did not submit data in October, so it is not possible to report on the percentage of RTT periods that were within 18 weeks of referral.

4.6. **The BHR SRG successfully bid to become a Vanguard site.** An Urgent and Emergency Care Programme Board has been established to lead the delivery of the programme. The SRG hosted a visit from the Vanguard team, the purpose of which was for the national care models team to understand the BHR vision and plans to transform urgent care. The final value proposition 2015/16 has been submitted to NHS England and SRG are awaiting the outcome. The next step is to write a value proposition for 2016/17.

**CQC Inspections**

4.7. **BHRUT remains in special measures**. Recent performance improvement highlights at BHRUT include the launch of the Trust's Falls Policy, communication

improvements, and the agreement of a pathway for young adults attending BHRUT Emergency Departments. NHS Barking and Dagenham CCG is working closely with the Trust Development Agency and NHS England, as well as local partners to act as the "system leader" to ensure that performance at BHRUT is recovered and then sustained.

4.8. **LAS NHS Trust rated 'inadequate' and placed into special measures**. Areas noted in the CQC report were the Trust's poorly performing response times, a culture of bullying and harassment and insufficient support to allow staff to do their jobs. As a result, the provider has been placed into special measures. The leadership of LAS have already taken action to address the issues raised, and support from external partners including the NHS Trust Development Authority and NHS England will be crucial in achieving the required improvements. Please see Appendix B for further information.

4.9. **Improvements are being made to maternity services at Homerton Hospital**. Following the CQC rating of 'requires improvement', a range of quality improvement changes have been implemented at Homerton Hospital. Particularly around the review of training, newly appointed consultants and a triage system in the delivery suite. NHS Barking and Dagenham CCG are working closely with colleagues to ensure that they shape and influence the development of the plans to improve the maternity services that our residents may access within their patch.

## 5. Mental Health

**CAMHS**

5.1. **The number of children and young people accessing CAMHS tiers 3 and 4 decreased** from 585 in Q1 2015/16 to 490 in Q2. This performance is also a reduction on the Q2 2014/15 figure of 546. This indicator has not been given a RAG rating as there is no target associated with this indicator.

5.2. **CAMHS waiting times for emergency assessment were consistently good throughout Q2.** In July and August 100% of children and young people requiring emergency assessment were seen by the end of the following working day, and in September there were no emergencies.

5.3. **DTOC remained above the threshold throughout Q2** and ended the quarter on 13.1%, indicating poor performance. This indicator counts the number of occupied bed days lost to DTOC. Good performance in this indicator would be a DTOC figure of less than 7.5%. The current restriction on placements as agreed with the London Borough of Barking and Dagenham is preventing the service from placing service users who require discharge from acute care into suitable provision. DTOC have been over the agreed target since June 2015 due to the restriction. This delay poses both safeguarding and deprivation of liberty safeguards (DoLS) risks to patients who are not moved from inpatient care in a timely manner. The DoLS are part of the Mental Capacity Act 2005, and aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

5.4. Production of a weekly DTOC list, with early identification, has been implemented to support the process. Weekly bed management meetings are also taking place. Further discussions on DTOC take place during the Section 75 executive steering group.

**Care Programme Approach (CPA)**

5.5. **The proportion of adults on CPA in settled accommodation has increased slightly** from 88.2% in Q1 2015/16 to 88.4% in Q2. Therefore performance in this indicator has improved. In contrast, **the proportion of adults on CPA in employment has marginally decreased** from 5.4% in Q1 2015/16 to 4.8% in Q2, indicating a decline in performance.

5.6. At the end of Q2 97.2% of adults and 97.7% of older adults on CPA had received a formal CPA Review within the past 12 months. The target associated with this indicator is 97.0% minimum, so this target was exceeded.

**IAPT**

5.7. NHS Barking and Dagenham CCG is required to deliver two mental health standards related to IAPT; 15% of adults with relevant disorders will have timely access to IAPT services with a recovery rate of 50%. The CCG did not deliver the access standard in 2014/15 nor in Q1 2015/16, and is one of a small number of CCGs in London that did not achieve the required access target. Q1 2015/16 figures are the most recent data available for this indicator.

5.8. There was a small discrepancy between data reported nationally and provider reported data for Q1 due to a North East London NHS Foundation Trust (NELFT) data submission problem to the Health and Social Care Information Centre (HSCIC), therefore accurate data may not be available until October. Furthermore, NELFT local data predicts that the CCG has not achieved the access standard of 15% of adults having timely access to IAPT services for Q2. The primary cause of under performance has been due to insufficient referrals being received into the service.

**Table 1: Performance against IAPT access target Q1 2015/16, Barking and Dagenham and neighbouring boroughs**

| | HSCIC published figures | NELFT local data | Target |
|---|---|---|---|
| **NHS Barking and Dagenham CCG** | 3.09% | 3.44% | 3.75% |
| **NHS Havering CCG** | 2.68% | 2.96% | 3.75% |
| **NHS Redbridge CCG** | 2.61% | 2.80% | 3.75% |

5.9. The CCG is implementing a Recovery Action Plan, as agreed at the September Governing Body meeting, to improve performance.

## 6. Adult Social Care

### DTOC

6.1. This is a measure that reflects both the overall number of DTOC, and the number of these delays that are attributable to social care services.

6.2. **There was a slight increase in DTOC from hospital,** from 7.2 per 100,000 population in Q1 2015/16 to 7.4 in Q2. This figure is below the England average of 9.7, but exceeds the London average of 6.9. There was a significant increase in the DTOC due to social care, which increased from 2.63 per 100,000 in Q1 2015/16 to 4.55 in Q2. This figure brings the borough to above both the England and London averages of 2.3 and 3.1 respectively.

6.3. The joint assessment and discharge service (JAD) has met with Barts Health NHS Trust to ensure a formal sign off process is implemented. The JAD have been assured that there is now a new manager in place who will ensure the formal sign off process is implemented. This measure should address DTOC reporting without verification by the JAD. The Social Care delays reported without following due process account for 9% of all DTOCs reported thus far. This issue with Barts Health NHS Trust (in particular Newham General Hospital) is not unique to Barking and Dagenham, as other Local Authorities have expressed the same issue.

6.4. The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement or rehabilitation services fell to 67.2% in 2014/15. This is the most recent data for this indicator. This figure is 21.1 percentage points below the Q1 figure of 88.3%, and also brings the Barking and Dagenham figure significantly below the England (82.1%) and London (85.3%) averages. An action plan is in place to improve performance in this indicator.

### Social Care Admissions

6.5. The number of permanent admissions to residential and nursing care homes is a good measure of the effectiveness of care and support in delaying dependency on care and support services.

6.6. In Q2 2015/16 there were 42 admissions into residential and nursing care homes. This is 5 admissions above the Q1 figure of 37. The annual target set by the Better Care Fund is 125 admissions (635.93 per 100,000 population), where good performance would not be higher than this figure. The cumulative figure by the end of Q2 2015/16 is 79 admissions, which equates to 401.91 admissions per 100,000 population. Therefore, if admissions continue at this high rate, it is unlikely that the target will be met. An action plan is in place to improve performance.

### CQC Inspections

6.7. **Appendix B contains an overview of CQC inspection reports** published during Q2 2015/16, including those relating to social care providers in the Borough, or

those who provide services to our residents. During this period 6 reports were published on local organisations using the new CQC ratings introduced in October 2014. Of the 4 providers inspected, **3 met the requirement for an overall rating of 'good'; the remaining provider was rated 'requires improvement'**.

6.8. **Lynwood rated 'requires improvement'.** Lynwood is a supported living accommodation with personal care and support for learning and physically disabled people over the age of 18. They have capacity for 7 residents and are located in Beccles Drive in Barking. There are currently 7 residents which are all supported by Barking and Dagenham.

6.9. The CQC found that the service provided required improvements to be made in several areas which accounts for the overall rating of 'requires improvement' (please see appendix B). All 7 residents have been reviewed to ensure that they are safe and looked after. The residents were found to be happy in their environment, had good relationships with their carers and each other. A CQC action plan is in place for improvements and Quality Assurance within the council is closely monitoring and supporting the provider to meet the CQC action plan requirements. Good progress is being made against the action plan.

6.10. Separately to the inspection and after it had taken place, a fire broke out at the home in November caused by a firework/flare being fired at the window. This was an indiscriminate event as several of these were fired at houses in the same street and is being investigated by the Police. The fire caused considerable damage and one resident was severely burned and is currently in intensive care. The other 6 residents were found temporary accommodation in 80 Gascoigne, the Council's own learning disability provision, and have now returned to Lynwood.

## 7. Children's Care

**Immunisation**

7.1. **The percentage uptake of DTaP/IPV by the age of 5 remains above the London average** of 79.8%, but below the England average of 87.9%. Performance in this indicator has decreased by 0.6 percentage points, from 84.4% in Q1 to 83.8% in Q2.

7.2. **The percentage uptake of MMR2 by the age of 5 slightly increased in Q2**, from 81.0% in Q1 to 81.2% in Q2**.** Performance in this indicator is also above the London rate of 80.5%, but below the England rate of 87.9%. **Performance for both immunisation indicators is below the national target of 95%,** which has resulted in a red RAG rating.

7.3. **The action plan to address areas of poor performance continues to be implemented.** In line with this action plan, the Director of Public Health and Immunisation Commissioning Manager (NHS England) have visited 8 practices, and have arranged visits to a further 12 practices. In addition, the Immunisation Commissioning Manager has been working with NELFT to develop and implement look forward reports, with a view to implementing this at the start of Q4. Steps are

also being taken to improve the recording of immunisation data.

**Annual Health Checks of Looked After Children (LAC)**

7.4. **Performance decreased in September.** The percentage of LAC with an up to date health check decreased from 82.0% in Q1 2015/16 to 72.0% in Q2. This brings performance below both the London (88.1%) and England (84.3%) averages. However, this level of performance is comparable with Q2 2014/15, when 73.0% of LAC had an up to date health check. In previous years, performance in this indicator has improved significantly towards the end of the year. Therefore, if performance follows this trend there may be an upturn in performance in Q4. This indicator has been rated amber.

7.5. **An action plan is in place to improve performance**. In line with the action plan, meetings between Health Commissioners and Providers, including CAMHS, are taking place on a monthly basis to look at improvement strategies and to track performance. The LAC Nurse also delivered a presentation at the Children's Social Care management meeting to highlight performance issues.

7.6. In addition, a performance spreadsheet is being sent on a weekly basis to all social care teams and their managers to highlight individuals with missing paperwork. The timeliness and quality of return forms is also being tracked, as a delay in the return of some reports following medical completion and quality issues have previously been highlighted.

## 8. Public Health

**Four week smoking quitters**

8.1. The four week quitter figure measures the number of individuals who have successfully quit for four weeks.

**Table 2: Barking and Dagenham four week quitters**

| | Q1 | Q2 | Total | Annual Target |
|---|---|---|---|---|
| **GP** | 32 | 20 | **52** | 2,000 |
| **Pharmacy** | 70 | 46 | **116** | |
| **Tier 3** | 18 | 14 | **32** | 1,000 |
| **Total** | **120** | **80** | **200** | 3,000 |

8.2. **There were 80 quitters in Q2 2015/16, which is 33.3 percentage points lower than the number of quitters in Q1 2015/16 (120 quitters)**. This figure is also lower than the Q2 2014/15 figure of 162 quitters. To achieve this year's annual target of 3,000, an average of 750 quitters would be required each quarter. This quarter's figure falls significantly short of this target, and as a result this indicator has been rated red.

8.3. Women smoking during pregnancy are being targeted via the babyClear programme. Key performance indicators have been agreed with BHRUT, and activity will begin being reported from October 2015. All maternity staff have now received introductory babyClear training, and Nicotine replacement therapy will be available on all maternity wards. The aim of the programme is to reduce smoking during pregnancy in Barking and Dagenham to less than 10% by October 2018. In 2014/15, 10.2% of women were recorded as smoking at the time of delivery. This is the most recent data for this indicator. The national target is to reduce this rate to 11% or less by the end of 2015.

8.4. **Public Health continues to implement a project plan to improve smoking cessation performance in the borough.** This involves proactive measures to identify and support general practices with the highest number of registered smokers and unplanned hospital admissions for chronic obstructive pulmonary disease (COPD). In line with this plan, Public Health has contacted all general practices in the borough with smoking activity and ongoing visits to providers with a stop smoking contract are taking place. This will provide ongoing support and contract management.

8.5. QuitManager (the database used to manage stop smoking services) training and telephony support for providers is being set up. Public Health will also be piloting a small call and recall centralised system to assist practices with patient retention and smoking quit rates. To pilot this, a smoking support officer has been recruited to assist with stop smoking service administration. As a result, it is expected that there will be improvements in performance within the next 3 to 6 months.

8.6. Furthermore, the Government recently announced that the first e-cigarette device (e-Voke) has been licensed by the Medicines and Healthcare Regulatory Agency for prescription as a smoking cessation aid alongside other existing nicotine replacement therapies. Commercial e-cigarettes have been cited as a major cause for the drop in people accessing specialist stop smoking services.

8.7. Both Level 2 and Level 3 smoking cessation services can now prescribe this licensed product to their service users. The introduction of this device should help increase the number of successful 4 week quits, as smokers using e-cigarettes can now be targeted.

8.8. A service review of issues and potential future models has commenced.

**NHS Health Check**

8.9. This indicator measures the percentage uptake of NHS Health Check among the

eligible population of persons aged 40-74 years. This is a mandatory target for local authorities.

8.10. **Performance in this indicator improved in Q2,** from 2.5% (1,104 completed health checks) in Q1 2015/16 to 2.8% (1,228 completed health checks) in Q2 2015/16. However, this is a large reduction on the Q2 2014/15 performance, when 4.2% of the eligible population received an NHS Health Check. Performance in this indicator has therefore been rated red.

8.11. To meet the national annual target of 15%, the uptake of health checks needs to maintain an average of 3.75% each quarter. This quarter's performance does not meet this target. **The year-to-date uptake is at 5.3% against the target of 7.5%.** This will make meeting the annual target challenging.

8.12. **An action plan is in place to facilitate performance improvement in this indicator.** Ongoing meetings with Lead GPs and Practice Managers are taking place to address the low uptake of Point of Care Testing (POCT). The POCT provider is also making direct contact with Primary Care providers to organise onsite POCT training to improve the uptake of health checks. Furthermore, as there has been no core training in the last few financial years, this is in the process of being arranged. This core training should help increase awareness and uptake of health checks.

8.13. Quarterly updates to providers have also been implemented to ensure timely performance reporting is shared.

8.14. Improved performance is predicted for Q3 as this service area is being tightly performance managed. Although it is not certain that the target will be achieved next quarter, Public Health remain optimistic.

**Number of positive chlamydia screening tests**

8.15. The chlamydia screening indicator is a measure of the number of positive tests from the screening process in young adults aged 16-24 years, compared with the expected numbers of positive tests.

8.16. **The number of positive chlamydia screening results increased** from 118 in Q1 2015/16 to 130 in Q2. This is slightly lower than the number of positive results reported in Q2 2015/16 (141 positive results). To achieve this year's annual target of 596 positive tests, an average of 149 positives would be required each quarter. This quarter's result falls short of this target by 20, and falls short of the year-to-date result by 50 (248 positives against the target of 298). As a result, this indicator continues to be rated red.

8.17. **To encourage performance improvement, continued support has been provided to both pharmacies and general practices** to maximise their screening potential. This has included site visits, refresher training sessions and resource drop offs. Monthly figures are sent to each pharmacy/general practice to allow them to keep track of their progress and encourage greater activity.

8.18. In September 2015, 8 new pharmacies signed up to deliver the chlamydia screening programme. Full training has been provided to 7 of these new pharmacies. They are now awaiting safeguarding training and Disclosure and Barring Service checks before they can provide the service.

**Conception rate in under 18 year olds**

8.19. Figures for the quarterly conception rate for women aged under 18 years show that **the conception rate has decreased** from 31.0 conceptions per 1,000 women aged 15 to 17 years in Q1, to 20.5 in Q2 2014. This is a decrease of 10.9 conceptions per 1,000 women aged 15 to 17 years. This is the most recent data for this indicator.

8.20. These new figures put Barking and Dagenham in line with the London average (20.4), and below the England average (21.9) conception rate in under 18 year olds for this quarter. The London borough with the highest quarterly conception rate was Southwark with 33.7 conceptions per 1,000 women aged 15 to 17 years, and the lowest was Harrow with 7.5.

8.21. **Considerable work is being undertaken within the borough to reduce the conception rates via commissioned public health services and local partnership working**. This includes expansion of the local C-Card condom distribution scheme for 13-24 year olds to 100% coverage by local community pharmacies, the development of a local teenage pregnancy strategy and improvements are being made to the range and quality of sex and relationships education in secondary schools. **Please note that this is by no means a comprehensive list of actions being taken within the borough**, but has been included to provide an insight to the work being undertaken.

**Cervical Screening**

8.22. This indicator measures the percentage of eligible women screened adequately within the previous 3.5 or 5.5 years (according to age) on 31st March.

8.23. **In 2014/15 cervical screening coverage in Barking and Dagenham was 70.1%.** This is the most recent data for this indicator. This is higher than the London average of 68.4%, but is below the national average of 73.5%. **There has been a year on year decline in performance in this indicator since 2011/12** (uptake was 75.0% in 2011/12, 74.9% in 2012/13 and 72.4% in 2013/14). A similar trend has been seen across London (uptake was 74.1% in 2011/12, 74.1% in 2012/13, 70.3% in 2013/14 and 68.4% in 2014/15).

8.24. **Nationally, promotional campaigns are being implemented to raise awareness and improve coverage.** Throughout London, sexual health services are being supported to provide cervical screening.

8.25. Other initiatives to improve cancer screening in general include the development of projects that will improve awareness of the signs and symptoms of cancer, particularly in those from lower-socioeconomic groups, men, those who are younger and those from ethnic minorities. This is in line with the National Cancer Equalities Initiative.

8.26. **In 2014 there was a 15% decrease in the rate of new cases of tuberculosis** (TB) notified among London residents (2014 rate was 30 per 100,000 population). A total of 2,572 cases were notified. This is the most recent data available. The largest reductions were in the areas of London with the highest incidence. Most of the individuals with TB in 2014 were born abroad (82%) and the age group with the highest rate was adults aged 20-39 years. The sustained decrease in TB numbers and rates is promising, however early detection and treatment remains essential.

8.27. To improve TB detection and treatment, an expression of interest to roll out testing of latent TB to the newly registered population via primary care has been submitted to the national TB programme jointly with Redbridge. Should this expression of interest be successful, NHS Barking and Dagenham CCG would receive funding and hold the commissioning responsibility, and Public Health would implement the programme in line with HIV rapid testing. The outcome is expected in Q3.

## 9. Mandatory implications

9.1. **Joint Strategic Needs Assessment**

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

9.2. **Health and Wellbeing Strategy**

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

9.3. **Integration**

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

9.4. **Legal**

Implications completed by: Dawn Pelle, Adult Care Lawyer, Legal and Democratic Services

There are no legal implications for the following reasons:
The report highlights how the various bodies have met specific targets such as the performance indicators: whether they have or have not been met in relation to the indicators for London and England. How the authority is measuring up against the National average.

9.5. **Financial**

Implications completed by: Carl Tomlinson Group Finance Manager

There are no financial implications directly arising from this report.

## 10. List of Appendices

Appendix A: Performance Dashboard
Appendix B: CQC Inspections Quarter 2 2015/16

**Key**

# Appendix A: Indicators for HWBB - 2015/16 Q2

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

| Title | 2013/14 | 2014/15 Q1 | 2014/15 Q2 | 2014/15 Q3 | 2014/15 Q4 | 2014/15 | 2015/16 Q1 | 2015/16 Q2 | 2015/16 Q3 | 2015/16 Q4 | 2015/16 | DoT | RAG Rating | BENCHMARKING England Average | BENCHMARKING London Average | HWBB No. | Reported to |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1 - Children** | | | | | | | | | | | | | | | | | |
| Percentage of Uptake of Diphtheria, Tetanus and Pertussis (DTaP) Immunisation at 5 years old | 83.4% | 82.8% | 83.3% | 80.9% | 86.2% | 85.1% | 84.4% | 83.8% | | | | ↘ | R | 87.9% | 79.8% | 1 | PHOF |
| Year end figures not yet published. Data is published each quarter but when the full year figures are published they adjust for errors in the quarterly data and comprise all the children immunised by the relevant birthday in the whole year. 2014/15 Q4 data is not yet published | | | | | | | | | | | | | | | | | |
| Percentage of Uptake of Measles, Mumps and Rubella (MMR2) Immunisation at 5 years old | 82.3% | 82.2% | 82.2% | 78.8% | 83.4% | 82.7% | 81.0% | 81.2% | | | | ↗ | R | 87.9% | 80.5% | 2 | PHOF |
| Year end figures not yet published. 2014/15 Q4 data not yet published. | | | | | | | | | | | | | | | | | |
| Prevalence of children in reception year that are obese or overweight | 26.6% | | | | | 27.5% | | | | | | ↗ | R | 21.9% | 22.2% | 3 | PHOF |
| Prevalence of children in year 6 that are obese or overweight | 42.4% | | | | | 40.6% | | | | | | ↘ | R | 33.2% | 37.2% | 4 | PHOF |
| Number of children and young people accessing Tier 3/4 CAMHS services | 1,053 | 528 | 546 | 635 | 563 | 1,217 | 585 | 490 | | | | ↘ | NC | | | 5 | HWBB OF |
| Year end figure is the number of unique people accessing CAMHS over the course of the year. | | | | | | | | | | | | | | | | | |
| Annual health check Looked After Children | 93.4% | 86.5% | 73.0% | 76.4% | 91.8% | 91.8% | 82.0% | 72.0% | | | | ↘ | A | 84.3% | 88.1% | 6 | HWBB OF |
| **2 - Adolescence** | | | | | | | | | | | | | | | | | |
| Under 18 conception rate (per 1000) and percentage change against 1998 baseline. | 42.4 | 31.0 | 20.5 | .. | .. | .. | .. | .. | | | | ↘ | R | 21.9 | 20.4 | 7 | PHOF |
| Number of positive Chlamydia screening results | 511 | 141 | 141 | 127 | 132 | 541 | 118 | 130 | | | | ↗ | R | | | 8 | HWBB OF |

* Data from 2011/12

## Key

## Appendix A: Indicators for HWBB - 2015/16 Q2

| | |
|---|---|
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| NC | No colour applicable |
| PHOF | Public Health Outcomes Framework |
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| BCF | Better Care Fund |

| Title | 2013/14 | 2014/15 | | | | 2014/15 | 2015/16 | | | | 2015/16 | DoT | RAG Rating | BENCHMARKING | | HWBB No. | Reported to |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | | Q1 | Q2 | Q3 | Q4 | | | | England Average | London Average | | |
| **3 - Adults** | | | | | | | | | | | | | | | | | |
| Number of four week smoking quitters | 1,174 | 142 | 162 | 139 | 200 | 643 | 120 | 80 | | | | ↘ | R | | | 9 | HWBB OF |
| Please note that the most recent quarter is an incomplete figure and will be revised in the next HWBB report. | | | | | | | | | | | | | | | | | |
| Cervical Screening - Coverage of women aged 25 -64 years | 72.4% | | | | | 70.1% | | | | | | ↘ | A | 73.5% | 68.4% | 10 | PHOF |
| Percentage of eligible women screened adequately within the previous 3.5 (25-49 year olds) or 5.5 (50-64 year olds) years on 31st March | | | | | | | | | | | | | | | | | |
| Percentage of eligible population that received a health check in last five years | 11.4% | 2.6% | 4.2% | 4.4% | 4.8% | 16.3% | 2.5% | 2.8% | | | | ↗ | R | 9.6% | 11.6% | 11 | PHOF |
| Please note that annual figures, and London and England figures, are a cumulative figure accounting for all four previous quarters. | | | | | | | | | | | | | | | | | |
| **4 - Older Adults** | | | | | | | | | | | | | | | | | |
| Breast Screening - Coverage of women aged 53-70 years | 71.2% | | | | | .. | | | | | | → | A | 75.9% | 68.9% | 12 | PHOF |
| Percentage of women whose last test was less than three years ago. | | | | | | | | | | | | | | | | | |
| Permanent admissions of older people (aged 65 and over) to residential and nursing care homes | 696.8 | 240.8 | 425.3 | 614.9 | 936.58 | 936.58 | 188.24 | 401.91 | | | | ↗ | A | 668.4 | 463.9 | 13 | BCF/ASCOF |
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services | 88.3% | | | | | 67.2% | | | | | | ↘ | R | 82.1% | 85.3% | 14 | BCF/ASCOF |
| Injuries due to falls for people aged 65 and over | 2027.0 | | | | | .. | | | | | | ↘ | A | 2064.0 | 2197.0 | 15 | BCF/PHOF |
| Directly age-sex standarised rate per 100,000 poulation over 65 years. Unable to calculate more recent figures due to lack of access to HES data. | | | | | | | | | | | | | | | | | |



* Data from 2011/12

**Key**

## Appendix A: Indicators for HWBB - 2015/16 Q2

| | |
|---|---|
| | Data unavailable due to reporting frequency or the performance indicator being new for the period |
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| Title | 2013/14 | 2014/15 Q1 | 2014/15 Q2 | 2014/15 Q3 | 2014/15 Q4 | 2014/15 | 2015/16 Q1 | 2015/16 Q2 | 2015/16 Q3 | 2015/16 Q4 | 2015/16 | DoT | RAG Rating | BENCHMARKING England Average | BENCHMARKING London Average | HWBB No. | Reported to |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **5 - Across the Lifecourse** | | | | | | | | | | | | | | | | | |
| The percentage of people receiving care and support in the home via a direct payment | 73.4% | 74.7% | 75.2% | 76.2% | 76.7% | 75.7% | 76.6% | 75.1% | | | | ↘ | A | 62.1% | 67.4% | 16 | ASCOF |
| Delayed transfers of care from hospital | 5.5 | 4.2 | 4.7 | 5.4 | 5.4 | 4.9 | 7.2 | 7.4 | | | | ↗ | A | 9.7 | 6.9 | 17 | ASCOF |
| Delayed transfers due to social care | 1.1 | 2.22 | 1.73 | 2.91 | 2.2 | 2.25 | 2.63 | 4.55 | | | | ↗ | A | 3.1 | 2.3 | 18 | ASCOF |
| Emergency readmissions within 30 days of discharge from hospital | 13.3% | .. | .. | .. | .. | .. | .. | .. | | | | → | A | 11.8% | 11.8% | 19 | PHOF |
| Percentage of emergency admissions occurring within 30 days of the last, previous discharge after admission, Indirectly standardised rate - 2011/12 is most recent data and was published in March 2014. | | | | | | | | | | | | | | | | | |
| A&E attendances < 4 hours from arrival to admission, transfer or discharge (type all) | 88.8% | 85.6% | 86.4% | 80.5% | 88.8% | .. | 93.4% | 92.3% | | | | ↘ | A | 94.2% | | 20 | HWBB OF |
| BHRUT Figure. 2014/15 annual figure not available. | | | | | | | | | | | | | | | | | |
| Unplanned hospitalisation for chronic ambulatory care sensititve conditions | 1,059.4 | .. | .. | .. | .. | .. | .. | .. | | | | ↘ | R | 799.6 | 776.9 | 21 | HWBB OF |
| Update due in February 2016. | | | | | | | | | | | | | | | | | |

* Data from 2011/12

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## Appendix B

| Provider Name | Location | Weblinks | Location Org Type | Report Date | Inspection Date | Rating |
|---|---|---|---|---|---|---|
| **MF Haq's Practice** | Abbey Medical Centre | http://www.cqc.org.uk/location/1-543772087 | GP | 05/11/15 | 12/05/15 | **Inadequate** |
| **MF Haq's Practice Comments / Summary**<br>**Safe: Inadequate**<br>Lessons learned from incidents were not communicated widely enough to support improvement.<br>Systems and processes used to assess risks to patients were not implemented well enough to ensure patients were kept safe.<br>**Effective: Requires improvement**<br>No evidence of completed clinical audit cycles**.**<br>**Caring: Requires improvement**<br>Patients rated the practice lower than others for several aspects of care.<br>**Responsive: Good**<br>Good facilities and well equipped to treat and meet patient needs.<br>**Well led: Inadequate**<br>Governance arrangements did not operate effectively; particularly regarding identifying and acting on risks.<br>Lack of communication an involvement causing division between clinical and non-clinical staff.<br>Placed into special measures and will be inspected again in 6 months. | | | | | | |
| **Dr N Niranjan's Practice** | Victoria Medical Centre | http://www.cqc.org.uk/location/1-528613695 | GP | 29/10/15 | 11 & 18/05/15 | **Requires Improvement** |
| **Dr Mohan and Associates** | Urswick Medical Centre | http://www.cqc.org.uk/location/1-569632930 | GP | 01/10/15 | 13/05/15 | **Good** |
| **Dr Mohan and Associates Comments / Summary**<br>**Safe: Inadequate**<br>Safety was not a sufficient priority. Significant events were not formally recorded so there was no evidence of learning from events. Non-clinical staff had not undertaken child protection, safeguarding adults or chaperone training.<br>**Effective: Requires Improvement**<br>Patient outcomes were average for the locality. Care was delivered in line with legislation.<br>**Caring: Good**<br>Patients rate the practice higher than others for several aspects of care.<br>**Responsive: Good**<br>Good facilities and well equipped to treat and meet patient needs. | | | | | | |

## Appendix B

| Provider Name | Location | Weblinks | Location Org Type | Report Date | Inspection Date | Rating |
|---|---|---|---|---|---|---|
| **Well led: Requires Improvement**<br>Some of leadership policies were out of date. Systems for recording risk and significant events needed development. | | | | | | |
| **Dr VK Chawla's Practice** | 60 Victoria Road | http://www.cqc.org.uk/location/1-523702115 | GP | 24/09/15 | 05/05/15 | **Good** |
| **John Smith Medical Centre** | 145 Bevan Avenue | http://www.cqc.org.uk/location/1-626549300 | GP | 12/11/15 | 07/05/15 | **Good** |
| **Dr Christopher Ola** | The Surgery | http://www.cqc.org.uk/location/1-523700864 | GP | 29/10/15 | 05/05/15 | **Good** |
| **London Ambulance Service (LAS)** | LAS HQ | http://www.cqc.org.uk/location/RRU01 | Ambulance Service | 27/11/15 | 1-5, 17-18/06/15 | **Inadequate** |
| **LAS Comments / Summary**<br>**Safe: Inadequate**<br>A culture of under-reporting of incidents was evident, and there was little evidence of learning from incidents. The LAS was affected by a national shortage of paramedics.<br>**Effective: Requires Improvement**<br>Since March 2014 there has been a substantial decline in response time performance and the target time had not been met in the required percentage of calls. Most frontline staff spoken with had not received an appraisal in the last 3 years.<br>**Caring: Good**<br>Staff spoke to people in a compassionate manner and treated them with dignity and respect.<br>**Responsive: Requires Improvement**<br>The call handling system allowed alerts to be recorded for frequent callers, patients with complex needs. However, it was not effective and did not allow access to important information promptly.<br>There were limited opportunities for learning from complaints.<br>**Well led: Inadequate**<br>There was a recognised issue with bullying and harassment and a perception of discrimination.<br>The LAS was placed into special measures. | | | | | | |
| **BUPA** | Chaseview | http://www.cqc.org.uk/directory/1-127503453 | Social Care Org | 30/07/15 | 11-15/05/15 | **Good** |
| **Triangle Community Services** | Colin Pond Court | http://www.cqc.org.uk/directory/1-1698526298 | Social Care Org | 31/7/15 | 19-22/06/15 | **Good** |

**Appendix B**

| Provider Name | Location | Weblinks | Location Org Type | Report Date | Inspection Date | Rating |
|---|---|---|---|---|---|---|
| **A D Hammonds Ltd** | Bluebird Care (Barking & Dagenham) | http://www.cqc.org.uk/directory/1-731634273 | Social Care Org | 17/09/15 | 14-18/08/15 | **Good** |
| **Dharshivi Ltd** | Lynwood | http://www.cqc.org.uk/directory/1-114143405 | Social Care Org | 14/08/15 | 07/05/15 | **Requires Improvement** |

**Dharshivi Ltd Comments / Summary**

**Safe: Requires Improvement**
Medicine management found to be lacking.

**Effective: Requires Improvement**
No regular supervision/appraisal for staff.

**Caring: Good**
Care and support was centred on people's needs.

**Responsive: Requires Improvement**
People's preferences to access activities at the weekend not always met.

**Well led: Requires Improvement**
The services own quality assurance processes were not robust.

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# HEALTH AND WELLBEING BOARD

## 26 JANUARY 2016

| **Title:** | **Draft Homelessness Strategy 2016/21** |
|---|---|

**Report of the Housing Strategy and Advice division**

| **Open Report** | **For Decision** |
|---|---|
| **Wards Affected: All** | **Key Decision: No** |
| **Report Author:**<br>Neil Pearce, Housing Strategy Officer<br><br>James Goddard, Group Manager, Housing Strategy | **Contact Details:**<br>Tel: 020 8227 5733<br>E-mail: neil.pearce@lbbd.gov.uk<br>Tel: 020 8227 8238<br>E-mail: james.goddard@lbbd.gov.uk |

**Sponsor:**
Faisal Butt, Divisional Director, Housing Advice and Strategy, London Borough of Barking and Dagenham

**Summary:**

Under the Homelessness Act 2002 local authorities are statutorily bound to review their homelessness services every five years, setting out a comprehensive assessment of emerging trends and examining interventions employed to prevent homelessness in the first instance and tackle crisis presentations when they occurred.

On the basis of the review the Council is expected to prepare a prevention strategy charting activities to tackle and mitigate against homelessness over the next five year period.

The Draft Homelessness Strategy 2016/21 seeks to comply with that duty and is attached as part of the public consultation process due to end on 15th February 2016. The final version is expected to be approved by Cabinet between March and April 2016.

**Recommendation(s)**

The Health and Wellbeing Board is recommended to:

Note and comment upon the Draft Homelessness Strategy as part of the public consultation process.

**Reason(s)**

- Enabling social responsibility
- Growing the borough

## 1. Introduction and Background

1.1 The Homelessness Act 2002 mandates the local authority to conduct a five-yearly review of current trends and homelessness, illustrate prevention activities and interventions and examine the offer of advice, services and resources.

1.2 Subsequently the borough is expected to produce a new homelessness strategy co-ordinating efforts to tackle and mitigate against homelessness in the next five year period.

1.3 There has been significant change since the publication of Barking and Dagenham's previous homelessness strategy in 2008 and the Council has taken stock of the changing policy context of homelessness when providing services to tackle it. The introduction of the Localism Act 2011 and the on-going reforms to welfare have been major influences in how local authorities approach housing need, homelessness, benefit entitlement and the delivery of affordable housing. Fiscal consolidation at a national level has led to reduced funding, requiring the Council to target its prevention strategy around carefully managed and finite resources.

1.4 The Homeless Review of 2015 concentrated on the impact of welfare reform, public funding reductions and a challenging housing market which heightened the demand for housing advice services and lead to the subsequent rise in housing applications over the last three years. Footfall and calls to the housing options team doubled to 2,449 by 2015; the total number of homeless decisions in 2014/15 stood at 1,900 and dwarfed the 408 recorded in 2011/12 while the number of preventative interventions against homelessness accounted for almost 2,000 cases.

1.5 Barking and Dagenham has responded to the increased volume of need by continuing to build on existing partnership arrangements, training staff and tenants alike on the impact of welfare changes and sustaining tenancies, reshaping its allocations policy and planning for new models of housing provision in response to reduced resources.

1.6 Through various data sets the statistical review examines the current climate around crisis presentations and homeless preventions to provide an analysis of the pressure points in homeless policy and create the subtext for the prevention objectives of the strategy. The review examines:

- The Council's duties and the main causes of statutory homelessness;
- Interventions and resources to prevent homelessness
- non-priority homelessness and support for vulnerable households
- temporary accommodation
- housing supply issues

1.7 The headline figures of the review suggested that residents seeking homelessness advice continues to rise. By November 2015, almost 3,000 people had contacted John Smith House for support. However the number of applications accepted as eligible, unintentionally homeless, in priority need and therefore owed a duty fell from 853 in 2013/14 to 764 in 2014/15.

1.8 A summary of the main homeless trends suggested:

- termination of assured short-hold tenancies in the private rented sector has become the largest cause of accepted homelessness
- parental ejection from the family home or the inability of the owner to continue to accommodate the client is the second largest cause
- the highest cohort of clients in priority need were households with children or with someone pregnant
- lone parents with dependent children made up the greatest number of acceptances
- applicants deemed homeless, eligible for advice but not in priority need rose dramatically

## 2. Proposal and Issues

2.1 Planning services for the next five years requires an appreciation of the current and emerging trends:

- Second phase of welfare reform is likely to create greater demand
- Loss of private rented sector accommodation continues to squeeze supply
- Parental ejection from the home is on an upward trajectory
- Rough sleeping appears to be on the rise
- Lone parent households in priority need have increased dramatically
- Demand for supported housing options and services is developing

2.2 Tackling these problems has to be balanced against diminishing resources and the cultivation of a different ethos to housing crisis resolution. This has to recognise:

- Local authority resources are likely to be squeezed much further
- Prevention initiatives and self-resolution will be critical in managing demand
- Housing advice services will have to be creative and integrated
- That resources and support has to be targeted at the most acute circumstances
- Partnerships with external providers and the voluntary sector needs to become robust
- Innovation in housing supply and choice is essential

2.3 Despite the financial constraints, the borough aspires to continually improve its housing advice services and ensure that our approach to homelessness is fit-for-purpose and creates a customer journey that provides appropriate housing solutions.

2.4 As part of this process, the Council will be seeking Gold Standard accreditation for its services in 2016, of which this homelessness review and the strategic actions below form the strategy going forward, requiring annual appraisal.

2.5 The strategy sets out fifty two strategic actions for consideration or improving services to meet nineteen expected outcomes under the following four strategic objectives:

- **Reducing demand through prevention**
- **Enabling pathways away from homelessness**
- **Creating an integrated service at first contact**
- **Providing appropriate accommodation options**

2.6 The strategy will be monitored and evaluated by the re-established Homelessness Forum and will be appraised and refreshed on an annual basis to comply with the requirements of Gold Standard accreditation. Further reporting to the Health and Wellbeing Board will be tabled throughout the period of the strategy.

## 3 Consultation

3.1 The draft strategy has been compiled with a significant input from a number of council services and organisations involved in delivering services including Housing Advice Services, Housing Strategy, environmental health, NELFT, mental health services, adult commissioning, children's services, private sector housing, regeneration, Elevate, the East London Housing Partnership to name but a few.

3.2 Public consultation on the draft began on 16 November inviting comment and responses from the general public, interested parties, housing providers, voluntary sector groups and the clinical commissioning group by 16 February 2016. The public response page can be found on Barking and Dagenham's website here: https://www.lbbd.gov.uk/residents/housing-and-tenancy/homelessness-strategy/overview/ . Invitation for comment can also be found on the Council's Facebook page and Twitter feed as well as through the e-newsletter, One Borough.

3.3 In addition the draft has been presented to various management teams within the Council and is tabled for discussion at the Health and Wellbeing Board, Community Safety Partnership, Landlords and Letting Agents Forum and Corporate Strategy Group.

3.4 Following the close of consultation and further revision and amendment of the draft, the Homelessness Strategy is expected to be approved by Cabinet in March or April 2016.

## 4 Mandatory Implications

### 4.1 Joint Strategic Needs Assessment

Homelessness is a key indicator in the JSNA's annual assessment of current and future health and social needs of the population and includes recommendations for public policy commissioners on strategic outcomes in reducing homelessness. This is reflected in the strategy

### 4.2 Health and Wellbeing Strategy

Housing, homelessness and fuel poverty are recognised as determinants of public health and critical to increasing the life expectancy of people living in Barking and Dagenham. The

homelessness strategy links with the health and wellbeing pledges to close the gap in life expectancy and to improve health and social care outcomes through integrated services.

**4.3 Integration**

Developing an efficient seamless, multi-agency approach to homelessness has been a key driver of national and regional policy. The Government's papers on Making Every Contact Council, No Second Night Out and the Cost of Homelessness encourages the design of locally integrated services which tackle the root causes of homelessness such as health inequalities, troubled families and improving access to employment.

The Strategy recommends a more robust approach to creating integrated services at first contact for homeless clients and draws on ways to improve the work of the Council in preparing links, pathways and referrals between support services to prevent homelessness in the first place or minimise its impact when it happens.

**4.4 Financial Implications**
(Carl Tomlinson, Group Manager, Finance and Resources)

There will be a full financial assessment undertaken alongside the development of the Strategy.

The gross General Fund Housing budget for 2015/16 is £18.056m and comprises of Housing Advice, Temporary Accommodation, Hostels, Landlord services and Housing Strategy. The net budget totals £97,000 once rental income and recharges have been taken into account. The direct homelessness budgets are Temporary Accommodation and Hostels and these are currently projecting to spend in line with budget in the current financial year. However, there is a risk to this position, due to the demand led nature of this service. Demand over recent months has been steadily increasing and is likely to be further exacerbated by ongoing Welfare Reforms and cuts in funding. Current levels of bed and breakfast placements are above the budget assumption and if this trend continues the budget will be under increasing pressure.

The primary risks to the homelessness budgets are the level of Bed and Breakfast placements and managing arrears. Significant savings are expected to be delivered through a reduction in temporary accommodation placements within Bed and Breakfast accommodation together with the renegotiation of Bed and Breakfast nightly rates.

The service currently employs a mix of Private Sector Landlord properties, bed and breakfast accommodation, nightly lets, homes with multiple occupancy and Council hostels in order to meet current demands.

The actions that are in place will hopefully ensure that the levels of expenditure incurred on temporary accommodation remain within budget going forward into 2016/17. This projection, however, needs to be viewed in the context of the increases in homelessness numbers that are being experienced nationally and there are clear risks to the position that is currently being projected

**4.5 Legal Implications**

(Martin Hall, Housing Solicitor/Team Leader, Legal Services)

There are no legal implications arising from the draft Homelessness Strategy.

### 4.6 Risk Management

There are no risk management implications at this stage of the consultation.

### 4.7 Patient / Service User Impact

A review and preventative strategy for homelessness and housing advice related services will have significant impact upon user groups and clients. The aims of the strategy seek to improve the customer journey by integrating services and ensure the provision of comprehensive quality advice.

The strategy details issues relating to service user and patient impact in various parts of the report.

## 5. Non-mandatory Implications

### 5.1 Crime and Disorder

The strategy and review examines the relationship between certain client groups at risk of being homeless, current support services and crime and disorder issues. The strategy looks at victims of domestic violence and the role of the Sanctuary scheme; the impact of rough sleeping; ex-offenders and those suffering from substance and alcohol misuses.

### 5.2 Safeguarding

In consultation with adult commissioning, NELFT, children's services and teams dealing with mental health, people without recourse to public funds, looked after children and leaving care teams the draft strategy has a dedicated section relating to support for vulnerable households and individuals. Recommendations in the strategy look at improving outcomes for vulnerable persons at risk of homelessness.

### 5.3 Property / Assets

The strategy looks at the Council's use of accommodation, stock and assets and suggests ways in which to utilise them better as part of a more innovative approach to relieving homelessness.

### 5.4 Customer Impact

The impact on patients, clients and user groups has been highlighted previously in the report. A full equality impact assessment will be carried out following the conclusion of the consultation process and subsequent amendments to the strategy.

### 5.5 Contractual Issues

Where the Homelessness Strategy indicates a procurement or contractual solution this will be delivered with best practice and in consultation with corporate procurement services**.**

### 5.6 Staffing issues

Any staffing related implications arising from this strategy will be dealt with though the policies, procedures and consultative processes agreed between the Council and the trade unions.

**List of Appendices:**

**Appendix A - Draft Homelessness Strategy 2016/21**

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# Draft Homelessness Strategy

London Borough of Barking and Dagenham
2016-2021

## One Borough, One community: tackling homelessness

## CONTENTS

# 1.Introduction

The borough recognises the importance of having a robust homelessness strategy in place which sets out the Council's services, resources, pathways and interventions in preventing and alleviating the experience of homelessness.

In preventing homelessness and attending to crisis presentations when they occur, the borough has to ensure there is comprehensive, universal assistance and advice to support people in making informed decisions about the options available to them.

In a number of circumstances the services which the Council and its partners provide are critical because all too often individuals affected by the loss of accommodation become and stay homeless through a complex combination of reasons. These range from domestic violence, addiction, debt, worklessness, poor health and wellbeing and sometimes through no fault of their own. This leads to isolation and a disconnection from pathways to essential support which help identify and break that downward cycle.

However, fundamental to our approach is the view that homeless people should be able to pursue options which allow them to resolve their own homelessness. Following in the Council's civic objective of a creating a socially responsible community, residents are encouraged to take responsibility and to become more resilient at a time of pressured and finite availability of accommodation.

As a result of the Homelessness Act 2002 every local authority is under a statutory duty to review their homelessness services every five years, setting out a comprehensive assessment of trends in homelessness. Subsequently the borough is expected to prepare a prevention strategy charting activities to tackle and mitigate against homelessness over the next five year period.

There has been significant change since the publication of Barking and Dagenham's previous homelessness strategy in 2008 and the Council has taken stock of the changing policy context of homelessness when providing services to tackle it. The introduction of the Localism Act 2011 and the on-going reforms to welfare have been major influences in how local authorities approach housing need, homelessness, benefit entitlement and the delivery of affordable housing. Fiscal consolidation at a national level has led to reduced funding, requiring the Council to target its prevention strategy around carefully managed and finite resources.

Against that challenging context, Barking and Dagenham remains committed to working with partner agencies and the voluntary sector in strengthening its housing

advice services and preventing homelessness in the first instance. Based on the evidence of its review, the borough has set itself the following objectives:

- To reduce demand through prevention (prevention)
- Enabling pathways away from homelessness (prevention)
- Create integrated services at first contact (presentation)
- Provide appropriate accommodation options (provision)

These objectives underlie the principles of the Council's ambition which aims to reduce demand, encourage responsible choices and behaviour change, manage expectations and tackle root problems by integrating service delivery and developing partnerships more effectively.

# 2.Policy Context

## 2.1 National Policy Context

The introduction of the Localism Act 2011 and on-going welfare reform has challenged the approach of how local authorities assess and meet housing need, prevent homelessness and manage resources to deliver affordable housing and advice services.

Developing and embedding an efficient seamless, multi-agency approach has been the driver of national and regional policy announcements with local authorities increasingly expected to be more innovative in preventing homelessness in the first instance, reducing demand and cope with crisis presentations with more efficient use of resources.

### 2.1.1 Cost of Homelessness and Making Every Contact Count

In 2012, the Government published the Making Every Contact Count report, drawing on the need for effective joint working to prevent homelessness. Based on the findings of the No Second Night Out strategy on rough sleeping in 2011 and the Cost of Homelessness review, it encouraged the design of locally integrated services which tackled the roots of homelessness, such as troubled family upbringings, health inequalities and addiction, involvement in crime and improving access to work and training opportunities, as well as creating financial resilience.

The National Practitioner Support Service has been developed to support local authorities seeking to lead in the continuous improvement of homeless advice and prevention services. Where the authority meets the ten corporate local challenge objectives it can apply for a Gold Standard as a measure of high quality standards.

### 2.1.2 Reform of the Welfare System

The Government's first tranche of welfare reform between 2012/15 had significant impact for housing services and homeless prevention in Barking and Dagenham, precipitating a surge in housing advice and a significant rise in homeless presentations based on familial ejection and loss of rented tenancies.

1,600 council tenants were affected by the reduction in Spare Room Subsidy for under-occupancy and 537 were subject to the £500 a week Total Benefit Cap with a

resulting inability to afford rent payments. The reduction averaged between £35 and £323 per week[1]

Reforms to the eligibility for the Single Accommodation Rate, changes to disability benefit, the devolution of local Council Tax Support and reductions in Local Housing Allowance (LHA) levels have aggravated tenancy sustainment as well as diminishing the supply of available lets for social placements in the private rental market.

The second phase of welfare reform unveiled in the Welfare Reform and Work Bill 2015 is expected to exacerbate existing problems. Proposals to remove automatic housing support to 18-21 year olds, the four year freeze in main rates of working age benefits and tax credits coupled with a further reduction in the Total Benefit Cap of a non-working family to £23,000 are likely to escalate the pressures upon the housing advice service. Projections for the numbers affected are still being collated by Revenues and Benefits in conjunction with the Department for Work and Pensions.

### 2.1.3 Localism Act 2011

In the Localism Act 2011, the Government devolved powers to encourage local authorities to tailor local policies and housing demand to local circumstances. The agenda allowed councils:

- to revise access to social housing supply with reforms to allocation policies;
- to offer different types of tenure
- to end their homelessness duty with direct offers of accommodation in the private rented sector.

In response Barking and Dagenham adopted a new Housing Allocation Scheme[2] in 2014 which introduced:

- residential qualifications
- reformed local preferences
- reserved the right to create flexible tenancies for specific circumstances
- affordable housing options for working families
- the discharge of its homelessness obligation into the private rented sector.

### 2.1.4 Housing and Planning Bill 2015

The Housing and Planning Bill is currently passing through its committee stage in Parliament and could have implications for housing supply in Barking and Dagenham. The introduction of Starter Homes as an affordable housing product

[1] Internal records 2013/14, Elevate
[2] https://www.lbbd.gov.uk/wp-content/uploads/2014/11/Choice-Homes-Allocation-Policy2.pdf

could reduce the number of generally affordable social housing tenures provided in the borough and the impact of forthcoming regulations on housing association Voluntary Right to Buy will be monitored carefully.

## 2.2 Local Policy Context

Notwithstanding the response to recent Government reforms, the Council has continued to rationalise resources and cement multi-agency working through its corporate strategies to prevent homelessness:

### 2.2.1 Corporate Strategies

*One Borough, One Community; London's Growth Opportunity*

In 2014 the Council unveiled its corporate vision of encouraging civic pride, enabling social responsibility and growing the borough's sense of opportunity. This included commitments to help residents shape their own quality of life, take responsibility for themselves, homes and communities as well as integrating services for the vulnerable, building high quality homes and supporting investment in housing.

*Housing Strategy 2012/17*

The borough's overarching housing strategy resolves to improve the quality of life of all residents through thriving sustainable communities and by addressing the needs of residents living in different types of tenure. It prioritises tackling homelessness through prevention activities and providing suitable housing options where crisis presentations require the Council to act[3].

*Tenancy Strategy Statement 2012*

Working in partnership with housing associations to deliver homes which address local need, the Council recognised the importance of allowing providers a flexibility of housing tenure. The borough's tenancy statement emphasises a desire for registered providers to give due regard to the Council's view on rent levels and accommodation for working families.

*Joint Strategic Needs Assessment 2015*

The Joint Strategic Needs Assessment (JSNA) is the annual assessment of current and future health and social care needs of a population. It provides a holistic outlook of the socio-economic issues facing the borough, including recommendations for public policy commissioners on strategic outcomes in reducing homelessness.

[3] https://www.lbbd.gov.uk/wp-content/uploads/2014/11/Barking-and-Dagenham-Housing-Strategy-2012-17.pdf

*Health and Wellbeing Strategy 2015/19*

Housing, homelessness and fuel poverty are recognised as determinants of public health and critical to increasing the life expectancy of people living in Barking and Dagenham. The strategy pledges to close the gap in life expectancy and to improve health and social care outcomes through integrated services.

*Growth Strategy 2013/23*

Aspirations for growth are entrenched in the 20-year plan which establishes the priorities of attracting investment, creating a higher skilled workforce, building businesses and widening housing choice[4].

### 2.2.2 Corporate Programmes

The reduction in resources has meant that the Council is addressing the provision of services creatively. To reduce demand the Council is focussing on more effective early interventions, nudging behaviour change and encouraging self-reliance while developing seamless integrated responses when demand is presented in the most acute of circumstances.

This overarching approach is captured in the Council's evolving corporate Ambition 2020 project coupled with the Housing Transformation Programme's development of Housing+ as a multi-disciplinary model of housing service delivery.

### 2.2.3 Demography and housing supply issues

Continuing change to the demographic and the socio-economic profile of the borough coupled with rising demands for a mixed supply of housing has intensified the need to have responsive services which can prevent homelessness in the first instance and provide adequate accommodation in the worst case scenario.

*Deprivation*

Barking and Dagenham has areas of high deprivation and is ranked 12$^{th}$ of 352 local authorities in the 2015 Index of Multiple Deprivation[5]. It also has the lowest household incomes in the capital, with almost 25% of those in work on the minimum wage; 10.4% of its population is unemployed and 60% in receipt of some kind of welfare entitlement. While there have been improvements in educational attainment and regeneration projects continue to attract new investment and employment

[4] https://www.lbbd.gov.uk/wp-content/uploads/2014/11/Growth-Strategy-2013-2023.pdf
[5] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

opportunities, housing affordability remains a barrier for many in accessing accommodation.

*Population*

Barking and Dagenham's population has seen unprecedented change in recent years. The 2011 Census recorded a significant overall population increase of 13.4% to 185,911. Barking and Dagenham has the highest population percentage of 0-19 year olds in the country including a 50% increase in 0-4 year olds, placing a huge pressure on school places. In addition there has been the largest decrease in the 65+ age group in London[6].

*Household size*

Trends identified in the borough's Strategic Housing Market Assessment and Housing Needs Survey 2011 saw the number and size of households increasing giving Barking and Dagenham the highest occupancy rate in the capital. Conversely, cultural shift towards smaller families, trends towards divorce and familial breakdown has led to the borough having the highest percentage of lone parent households in all of England and Wales.

In terms of homelessness the shift to smaller households manifested itself between 2012 and 2015 with an increased number of homeless presentations based on persons not being able to live with parents or in the familial home and therefore pressurising demand for one-bed, two-bed or shared accommodation.

*Diversity*

The ethnic diversity of Barking and Dagenham underwent significant change between 2001 and 2011 with the number of foreign-born nationals residing in the borough increasing by 205%. Since 2001, there has been a 30% decrease in the borough's White British population and the Black African population has grown by over 20,000, which is the largest increase of the Black African population in London. The White Other population has also continued to grow from 4,348 in 2001 to 14,525 in 2011[7]. Like much of east London, the enlargement of the European Union since 2004 has seen the borough become a destination for migrants from eastern Europe and the former accession countries.

[6] https://www.lbbd.gov.uk/wp-content/uploads/2014/09/2011-Census-Borough-Analysis.pdf
[7] https://www.lbbd.gov.uk/wp-content/uploads/2014/09/2011-Census-Borough-Analysis.pdf

*Housing Affordability*

The cost of buying a home in Barking and Dagenham is still 12 times more than the total median annual household income of the borough (£25,499)[8] and affordability continues to hamper the ability of residents to access home ownership. Average house values were recorded at £302,625 in November 2015[9] but despite Barking and Dagenham remaining one of the most affordable places in London to purchase a home, property prices continue on an upward trajectory.

It is conservatively estimated that between 12,000 and 14,000 homes supply the private rented market (PRS) in the borough representing 17% of all stock and continuing to grow. The PRS has quadrupled in a decade but demand is once again outstripping supply. Analysis of quarterly returns from local letting agent surveys recorded an average rent level of £1,231 per month in September 2015 with 62% of respondents expecting further rent increases placing pressure on the budgets of vulnerable households. The anecdotal survey suggested that three quarters of landlords were pitching their lets to in-work tenants in recognition of the borough being an attractive low-rent hub for professionals[10].

Importantly, figures from the Ministry of Justice in July 2015[11] illustrated that sustainment of home ownership and private tenancies were under strain with 1 in every 45 homes subject to a possession claim. With wages only just beginning to return to pre-Recession levels and falling levels of housing welfare, there has been a significant three year spike in homeless applications based on repossession of the home and lets due to mortgage and rent arrears.

The supply of affordable homes was identified as a decisive issue in the 2011 Housing Needs Survey which recommended an additional 1,333 new affordable homes a year, particularly around family-sized accommodation and drawing on concerns of overcrowding and high levels of occupancy. 1,973 new affordable[12], intermediate and social homes have been delivered in Barking and Dagenham in the last five years however the recession, reductions in development grant and rationalisation among registered providers has led to only a trickle of new supply.

## 2.3 Regional Context and the East London Housing Partnership (ELHP)

The issue of homelessness also cuts across boundaries and Barking and Dagenham works to the strategic objectives set out in the Mayor of London's Housing Strategy.

[8] http://www.caci.co.uk/
[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/488368/November_2015_HPI.pdf
[10] Barking and Dagenham Quarterly Letting Agents Forum – September 2015
[11] https://www.gov.uk/government/collections/mortgage-and-landlord-possession-statistics
[12] http://data.london.gov.uk/gla-affordable-housing-statistics/

The borough also works with the Greater London Authority and sub-regional partners to share information, best practice and harness resources around joint projects. In particular we co-operate with the East London Housing Partnership which is based in the offices of Barking and Dagenham.

The ELHP comprises the seven east London boroughs of Barking and Dagenham, Tower Hamlets, Newham, Havering, Hackney, Waltham Forest, Redbridge and the City of London Corporation. The partnership collaborates on addressing the sub-region's strategic housing needs and pressures. One of its core priorities is to contribute to minimising and preventing homelessness.

ELHP created a homelessness and lettings group in response to having the highest housing need in the capital which was evidenced by increasing numbers of rough sleepers, significant levels of domestic violence, high volumes of placements from other sub-regions and greater loss of private rented tenancies.

The ELHP has been particularly successful in recent years in helping tackle homelessness for households who are not necessarily owed a duty by the local authority. Projects like the East London Single Homelessness Project and the East London Women's Project all provided housing solutions for single non-priority victims of sexual abuse, domestic violence, discrimination on the grounds of sexual orientation and multiple needs clients who were either homeless or at risk of homelessness. The East London Women's Project has to date assisted 27 women with multiple and complex needs and the Single Homelessness Project supported 337 people with rent deposits and support to sustain a tenancy[13].

ELHP has also worked with other London sub-regions to help achieve cost reductions on temporary accommodation through the Inter-Borough Accommodation Agreements (IBAA).

This year the ELHP approved its Homelessness and Lettings Strategy 2015/20, binding sub-regional partners to the following clear commitments:

- Preventing homelessness before people reach the streets
- Greater collaboration with regard to the impacts of welfare reform and Universal Credit
- Improve services offered to single homeless people deemed not in priority need
- Reduce and prevent homelessness caused by domestic violence, particularly against women
- Adopt a No Second Night Out approach to rough sleeping

[13] http://www.elhp.org.uk/single-homelessness.html

# 3. Homeless Review

### 3.1.1 Homelessness Strategy 2008/13

The 2008/13 strategy outlined a number of key performance details at a time when resources were significantly greater and the emphasis was on initiating fresh prevention activities. As the policy context has significantly changed since 2008 this review only summarises some of the key results pertaining from the following objectives:

*Early intervention*

- Developed joint assessments and protocols in relation to safeguarding children
- Achieved the national target to end use of B&B accommodation for 16-17 year olds by 2010
- Developed the East Street housing advice and The Foyer projects
- Increased take up the Sanctuary scheme
- All housing advice staff trained in substance misuse and domestic violence

*Increased choice and promoting independence*

- Delivered 758 rent deposit tenancies by 2013
- Increased the number of accredited landlords offering quality homes to 450
- Returned 531 long-term empty private dwellings back to use by 2013

*Partnership working*

- Worked with the East London Housing Partnership to deliver sub-regional approaches to single persons homelessness and collaborated with the ELHP Reciprocal Agreement, a partnership of eight local authorities and twenty registered providers to reduce and prevent homelessness

### 3.1.2 Responding to homelessness

The Homelessness Act 2002 mandates the local authority to conduct a five-yearly review of current levels of homelessness, observe trends and analysis, illustrate prevention activity and interventions and examine the offer of advice, services and resources.

The impact of welfare reform, public funding reductions and a challenging housing market have heightened the demand for housing advice services and lead to the subsequent rise in housing applications over the last three years. Footfall and calls to the housing options team doubled to 2,449 by 2015; the total number of homeless decisions in 2014/15 stood at 1,900 and dwarfed the 408 recorded in 2011/12 while

the number of preventative interventions against homelessness accounted for almost 2,000 cases.

Barking and Dagenham has responded to the increased volume of need by continuing to build on existing partnership arrangements, training staff and tenants alike on the impact of welfare changes and sustaining tenancies, reshaping its allocations policy and planning for new models of housing provision in response to reduced resources.

Through various data sets the following statistical review examines the current climate around crisis presentations and homeless preventions to provide an analysis of the pressure points in homeless policy and create the subtext for the prevention objectives of the strategy. The review examines:

- The Council's duties and the main causes of statutory homelessness;
- Interventions and resources to prevent homelessness
- non-priority homelessness and support for vulnerable households
- temporary accommodation
- housing supply issues

## 3.2 The Duty and Main Causes of Homelessness

### 3.2.1 The Council's Duties on Homelessness

In reviewing the local authority's obligations under housing legislation, essential distinctions between various scenarios of housing need and where the duty applies needs to be made.

**Priority homelessness** – individuals who have been accepted by the Council as eligible for assistance, are homeless and in priority need, have met the legislative criteria and have made a homeless application:

- Council has a statutory duty to provide temporary accommodation
- normally households who are going to be evicted or living in accommodation which is unreasonable for them to remain in
- includes families, pregnant women and single vulnerable people

**Non-Priority homelessness** - applicants who are not assessed as in priority need but entitled to advice and assistance such as available options in the private rental market or support agencies

- normally single homeless people and childless couples
- includes rough sleepers

### 3.2.2 Statutory homelessness in Barking and Dagenham

***Overview***

Residents seeking homelessness advice continues to rise. By November 2015, almost 3,000 people had contacted John Smith House for support. The number of applications accepted as eligible, unintentionally homeless, in priority need and therefore owed a duty also fell from 853 in 2013/14 to 764 in 2014/15[14].

The slight decline in acceptances is a reflection of some of the prevention activities employed when residents make their initial approach.

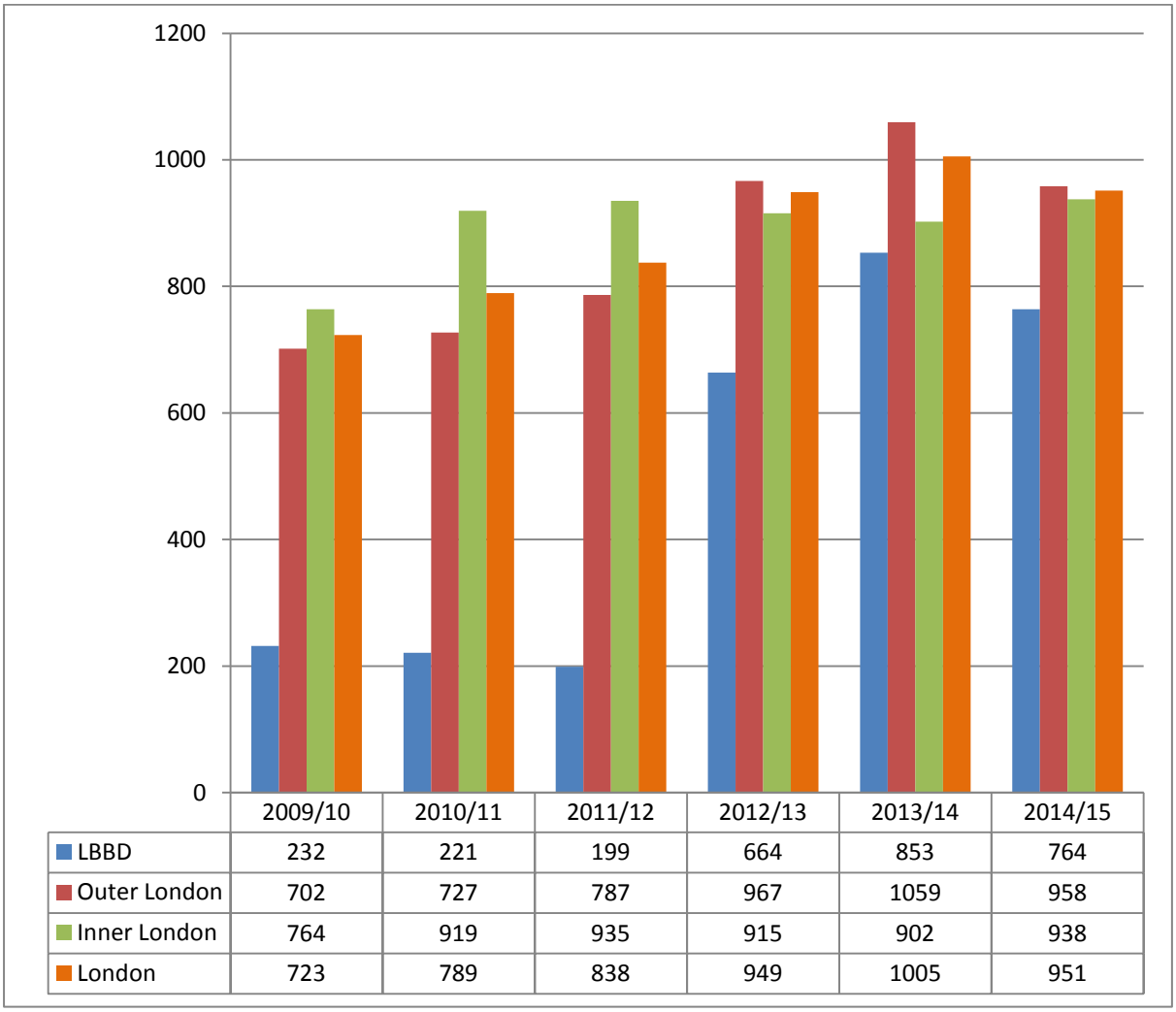
***Statistical analysis***

The statistical analysis below highlights the number of annual applications made in Barking and Dagenham over the last five years and compares with the average number of applications made across the capital and the east London sub-region. It

[14] National P1E homelessness returns and internal records, Housing Options Team

suggests that demand has slightly dipped through effective pre-intervention activities and is still lower than sub-regional and London average:

***Fig.1: Number of homelessness applications made in Barking and Dagenham compared to London and inner/outer London sub-regions***




| | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|---|---|
| LBBD | 232 | 221 | 199 | 664 | 853 | 764 |
| Outer London | 702 | 727 | 787 | 967 | 1059 | 958 |
| Inner London | 764 | 919 | 935 | 915 | 902 | 938 |
| London | 723 | 789 | 838 | 949 | 1005 | 951 |

Source: DCLG Live Tables

The proportion of all homeless decisions which go on to be accepted by a local authority as statutorily homeless and eligible for support represents the homeless acceptance rate. In 2014/15, Barking and Dagenham had the 12th highest acceptance rate nationally and 9th highest in London[15].

Decisions on homelessness fell from over 700 to just over 400 in 2011/12 just before the impact of welfare and housing reforms started to bite. The succeeding year saw that figure almost treble to 1,186 decisions and rise to 1,900 by 2014/15. The eligibility of those approaches is captured below and shows a rise in households which are eligible, unintentionally homeless and in priority need but records a more dramatic spike in those deemed to be eligible but not in priority need:

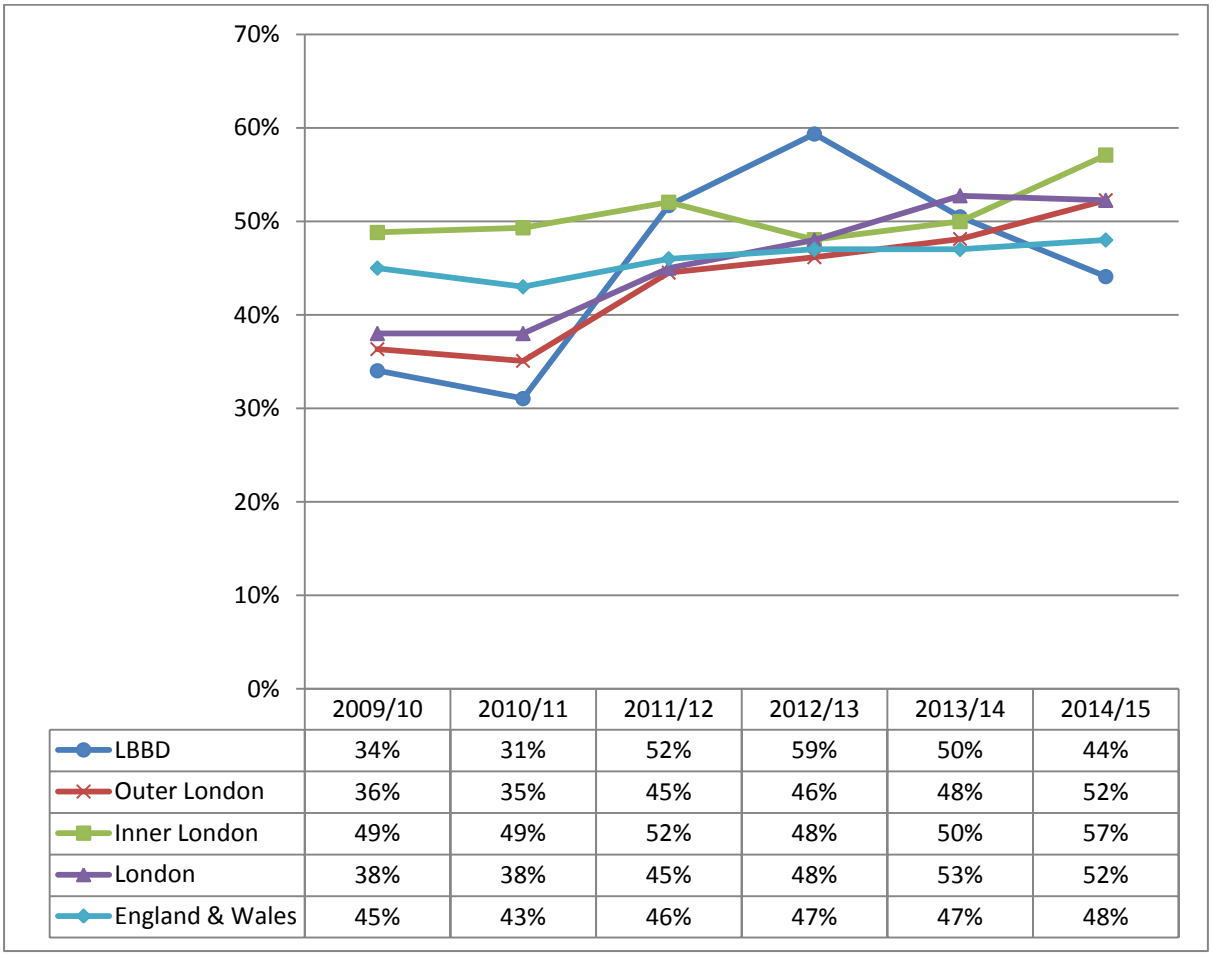
[15] https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

*Fig.2: Number of homeless decisions*

| Homeless decisions | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|---|
| Eligibility, unintentionally homeless and in priority need | 221 | 199 | 664 | 853 | 764 |
| Eligible, homeless and in priority need but intentionally so | 25 | 12 | 49 | 76 | 137 |
| Eligible, homeless but not in priority need | 197 | 46 | 82 | 425 | 557 |
| Eligible but not homeless | 269 | 128 | 324 | 336 | 275 |
| Ineligible | 27 | 23 | 67 | 100 | 167 |
| **Total decisions** | **739** | **408** | **1186** | **1790** | **1900** |

Source: P1E form on homelessness

*Fig. 3: Number of statutory homeless acceptances made in Barking and Dagenham compared to London, sub-regions and England 2009/15*




| | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|---|---|
| LBBD | 34% | 31% | 52% | 59% | 50% | 44% |
| Outer London | 36% | 35% | 45% | 46% | 48% | 52% |
| Inner London | 49% | 49% | 52% | 48% | 50% | 57% |
| London | 38% | 38% | 45% | 48% | 53% | 52% |
| England & Wales | 45% | 43% | 46% | 47% | 47% | 48% |

Source: DCLG Live Tables

## 3.2.3 Main causes of homelessness

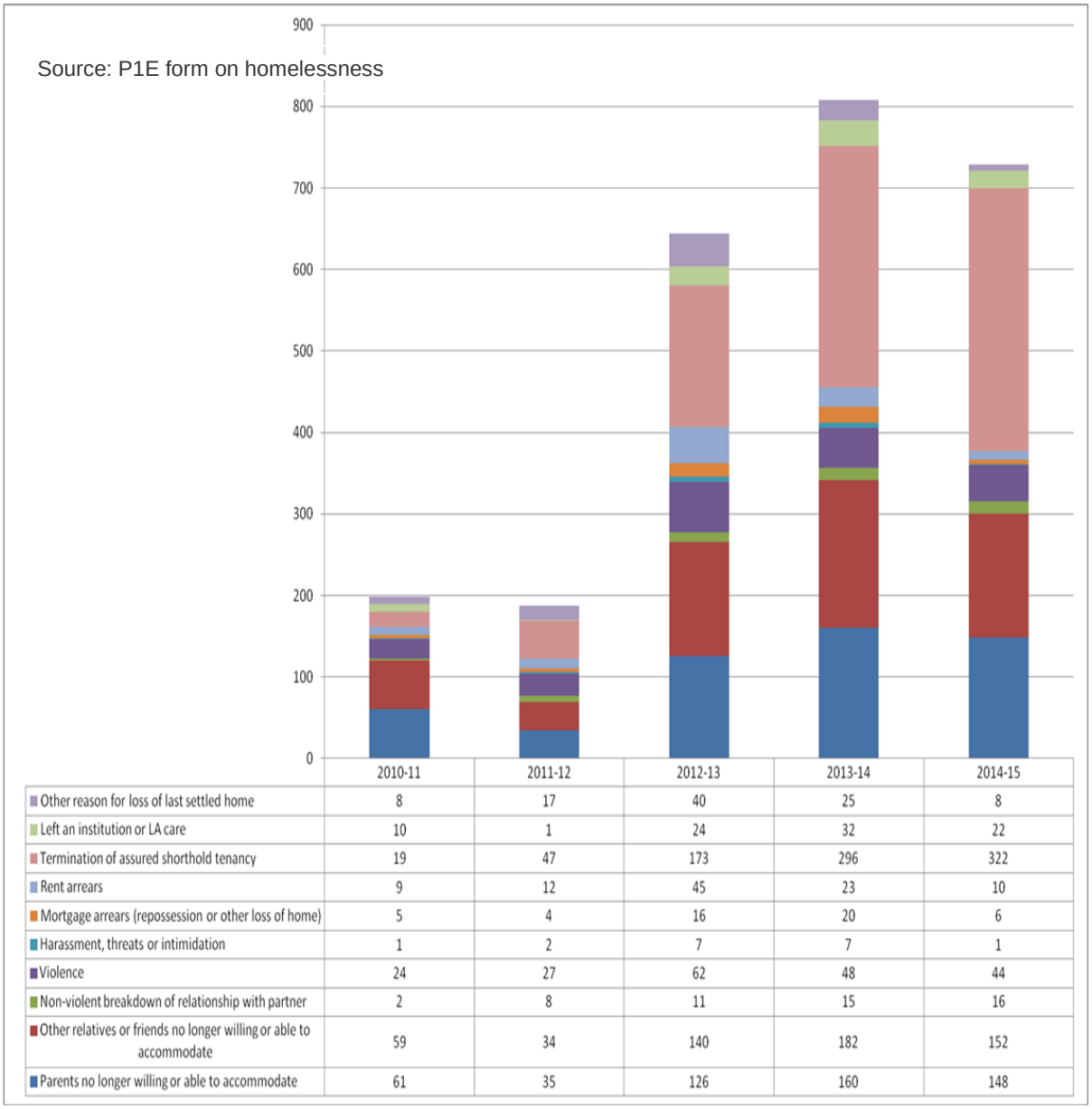
The main reasons for homelessness are documented below illustrating an upward trajectory in the termination of assured short hold tenancies (ASTs).The breakdown of parental and familial relationships also accounts for a sizeable portion. The growth in terminated ASTs appears to be a reflection of capped local housing allowance and the impact of welfare reductions forcing private landlords to pitch their market to in-work tenants.

*Fig.4: Main causes of statutory homelessness 2010/15*

| Main causes of homelessness | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|---|
| Parental ejection or other household ejection | 120 | 69 | 340 | 342 | 300 |
| Relationship breakdown | 22 | 28 | 81 | 55 | 53 |
| Violent relationship breakdown with partner/associated other | 23 | 25 | 55 | 40 | 37 |
| Loss of assured shorthold tenancy in PRS | 47 | 64 | 333 | 339 | 341 |
| Mortgage arrears | 5 | 4 | 20 | 20 | 6 |

Source: P1E form on homelessness

***Fig.5: Reasons for statutory homelessness 2010/15***




Source: P1E form on homelessness

| | 2010-11 | 2011-12 | 2012-13 | 2013-14 | 2014-15 |
|---|---|---|---|---|---|
| Other reason for loss of last settled home | 8 | 17 | 40 | 25 | 8 |
| Left an institution or LA care | 10 | 1 | 24 | 32 | 22 |
| Termination of assured shorthold tenancy | 19 | 47 | 173 | 296 | 322 |
| Rent arrears | 9 | 12 | 45 | 23 | 10 |
| Mortgage arrears (repossession or other loss of home) | 5 | 4 | 16 | 20 | 6 |
| Harassment, threats or intimidation | 1 | 2 | 7 | 7 | 1 |
| Violence | 24 | 27 | 62 | 48 | 44 |
| Non-violent breakdown of relationship with partner | 2 | 8 | 11 | 15 | 16 |
| Other relatives or friends no longer willing or able to accommodate | 59 | 34 | 140 | 182 | 152 |
| Parents no longer willing or able to accommodate | 61 | 35 | 126 | 160 | 148 |

### 3.2.2 *Priority need categories of statutory homelessness*

To be accepted as statutorily homeless and receive assistance from the local authority, the applicant must have an established priority need defined under the Housing (Homeless Persons) Act 1977 and subsequently amended by the Housing Act 1996 and the Homelessness (Priority Need for Accommodation) (England) Order 2002.

The following table depicts the different categories of those accepted of which being a household including dependent children is the most consistent factor.

***Fig.6: Statutory homelessness by priority need 2008-***

| Main priority need group | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|---|
| Household with children/pregnancy | 156 | 150 | 501 | 628 | 602 |
| Single people 16/17-18/20 years | 9 | 8 | 10 | 9 | 4 |
| Physical disability | 18 | 9 | 39 | 52 | 46 |
| Mental illness | 25 | 21 | 69 | 102 | 66 |

Source: P1E form on homelessness

### *3.2.3 Age profile of statutory homeless households*

The most significant age profile of those accepted as statutorily homeless is 25-44 years of age.

***Fig.7: Statutory homelessness by age profile 2008-***

| Age | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|---|
| 16-24 | 79 | 54 | 171 | 209 | 163 |
| 25-44 | 115 | 125 | 401 | 501 | 469 |
| 45-59 | 21 | 15 | 81 | 116 | 107 |
| 60-64 | 1 | 4 | 6 | 16 | 12 |
| 65-74 | 4 | 1 | 3 | 8 | 12 |
| 75+ | 1 | 0 | 2 | 3 | 1 |

Source: P1E form on homelessness

### *3.2.4 Family/household type of statutory homeless*

The following graph represents the types of household which have been granted statutory homelessness acceptances. Lone parent households headed by a female translated into the largest cohort.

***Fig.8: Statutory homelessness by household type***

| 2014-15 | Couple with Dependent Children | Lone Parent Household with Dependent Children | | One Person Household | | All Other Household Groups | Total |
|---|---|---|---|---|---|---|---|
| | | Male Applicant | Female Applicant | Male Applicant | Female Applicant | | |
| Apr – Jun | 44 | 6 | 92 | 21 | 27 | 4 | 194 |
| Jul - Sept | 43 | 6 | 100 | 22 | 16 | 4 | 191 |
| Oct - Dec | 59 | 6 | 103 | 18 | 19 | 3 | 208 |
| Jan - Mar | 36 | 9 | 98 | 19 | 2 | 7 | 171 |
| **Total** | **182** | **27** | **393** | **80** | **64** | **18** | **764** |

Source: P1E form on homelessness

### *3.2.5 Ethnic origin of priority homeless households*

The following charts provide insight into the ethnic origin of accepted homelessness cases.

***Fig.9: Statutory homelessness by ethnicity***

| Statutory Homeless | White | Black | Asian | Mixed | Other | Ethnicity Not Stated | Total |
|---|---|---|---|---|---|---|---|
| 2010-11 | 133 | 59 | 19 | 2 | 5 | 3 | 221 |
| 2011-12 | 88 | 86 | 15 | 3 | 3 | 4 | 199 |
| 2012-13 | 340 | 206 | 38 | 61 | 2 | 17 | 664 |
| 2013-14 | 402 | 295 | 63 | 78 | 12 | 3 | 853 |
| 2014-15 | 327 | 276 | 71 | 74 | 12 | 4 | 764 |

Source: P1E form on homelessness

### 3.2.6 Non-priority homelessness

An applicant is owed a non-statutory duty if found to be homeless but is either intentionally so or not in priority need. There is only a duty to provide advice and assistance and not the same duty to procure permanent housing. Notwithstanding the lesser duty, local authorities are increasingly encouraged to work with partner organisations towards finding solutions for this wide-ranging group to prevent and relieve periods of homelessness.

***Fig 10: Non-priority homeless cases in Barking and Dagenham 2010/15***

| Year | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|---|
| Non-priority homeless | 491 | 186 | 455 | 837 | 969 |

Source: P1E form on homelessness

In circumstances where the main homeless duty is not owed, the Council still works to prevent the risk of homelessness among vulnerable people through integrated services and supported housing options. Supported housing schemes encourage independent living and are tailored to the particular needs of the client group.

### 3.2.7 Single homelessness

Local authorities are under no duty to provide temporary accommodation to single homelessness persons who are not in priority need but do have the discretion should they chose to do so in order to avoid homelessness. These are largely represented by single people and childless couples, particularly in the under-35s age group.

Barking and Dagenham are only obliged to provide advice and assistance in accessing alternative accommodation despite the biggest rise in approaches to the Council coming from those deemed homeless but not in priority need[16]. This is a group where prioritisation and funding for homelessness services is dwindling across the capital.

Working with the ELHP through funding from the Department for Communities and Local Government, Barking and Dagenham engaged in the East London Single Homelessness Project providing a rent deposit and tenancy sustainment with 337 single homeless persons who had a connection to the East London sub region area. Established in 2011 it helped to provide access to 23 private sector tenancies for single homeless persons from Barking and Dagenham.

Following the closure of the project, the East London Housing Partnership is bidding for a £300,000 Big Lottery Funding grant to carry on its work for single homeless households to provide advice and tenancy support. It plans to work with the Credit Union which will provide rent deposits guaranteed by the ELHP.

[16] National P1E statistical returns on homelessness

## 3.3 Resources and Preventing Homelessness

### 3.3.1 Overview

Barking and Dagenham has striven to support vulnerable residents in housing need and offer homelessness prevention assistance against a very challenging financial backdrop. The borough has increasingly funded invest to save initiatives, rationalised its housing procurement options and utilised external funding streams to reduce rising expenditure on temporary accommodation and ensure reliable advice services.

***Housing Choice and personal responsibility***

A fundamental first approach is the view that homeless people and those at risk of homelessness should be able to pursue options which allow them to resolve their housing problems. This thinking is captured in the Council's evolving Ambition 2020 programme.

Residents are encouraged to take personal responsibility and to become self-reliant so this strategy supports access to the right kind of information, advice and guidance on their options and the consequences of the choices they make. That includes training, employment, good tenanting skills and financial self-management to avoid homelessness and a review of all available housing choices and opportunities when crisis happens.

Faced with reduced government resources and the impending impact of the second phase of welfare reform, the Council has to target its prevention strategy around carefully managed and finite resources.

Barking and Dagenham remains committed to working with partner agencies and the voluntary sector in strengthening its approach to homelessness. However it will continue to seek to reduce demand on its services by:

- encouraging persons at risk to fully appraise all of their options
- intervening early to create pathways away from homelessness
- support independent living and self-reliance

Early intervention is a central feature of any prevention strategy and targeting our approaches at the primary reasons for accepted homelessness cases suggests there is a growing requirement for mediation, conflict resolution where appropriate, counselling services, income maximisation and debt reduction services and parenting initiatives

### 3.3.2 Resources

***Housing Options***

The Housing Options team play a crucial role in preventing homelessness through the provision of appropriate information and advice on available housing solutions, particularly encouraging self-resolution of peoples housing crises. Housing Options works closely with other housing advice teams including Choice Homes, accommodation services and the strategic delivery team.

***Fig.11: Housing Advice Services at John Smith House, Dagenham***


The need for housing advice services has also significantly increased over the same period with twenty three members of staff advising clients daily. The following table shows numbers visiting John Smith House seeking assistance:

***Fig.12: Footfall to John Smith House 2013/15:***

| Que-matic reports – Footfall to Housing Advice Services | |
|---|---|
| Numbers for March 2013 | 1436 |
| Numbers for March 2014 | 2269 |
| Numbers for March 2015 | 2449 |

Source: Que-matic internal reports, Housing Options Service

### *Homeless Prevention Grant (HPG)*

The Department of Communities and Local Government provides an annual non-ring fenced grant through the Council's baseline and revenue support grant to fund activities related to the prevention of homelessness in Barking and Dagenham.

However, the amount of HPG provided to Barking and Dagenham fell from £600,000 in 2011/12 to £416,280 in 2014/15, representing a 31% reduction in grant[17].

### *Discretionary Housing Payments (DHP)*

The Department for Work and Pensions supplies an annual grant settlement to support housing benefit recipients whose entitlement does not cover the full costs of their rent. As a result of the recent welfare reform programme the distribution has been mainly targeted at mitigating its adverse impact upon tenants. DHP is now awarded in tranches and recipients are monitored case-by-case and awarded further payment on proof that they are proactively maintaining their rent and seeking training or employment.

Barking and Dagenham was awarded £1,176,392 in 2014/15 and payment has been used to counteract the risk of 1,393 cases of potential homelessness through rent arrears and to assist tenants subjected to income reductions through the Spare Room Subsidy. In 2013/14 the Council received £1,289,696 which assisted 1,369 households[18].

### 3.3.3 Prevention Initiatives

The introduction of the Housing (Homeless Persons) Act 1977 required local authorities to advise and assist people at immediate risk of becoming homeless by making reasonable interventions to prevent the loss of existing accommodation. The crux of the Homelessness Act 2002 was the review of prevention policy every five years and the resulting development of prevention-orientated strategies.

Barking and Dagenham has deployed a broad range of preventative interventions to alleviate the risk of homelessness through debt advice, assisting with rent deposits, resolving housing benefit problems, family mediation and preventing house repossessions. These interventions have helped to sustain tenancies and accommodation, minimising the number of households who would otherwise trigger an obligation to be housed under the statutory homelessness route.

[17] https://www.gov.uk/government/collections/final-local-government-finance-settlement-england-2014-to-2015
[18] https://www.gov.uk/government/collections/final-local-government-finance-settlement-england-2014-to-2015

***Fig.13: Cases prevented from become homeless 2010/15***

| Homeless prevention | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|---|
| Total case prevented | 516 | 724 | 1856 | 2181 | 1947 |

Source: Internal records, Housing Options service

***Preventing loss of assured shorthold accommodation***

The largest recent cause of homelessness has been the rise in private rented assured shorthold tenancies being terminated under section 21 of the Housing Act 1988. Although the reasons for this are difficult to measure, the Housing Options team currently work to prevent the loss of a tenancy under the following process:

- Check if the Section 21 notice to quit is valid
- Check if the property is licensed
- Explore if there are rent arrears
- Contact the landlord and attempt to negotiate incentives for a new tenancy
- Request a Call Credit 360 report
- If there are no rent arrears make a referral to B&D Lets for affordable housing if customer meets the income threshold
- Give customer a letter outlining their visit and actions taken

***Preventing parental/others ejection from accommodation***

Another recent major cause of homelessness has been the loss of accommodation due to parental ejection or where other parties are no longer in a position to accommodate the client. In such cases the Housing Options teams will adopt the following process:

- Contact the parent to confirm ejection/collect proof of abode for last six months
- Attempt mediation where appropriate
- Dispel myths regarding ease of access to social rented properties
- Brief Visiting Officer on situation and complete an Excluders Questionnaire

### *Rent Deposit Scheme (RDS)*

The RDS scheme allows for selected homeless households to sign up to a tenancy with a private landlord as a solution to their homelessness. The Council has assisted 903 households since 2008/09[19] by offering landlords four weeks rent as a deposit and an additional four weeks rent in advance in agreement for a 12 month tenancy and a guarantee that the tenant placed is given 'good tenancy' training.

***Fig.14: Number of tenancies created using Rent Deposit Scheme 2013/5***

| Year | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| Tenancies | 152 | 107 | 38 |

Source: Internal records, Housing Options service

Barking and Dagenham's participation in the East London Single Homelessness Project also provided a rent deposit scheme for single homeless persons giving 23 individuals access to private sector tenancies between 2012/14.

### *Court Service Representation*

Barking and Dagenham previously funded the role of a court advocacy advisor who attended court to protect vulnerable homeowners subject to possession proceedings from eviction. It successfully prevented almost one hundred possession orders from being granted between 2008/12. The scheme is now administered by the Citizens Advice Bureau in conjunction with Edward Duthie solicitors.

### *Tenancy Sustainment Measures*

Sustaining tenancies is an effective way of preventing homelessness in the first instance and providing tenants with a clear understanding of their rights and responsibilities is key. The Housing Options team helps in numerous ways by:

- providing 'good tenancy' training for clients with Rent Deposits
- using a Tenant Relations Officer working through the private sector housing team
- entering schools and explaining housing options in a creative way
- joining landlord services on the Rent Arrears Eviction Panel to work on prevention options

### 3.3.4 Housing Access and Referral Team (HART)

The Housing Access and Referral Team has been an essential component in preventing homelessness and assisting independent living.

[19] Internal records, Housing Options Team, 2008-2015

The team provides a gateway service offering advice and short-term support on matters including rent arrears, money management, benefit entitlement and securing suitable accommodation. To deliver this support HART works closely with other council teams and assists vulnerable persons with referral to appropriate agencies where additional support and independent living issues are evident. Where more intensive and longer-term support is required, HART refers the individual to East Living or the Independent Living Agency, the two external agencies contracted to provide housing-related floating support.

Referrals to the HART team are growing with 404 people assessed in 2012/13, 419 in 2013/14 and 454 in 2014/15[20]. The greatest demand continues to come from clients who have the primary vulnerabilities identified as mental health, living in temporary accommodation, physical disabilities or are teen parents. The greatest primary support need has been support because eviction is imminent, support connected with homelessness (meaning the person is in temporary accommodation and needs help to sustain it or is sofa surfing and needs help to secure stable accommodation), general housing options advice and rent arrears.

***Fig.15: Primary vulnerabilities and primary needs of clients approaching HART team 2013/15***

| Primary Vulnerability | 2013/14 | 2014/15 | Primary Needs | 2013/14 | 2014/15 |
|---|---|---|---|---|---|
| Homeless/TA | 154 | 61* | Eviction imminent | 25 | 143 |
| Mental health | 93 | 142 | Housing advice | 16 | 90 |
| Physical disability | 89 | 72 | Homelessness | 29 | 72 |
| Teen parent | 8 | 60 | Rent arrears | 84 | 61 |
| No needs | 3 | 44 | Forms/paperwork | 37 | 29 |
| Older person | 16 | 13 | Benefits/appeals | 59 | 17 |
| Drugs/alcohol | 21 | 11 | Move/MCIL | 46 | 9 |
| Learning disability | 19 | 13 | Other service need | 17 | 7 |
| Young person | 9 | 13 | Resettlement need | 17 | 4 |
| Domestic violence | 3 | 6 | Budget/life skills | 56 | 6 |

[20] Internal records, Housing Referral and Access Team 2012-2015

| | | | | | |
|---|---|---|---|---|---|
| Offenders | 2 | 4 | Tenancy support | 14 | 3 |
| Other | 2 | 15 | Other | 22 | 12 |

Source: Internal HART records

**The reduction in the figure for homelessness for 2014/15 compared to the previous year is not an indication of fewer homeless/TA cases but the fact there were more cases with pronounced primary vulnerabilities, in particular mental health*

### 3.3.5 Employment and Skills support

Employment, education and development of skills are critical to ending the cycle of homelessness and poverty. Residents in employment are less likely to experience debt and social isolation while for households with children, attendance at school and participation in extra-curricular activities are the building blocks for social skills and obtaining technical knowledge to sustain employment in later life. Employment and education break the cycles of worklessness and homelessness.

The Government has taken the view that a key barrier to taking up employment in recent years has been the disincentives posed by low pay and benefit levels. The combination of welfare reform and the Work Programme has tried to address that imbalance.

As of September 2015 all young people are expected to remain in education or training up to the age of 18. Low aspirations have contributed to Barking and Dagenham having the highest percentage of 18-24 year olds claiming Jobseekers Allowance and rising numbers presenting as homeless due to familial eviction. Continued effort to get people into work has become crucial.

Barking and Dagenham's Employability Partnership embeds joint working with the Adult College, Barking and Dagenham College, Jobcentre Plus and the Government's Work Programme to feed through pathways into training, education and employment. Access to higher skills and higher incomes increases the chances of tenancy and home ownership sustainment reducing the risk of homelessness.

The Council's JobShop service provides a range of employment support to borough residents, working in partnerships with other providers. The service is a key referral option for housing officers working with homeless or potentially homeless residents. In the first half of 2015/16 the service assisted over 500 residents into work and apprenticeships. Professional in-work benefit advisors support residents to make informed choices about the benefits of work and can assist with the claiming of in-work support.

## 3.5 Support for Vulnerable People

The next section of the review looks at particular client groups, who in some cases may be owed a duty but often make up significant numbers of non-priority cases. The review examines current services provided to vulnerable cohorts.

### 3.5.1 General Youth Homelessness

Youth homelessness numbers presented to the Council are relatively small but have grown from 19 in 2012 to 118 in 2013 and 119 in 2014[21]. The surge has been through a loss of accommodation due to familial breakdown mainly with parents. The Council employ a social worker from the Multi-Agency Safeguarding Hub (MASH) for four days a week to help assess the housing options of vulnerable young people at risk of homelessness. This is particularly pertinent where the Council establishes it has duties to offer services or accommodation to a child in need under section 17 and section 20 of the Children's Act 1989 and has a protocol in place to deliver it.

In previous years shared accommodation support had been offered through the use of houses in multiple occupation (HMOs) or through East Thames using The Foyer in Barking. But more recent procurement of suitable properties has not been successful and a rationalisation of assets by the Council has seen The Foyer utilised for much wider temporary accommodation.

Due to financial constraints the Council decommissioned The Foyer and a supported housing unit at Bevan House. However the Council has worked in partnership with East Thames and Look Ahead to facilitate a smooth transition supporting residents to relocate with Floating Support where necessary. The Council still maintains accommodation for mothers with babies at Summerfield House.

Reductions in funding have required the council to approach youths in crisis, holistically through integrated channels instead of through specialist officers. Those at risk will generally be indentified through Multi-Agency Pathway Panels (MAPP), youth offending panels and the Troubled Families Programme. In half of the boroughs schools Parent Support Advisers have become an integral method of mediation and support mitigating against youth homelessness.

Integrated Youth Services sit on the borough's three MAP panels which serve to identify key workers for young people at risk of poor outcomes, including homelessness. IYS also acts as one of the delivery partners for the Troubled Families Programme, where risk of homelessness is one of the potential indicators. IYS has overall responsibility for the tracking and support of all 16-19 year olds who are Not in Education, Employment or Training (NEET). Through 1-2-1 support

[21] Internal records, Children's Services, 2012-2014

provided to these young people IYS are able to identify and address housing need which may be preventing the young person from developing their potential.

Where appropriate the Council has sign-posted customers to mediation services in the case of familial conflict; suggested private rented sector options and YMCA facilities as well as JobCentre Plus support. The borough encourages referrals to:

- counselling services such as those offered by the Listening Zone in Dagenham
- Night Stop which assists 16-25 year olds with the provision of emergency accommodation with local volunteers for one night or up to six weeks

However there is still scope for improving the integration of services to provide a positive gateway for youngsters at risk.

***Looked after children and care leavers***

Under the Children (Leaving Care) Act 2000, the borough is responsible for the assessment and needs of looked after children aged 16-17 and other leavers of care from the ages of 18-21 (or 25 if still in full-time education). In 2014/15 the Council had responsibility for 65 16-17 year olds and 230 people of 18 years plus[22]. Of this cohort 20 were children of asylum seekers and 4 had high-level, high-cost disabilities.

The Council has reduced to zero the number of 16-17 year old care leavers housed in temporary accommodation and prioritised assisting clients in the preparation of applying for the Council's housing register. This is to fulfil their statutory duty to provide reasonable move-on accommodation when they leave care. The accommodation needs of the 16-17 cohorts are administered by specialist providers such as Advanced Care, Crossroads and Silver Birch.

To promote independent living the Leaving Care Team requires mandatory attendance at employment skills workshops, job fairs, education enrolment opportunities and activity with Jobcentre Plus. Attendance in 2014/15 was slightly under 50% suggesting more work is required to foster financial resilience which can sustain tenancies.

Due to high demand for social housing, a significant number of care leavers have been placed in shared accommodation to promote independent living. Procured through the private rented sector, the most suitable accommodation are houses in multiple occupation (HMOs).

[22] Internal records, Children's Services 2014/15

Historically there have been 10 offers of social housing made each year with an average leaving care waiting list of 45. Ideally the service moves on clients by the age of 19 through offers of social housing or assured short-hold tenancy in the private rented sector but lack of supply has led to bottlenecks in accommodation. Care leavers over the age of 18 are staying longer in move-on accommodation such as HMOs, reducing available accommodation to the 16-17 cohort coming through the system. In turn accommodation costs are rising unsustainably.

***Fig.16: Number of looked after children under Barking and Dagenham's care 2011/15***

| Year | No. of Looked after Children |
|---|---|
| 2011 | 232 |
| 2012 | 232 |
| 2013 | 212 |
| 2014 | 223 |
| 2015 | 222 |

Source: Internal records, Leaving Care team

***Teenage parents***

Although Barking and Dagenham still has the highest teen pregnancy rate in London, it has fallen by 26% in the last fifteen years[23]. 154 under-18s conceived in 2014/15 and 59% ended in terminations.

The numbers of teenage parents and expectant mothers subject to the risk of homelessness is therefore relatively small, although the numbers continue to rise. The Family Nurse Partnership, the Baby Intervention and targeted personal advisors offer avenues of mediation and support.

***Fig.17: Number of teen parents reported as homeless 2012/15***

| Year | No. of Homeless Teen Parents | Age of Homeless Teen Parents | | | |
|---|---|---|---|---|---|
| | | 16 | 17 | 18 | 19 |
| 2012/13 | 26 | 1 | 3 | 11 | 11 |
| 2013/14 | 32 | 0 | 3 | 21 | 8 |
| 2014/15 | 37 | 1 | 6 | 13 | 17 |

Source: P1E form on homelessness

[23] http://www.barkinganddagenhamjsna.org.uk/Section7/Pages/Section7-17.aspx

### 3.5.3 Lesbian, Gay, Bisexual and Transgender persons

The Council is mindful of incidents of LGBT homelessness becoming more evident when previously it was considered a 'hidden' cause of homelessness and is working to capture more data in this area. The Council wishes to develop referrals for LGBT advice and support, particularly for young LGBT people and those suffering from domestic violence and abuse. There is currently a Public Health funded support programme for LGBT young people, Flipside, delivered by Integrated Youth Services. In addition, on its website the borough currently signposts support to the Albert Kennedy Trust and Stonewall for confidential advice.

### 3.5.5 People without recourse to public funds

People with no recourse to public funds (NRPF) are deemed to be destitute persons from abroad subject to immigration controls which prevent them from accessing welfare entitlement, certain services and public housing. Categories of NRPF households include:

- Those entering the UK illegally and are unknown to the authorities
- Those entering the UK and overstayed on a student, spousal or visitor visa
- Those with limited leave to remain on condition that cannot claim public funds
- failed asylum seekers
- citizen of the European Economic Area subject to restrictions

The borough has a duty under the law to assist and advice NPRF households in finding pathways out of their destitution and in limited circumstances can offer accommodation and care services or financial support, particularly where children are concerned.

Since 2011 the number of cases have escalated and in October 2015 204 children of NRPF families were subject to section 17 assessments[24]. Although housing services has worked on behalf of Children's Services to reduce the temporary accommodation cost, there is a requirement to home these families during the lengthy assessment process which can average upto six months.

### 3.5.6 Supported Persons

The Council's Adult Social Care team has been at the forefront of commissioning and procuring housing related services for many of the vulnerable groups generally found to be at risk of single persons homelessness. In 2012/13 the service assisted

[24] Internal records, Children's Services 2015

4,889 clients and 3,862 in 2013/14. The Care Act 2014 places a duty on local authorities to prevent, reduce and delay needs for care and support.

### *Persons with learning disabilities*

Barking and Dagenham commissioned a two year contract in 2015 for nine units of supported housing for clients with high-level learning disabilities. Through referrals from the Community Learning Disabilities Team tenants are helped to manage their finances to sustain their tenancies and establish long-term independent living until such a time as move-on accommodation can be arranged through nomination rights to council or registered provider housing. The Council's HART team assisted 32 clients with learning disabilities in assessing their housing options[25].

### *Mental health*

There is a higher risk of vulnerability and homelessness among mental health clients, particularly those suffering with severe and enduring illnesses like dementia or schizophrenia meaning support in tenancy sustainment is a critical intervention.

The North East London NHS Foundation (NELFT) has a mental health team working with housing options to facilitate the discharge planning and accommodation options of clients through its Resource Allocation Management Panel (RAMP). The RAMP in conjunction with housing and commissioning services, reviews the recommendations and package proposed by the client's care co-ordinator which may involve residential care, a supported living scheme or a support in the community package

Protocols are also in place with local hospitals through the Care Programme Approach which co-ordinates the discharge process through King George's and Goodmayes, ensuring clients do not leave while being at risk of homelessness prior to a referral to housing services. The Housing Access and Referral Team dealt with 235 mental health clients between 2013/15 and the numbers continue to rise[26].

However the need for mental health accommodation for specific cohorts is growing and the lack of 'step-down' properties in social or private rented stock for clients ready for independent living means they cannot be moved on, which creates bottlenecks for other clients. The borough's adult commissioning team and NELFT are undertaking a review of their current approach to mental health commissioning and housing-related provision.

### *Domestic Violence*

During 2013/14 1,991 domestic violence crimes were reported to the police in the borough and it continues to have the highest domestic violence reported incident

[25] Internal records, Housing Access and Referral Team 2012-2015
[26] Internal records, Housing Access and Referral Team 2012-2015

rate in London. The 2013 Government definition of domestic violence includes incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members. This can encompass psychological, emotional, physical, sexual abuse. This definition includes 'honour' based violence, female genital mutilation (FGM) and forced marriage.

Reducing domestic violence and abuse is at the centre of the revised draft Domestic and Sexual Violence Strategy which aims to help deliver a coordinated community response model and MARACs (Multi-Agency Risk Assessment Conference) which:

- Increases survivor safety.
- Holds perpetrators accountable for their behaviour.
- Challenges the social tolerance of domestic violence

Despite the fact domestic violence in Barking and Dagenham is high, the number of cases of homelessness caused by it have been gradually falling as demonstrated in the accompanying table:

***Fig.18: Number of homeless cases caused by domestic violence 2010/15***

| DV reason for accepted homelessness | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|---|
| Violent relationship breakdown with partner | 19 | 23 | 43 | 30 | 27 |
| Violent relationship breakdown with associated person | 4 | 2 | 12 | 10 | 10 |

One of the key elements of the preventing homelessness through domestic violence and abuse has been Barking and Dagenham's support of a Sanctuary Scheme run through Victim Support's Safer Homes Project and providing high level security improvements at the victim's property to prevent assailants from entering the home, such as change of locks, extra locks on doors and windows, fireproof letterboxes and stronger doors. There were 1,517 referrals from Sanctuary between 2010 and 2014:

***Fig.19: Number of persons at risk of homelessness but prevented through Sanctuary scheme 2010/15***

| | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|---|
| **Homeless cases prevented by Sanctuary** | 16 | 136 | 917 | 295 | 153 |

Source: P1E form on homelessness

### *Troubled Families*

As a result of the civil disturbances across London in August 2011, the Government established a Troubled Families agenda with a focus on turning around the lives of Britain's most troubled families.

Between 2012/15, Troubled Families Phase 1 (TF1) worked with 645 families in the borough, a significant amount of whom had housing issues and the programme was able to reduce the demand on housing advice services. The Council had a 100% success with the cohort of families due to multiagency actions guided by a service level agreement with the Early Intervention team[27].

In September 2014, the Government announced that 51 high performing local authorities in the current programme, including Barking and Dagenham, would start delivering the expanded programme ahead of national roll-out in April 2015 and it is our task to evidence that we will achieve significant and sustained progress with 492 families over the 5 year period from 2015/2020

The 6 criteria that we have identified as being significant for this borough are

- crime and antisocial behaviour
- poor health
- domestic violence and abuse
- children who need help
- poor school attendance
- unemployment

The scheme has had to evaluate sustained change within families evidenced by reduced demand on reactive services therefore achieving better value for money.

There are links between anti-social behaviour and wider housing issues. Housing organisations play a central role in reducing anti-social behaviour and linking with the housing department benefits all through the de-escalation of eviction proceedings and reduced repair bills.

### *Prison client and ex-offenders*

There is a pressing need to provide advice and accommodation to prisoners, some of whom will suffer from mental health and others from a history of substance misuse. There is also a particular need to steer away young offenders and those with short sentences from the risk of re-offending. The borough uses Multi Agency Public Protection Arrangements (MAPPA) to take into consideration the housing needs of these clients as well as offering floating support via Probation Services and the Youth Offending Team.

[27] Internal records, Children's Services 2012/15

Occasionally some council tenant clients will enter prison and housing services will only hold their accommodation for a maximum of three months and in arrears. Resettlement teams try and manage the process but clients with longer sentences will work with their link officer to see what options can be found with housing advice or alternatively with homeless charity St Mungos. Younger clients may be directed to DePaul UK London Night Shelter.

The Council currently commissions the Crime Reduction Initiative (CRI) and Addaction to create pathways away from addiction and offending through via a prison link worker and into housing through tenancy and budget training.

***Substance and alcohol misusers***

In 2014 there were an estimated 1,079 drugs users in Barking and Dagenham of which only 45% were assumed to be seeking treatment. CRI also tackles substance and alcohol misuse through a referral system for treatment or advice called the Recovery Management Service. With the support of Horizon, a structured day programme is offered to counsel clients. Clearly addictions can be critical causes leading to loss of accommodation and rough sleeping[28].

***Older and physically disabled persons***

Historically there have been very low levels of older persons homelessness but demand for elderly adult social care is increasing as the older population is actually declining.

However promoting independence for older people is the corner stone of adult commissioning's strategy for delivery. In Barking and Dagenham there are 31 sheltered housing schemes over 23 sites designed for people aged 55 or over as well as those with physical disabilities.

Eight extra care schemes delivering 268 beds provide additional support to frail households while maintaining their independence.

***Fig.20: Extra care schemes operating in Barking and Dagenham 2015***

| Commissioned Extra Care Schemes | Beds | Council Extra Care Schemes | Beds |
|---|---|---|---|
| Harp House | 36 | Millicent Preston | 33 |
| Fred Tibble Court | 31 | Ted Hennem | 41 |

[28] http://www.barkinganddagenhamjsna.org.uk/Pages/jsnahome.aspx

| | | | |
|---|---|---|---|
| Colin Pond Court | 31 | George Crouch | 31 |
| Darcy House | 52 | Fews Lodge | 13 |

Nursing and residential care places are also provided where sheltered or extra care provision is no longer a viable option. In 2014 the Council had 324 older persons living in independent care homes both inside and outside of the borough plus the availability of 37 care bed at Kallar Lodge which specialises in dementia.

The Council is reviewing its approach to older persons housing need by establishing an older person's pathway model and is due to be developed by April 2016.

### 3.5.7 Rough Sleepers

Rough sleepers cover a wide range of 'roofless' persons who are either sleeping or bedding down in the open air, buildings or places not designed for habitation. Rough sleepers tend to be in the most vulnerable categories of homeless often becoming roofless due to long-term mental health issues, crime, destitution, substance misuse or addiction. They have more likelihood of contracting communicable diseases such as tuberculosis or HIV and studies suggest that they live thirty years less than the average member of the public.

Housing legislation does not convey a duty upon the local authority to relieve rough sleeping but there is a very strong policy ethos to tackle the problem and good evidence for an early intervention in order to prevent it, which if left unaddressed can lead to complex or multiple needs developing for the individual that later place a burden on local authorities. The Government's No Second Night report in 2011 and the creation of the Mayor of London's Rough Sleeping Group in 2013 has prioritised action in the capital where rough sleeping has been increasing.

Rough sleepers may have very complex needs and in some cases are disengaged from local services and support networks leading to a chaotic lifestyle that exacerbates their problems. Although some present themselves to night shelters where they can be put on a pathway of referral to social, mental health and employment services, many remain hidden to protect themselves and therefore do not obtain the assistance they desperately require.

In comparison to the rest of London, Barking and Dagenham does not have high levels of rough sleeping but with the sub-region attracting migrants from eastern Europe looking for established communities and links, there has been an anecdotal rise in rough sleepers. Ascertaining a credible baseline for the level of rough sleeping is challenging and local authorities are dependent upon Street Count and CHAIN reporting to gauge the numbers in the borough:

- Street Count – a bi-annual 'on-the-spot' survey conducted with partner agencies to evaluate the level of rough sleeping by counting the number of rough sleepers on a given night in the borough

- Combined Homelessness and Information Network (CHAIN) - real time reporting from agencies dealing with rough sleepers collated by St Mungos charity and funded by the Mayor of London

CHAIN monitoring categorises rough sleepers as 'flow clients' who have had no previous contact; 'returner clients' who have intermittent periods of rough sleeping and use of outreach services and 'stock clients' who tend to be regular uses of outreach support and likely to be permanent rough sleepers.

The socio-economic data of identified rough sleepers is not broken down by borough but the 2014/15 analysis of 'outer boroughs' (which includes Barking and Dagenham) suggested that 50% of rough sleepers were British and central and Eastern Europeans accounted for 29%. In all 79% of all rough sleepers were previously flow clients and had no previous contact with 8% being stock and 13% returners[29].

However CHAIN can only be used an indicator as it generally only captures the male experience when female rough sleeping levels tend to be hidden. Through the ELHP, boroughs have been making awareness of the data risks of the count.

The following table shows the estimated number of rough sleepers in Barking and Dagenham compared to our sub-regional partners:

***Fig.21: Number of rough sleepers compared to east London sub-region 2011/15***

| Borough | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|
| LBBD | 17 | 12 | 14 | 27 |
| Havering | 7 | 18 | 11 | 25 |
| Redbridge | 57 | 83 | 83 | 121 |
| Waltham Forest | 46 | 72 | 75 | 118 |
| Hackney | 81 | 103 | 141 | 155 |
| Newham | 79 | 124 | 202 | 221 |

Source: Annual CHAIN reports

[29] http://data.london.gov.uk/dataset/chain-reports

There has been anecdotal evidence of rising levels of rough sleeping in the past year and the Council has re-established a new Rough Sleepers Forum to review what has traditionally been a low-level form of homelessness in the borough.

The Forum is currently organising a fresh set of rough sleeping counts and ensuring that arrangements are in place to deal with homeless assessments. The group is establishing clear pathways for those requiring assistance; working up a plan for those ineligible for assistance; developing links with the emergency services; monitoring those not exercising their right to reside under the European treaties; developing services for rough sleepers as part of the Severe Weather Plan and through the Warmer Homes Healthy People run with CVS.

## 3.6 Temporary Accommodation

### 3.6.1 Overview of temporary accommodation

Temporary accommodation is an interim solution provided by local authorities to satisfy the statutory duty to house homeless families until such time as that homelessness duty ends. Under the Homelessness (Suitability of Accommodation) (England) Order 2012 the accommodation must be suitable in terms of size, location and the health needs of the client. It must be properly managed, free of hazards and affordable. In particular families should not remain in bed and breakfast for longer than six weeks.

Such households are expected to pay rent and any other ancillary charges which may come with the accommodation. Some households will be eligible for housing benefit which may cover all or some of the costs.

There is no statutory cap on the length of time in which a homeless family may remain in temporary accommodation and the duty is owed until the client either:

- Moves out of their own accord or is no longer eligible for assistance
- Moves into settled accommodation arranged by the council
- Refuses a final offer of suitable settled accommodation
- Is evicted for arrears or anti-social behaviour

For the accounting quarter of March 2015 Barking and Dagenham ranked as seventeenth highest in the number of total households in temporary accommodation with 1,317 dwellings being used. This is still lower than all our sub-regional partners except Havering. The following chart shows the number of statutorily homeless households in temporary accommodation across the capital in comparison to the sub-region and Barking and Dagenham illustrating that the borough remains below the average:

***Fig.22: Numbers of statutory homeless in temporary accommodation by national ranking 2012/15***

| Statutory Homeless in Temporary Accommodation | National Rank | 2014/15 | 2013/14 | 2012/13 |
|---|---|---|---|---|
| Newham | 1 | 3,302 | 2,877 | 2,633 |
| Brent | 2 | 3,161 | 3,341 | 3,249 |
| Haringey | 3 | 2,997 | 2,869 | 2,832 |
| Croydon | 4 | 2,770 | 2,161 | 2,414 |
| Enfield | 5 | 2,764 | 2,226 | 2,143 |
| Barnet | 6 | 2,758 | 2,401 | 2,372 |

| | | | | |
|---|---|---|---|---|
| Ealing | 7 | 2,433 | 1,931 | 1,106 |
| Westminster | 8 | 2,397 | 2,283 | 2,450 |
| Redbridge | 9 | 2,152 | 2,063 | 2,113 |
| Hackney | 10 | 2,021 | 1,755 | 1,523 |
| Tower Hamlets | 11 | 2,007 | 1,935 | 1,845 |
| Waltham Forest | 12 | 1,990 | 1,469 | 1,325 |
| Lambeth | 13 | 1,865 | 1,533 | 1,276 |
| Kensington & Chelsea | 14 | 1,793 | 1,754 | 1,638 |
| Lewisham | 15 | 1,724 | 1,441 | Not data |
| Brighton and Hove | 16 | 1,456 | 1,266 | 1,064 |
| ***Barking & Dagenham*** | ***17*** | ***1,317*** | ***1,386*** | ***1,188*** |
| Hammersmith & Fulham | 18 | 1,197 | 1,139 | 1,203 |
| Hounslow | 19 | 1,108 | 1,087 | 1,067 |
| Wandsworth | 20 | 1,013 | 774 | 590 |

Source: DCLG Live Tables

The average length of stay in temporary accommodation ultimately depends on the availability and supply of suitable housing and the table below shows the average time spent between being placed in TA and being moved into permanent accommodation as of September 2015[30]. The average waiting time is 20 months.

***Fig.23: Average times spent in TA for homeless household in 2015:***

| Waiting time | No. of cases |
|---|---|
| 1 year | 153 |
| 2 years | 108 |
| 3 years | 66 |
| 4 years | 32 |
| 5 years | 20 |
| 6 years | 5 |
| 7 years | 2 |
| **Total** | **386** |

Source: Internal records, Accommodation team

Although Barking and Dagenham succeeded in meeting the target of reducing use of temporary accommodation by 50% before March 2010, the pressures of welfare reform, housing need and limited affordable housing supply have seen TA figures rise ever since.

[30] Internal records, Accommodation Team 2015

Managing the growing demand for temporary accommodation against pressured budgets and in a highly competitive local housing market with spiralling rents has forced the Council to reassess its strategy of using such accommodation.

### 3.6.2 Supply of temporary accommodation

The Council has recently managed to rationalise some of its assets in the face of rising demand for temporary accommodation. The Council currently manages three hostel facilities, two of which were converted from former care homes for the elderly. A fourth hostel is due to open in February 2016 following the conversion of a former teacher's accommodation unit.

116 flats in The Foyer in Barking have been taken over by the Council and voids are utilised for temporary accommodation as residents are relocated. In addition, the Council makes best use of all properties either decanted or earmarked for regeneration as well as procuring dwellings and rooms through private sector leasing, bed and breakfast arrangements and nightly lets.

The following table presents the various accommodation options and numbers used in Barking and Dagenham in November 2015:

***Fig.24: Types of temporary accommodation used in Barking and Dagenham 2015***

| Temporary Accommodation Type | No. Of Households | Description |
|---|---|---|
| Bed and Breakfast (B&B) and nightly let accommodation | 77 – B&B<br>71 – nightly Lets | Last resort and emergency accommodation comprised of self-contained and shared facilities procured on a nightly let cost basis |
| Hostels | 103 | The Council owns and manages a mix of contained and non-contained hostels such as Riverside House, Butler Court, Boundary Road and Brockelbank Lodge |
| Private Sector Licensing (PSL) | 891 | Self-contained PRS accommodation leased by the Council through private landlords on guaranteed rent levels and managed by landlords/letting agents |
| GLA Empty Homes Programme units | 13 | Self-contained vacant PRS dwellings returned to use by GLA grant and managed by the Council on five year leases |
| Housing Association Leasing Scheme (HALS) | 148 | Self-contained accommodation leased by the Council from registered providers including Bevan House and The Foyer |
| Short-life housing | 316 | Decanted properties on estate renewal projects awaiting demolition |

Source: Internal records, Accommodation team

The following table charts the overall rise in TA households and how the local authority has accommodated them. Note that the Council has continued to reduce use of B&B but sought to optimise its own assets for accommodation:

***Fig.25: Number of TA households and type of temporary accommodation they are housed in 2010/15***

| Accommodation Type | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|---|
| B&B | 42 | 154 | 180 | 65 | 47 |
| Shared nightly lets | 10 | 14 | 18 | 6 | 0 |
| Self-contained nightly lets | 0 | 0 | 18 | 107 | 91 |
| Hostels | 21 | 25 | 72 | 104 | 99 |
| PSL/HALS | 620 | 744 | 825 | 915 | 824 |
| LA stock | 0 | 144 | 146 | 189 | 256 |
| Registered providers | 8 | 0 | 1 | 0 | 0 |
| Other | 3 | 4 | 0 | 0 | 0 |
| **Total** | **704** | **1085** | **1260** | **1386** | **1317** |

Source: P1E form on homelessness

### 3.6.3 Financial and supply pressures on temporary accommodation

The impact of welfare reform has driven up the number of crisis presentations made to housing advice services which has seen households placed in temporary accommodation rise by almost 49% in 2013/14 to 1,386. The figure dipped slightly in 2014/15 to 1,317 but will remain under pressure as the second phase of welfare caps and reductions kicks-in.

With reduced resources the Council is trying to cut the cost of temporary accommodation and find innovative solutions to dealing with demand but within budget. The Council has targeted B&B and nightly let rates for savings because it represents a very expensive form of TA and the problem has been exacerbated in recent years by other local authorities using Barking and Dagenham for preventative placements. To control spiralling nightly let rates and prevent other boroughs outbidding Barking and Dagenham for much sought after local accommodation, the borough has joined with London Councils and sub-regional partners in agreeing the London Inter Borough Accommodation Agreement (IBAA) which includes the introduction of a maximum nightly let rates. The Council has increasingly sought to use its own buildings to manage temporary accommodation, reduce the associated costs and generate rental income. The return of The Foyer to TA, the conversion of buildings for the use as hostels and numerous decant estates awaiting regeneration has generated income for the Housing Revenue Account.

### *Estate Renewal and Decant Programme*

However significant progress on estate renewal regeneration schemes has added additional pressure. The removal of these general needs properties, the need for alternative decant properties and the subsequent loss of short-life dwellings for temporary accommodation has exacerbated the problem of supply.

Estate renewal schemes on Gascoigne East, Gascoigne West and Sebastian Court requires the movement of 274 tenants and the provision of alternative accommodation. In addition 28 households in temporary accommodation need to be rehoused. Futher regeneration schemes in Gascoigne, Thames View and Rainham Road South are expected to be completed by 2021 and will also require the movement of 878 tenants. This is to be managed in small programmes, working with housing providers to house some of the decants on new schemes as they progress.

### *Private Rented TA*

The cost of private sector licensing arrangements has also posed significant financial burden in recent years leading to the Council retendering its contract for leased properties in 2014 and approving a new framework of 17 managing agents to source and manage suitable quality properties which offer value for money.

The procurement of Bed and Breakfast accommodation has also for the first time been through a price reduction exercise, which has helped to significantly reduce the nightly costs of placements.

The borough strives to remain resourceful and is testing the feasibility of establishing a local lettings agency. Based on a similar model to Reside, the Council's letting arm to working families on affordable rents, the agency would act as part of the preventative strategy by sourcing (and managing) a new tranche of private sector rented properties for rent deposit and homeless prevention, thereby reducing administrative costs for the local authority.

While the cost of temporary accommodation presents one challenge, the provision of new supply is just as formidable. Landlords are increasingly reluctant to lease or renew tenancies to tenants on capped benefits. With rising house prices, landlords are looking at either realising their assets or tapping into the burgeoning and attractive professional rental market with higher rental yields. The Council has sought to address the matter by offering competitive incentives to increase supply whilst adhering to the Local Housing Allowance rate to encourage and maintain PRS supply and avoid nightly lets.

### 3.6.4 Bed and Breakfast Accommodation

The borough has sought to reduce its reliance on B&B and this is encouraged by the legal requirement not to house families in such accommodation for any longer than six weeks and in the case of 16 and 17 year olds never at all.

Since 2013 the Council has reduced dependency on B&B within borough boundaries but it has become necessary to utilise accommodation in neighbouring boroughs, mainly in Redbridge and Newham. This arrangement is adherent to the IBAA and monitored on a weekly basis.

### 3.6.5 Sub-Regional Approach to Temporary Accommodation and the IBAA

The London Inter Borough Accommodation Arrangement (IBAA) became operative in April 2014 as a means to govern how all 32 boroughs and the city corporation discharged their homeless duty into TA throughout the capital, outside of their own municipal boundaries.

Information is collected every month from each borough about where placements are made, the number, the type and kind of accommodation procured, all bar placements made by social services.

To mitigate the cost of rising London rents and prevent borough's outbidding each other for precious accommodation resource, the IBAA protocols agreed by housing directors placed a cap on maximum nightly let rates. In Barking and Dagenham this arrangement also allowed for an increase in PSL properties becoming available for local as opposed to pan-London usage.

With east London having some of the cheapest private rents in London, particularly Barking and Dagenham and Waltham Forest, the sub-region has become a net importer of placements from across the capital.

Since 2013 however there has been a significant decline in placements from west London councils like Westminster and Kensington & Chelsea and a surge in temporary accommodation being sought by east sub-regional partners. West London placements have dropped from 51% to 26% while east London has climbed from 49% to 65% - with the largest net contributors being Redbridge, Newham and Waltham Forest. By 92% the majority of the other borough placements into Barking and Dagenham are emergency lets as opposed to a discharge of the homeless duty into settled accommodation[31].

The table illustrates the annual number of pan-London placements in each sub-regional partner:

[31] IBAA quarterly returns, produced by the Royal Borough of Greenwich

***Fig.26: Pan-London placements in east London sub-region 2012/14***

| Borough | 2012/13 Placements | 2013/14 Placements |
|---|---|---|
| Redbridge | 772 | 1119 |
| Hackney | 620 | 814 |
| Newham | 586 | 748 |
| Waltham Forest | 544 | 671 |
| **Barking and Dagenham** | **378** | **510** |
| Havering | 113 | 153 |
| Tower Hamlets | 108 | 146 |

Source: IBAA reports

## 3.7 Housing Supply

### 3.7.1 Choice Homes and Allocations

***Overview***

Choice Homes is Barking and Dagenham's choice-based lettings scheme run by housing advice and open to residents enlisted to the borough's housing register. Applicants can bid for social, affordable or housing association properties in a borough location of their choice.

The Localism Act 2011 allowed the Council to review and revise its allocations scheme to take into account local considerations of how best it manages a diminishing supply of stock. With new supply being delivered slowly and Right to Buy approvals on the rise, it allowed the borough to amend its allocation scheme to efficiently allocate stock to the highest need households.

Applicants must be over 18 years of age and meet a residency qualification of residing in Barking and Dagenham for at least three years, continue to reside and fall into a reasonable preference category. Exceptions to the qualifying person's criteria include:

- some victims of domestic violence
- accepted referrals under the MAPP and National Witness Mobility Scheme
- applicants owed a homeless duty under part 7 and that duty is ongoing
- categories of the armed forces and associated family
- applicants whose application would attract additional preference

These reforms have substantially reduced access to the housing register cutting eligible numbers from 14,500 in 2014 to 7,000 in 2015. 6,000 applicants with no identified need have been removed and another 1,400 registrants living outside of the borough have been filtered out effectively allowing supply to be targeted at higher categories of local need[32].

***Fig. 27: Lettings by bedroom size by LBBD and registered providers in 2014***

| Bedroom size | LBBD lettings (1,063) | RP lettings (166) | Grand total (1,048) |
|---|---|---|---|
| 1-bed | 421 | 27 | 448 |
| 2-bed | 414 | 50 | 464 |
| 3-bed | 218 | 87 | 305 |
| 4-bed | 10 | 1 | 11 |
| 5-bed | 0 | 1 | 1 |

[32] Internal records, Choice Homes team 2015

### *Reasonable Preferences*

Tailoring together the personal circumstances of the applicant, bedroom size requirements and the level of housing need, the level of priority will be determined. The borough is under a legal duty to give reasonable preference to following households:

- Homeless persons within the meaning of the Housing Act 1996, as amended
- Homeless persons owed certain duties by any authority until such time the duty ceases
- Persons occupying insanitary, unsatisfactory or overcrowded housing
- Persons who need to move on medical or welfare grounds, including domestic violence
- Persons who need to move to an area to give or receive care where failure to meet that need would cause hardship to themselves or to others

The Localism Act 2011 provides local authorities the flexibility to introduce non-statutory reasonable preferences. To reflect a local priority of this borough and to support central governments agenda on worklessness, the Council have introduced a non-statutory reasonable preference if an applicant and / or partner included on the application is in work.

### *Right to Move*

Local authorities must not disqualify social tenants seeking to transfer from another district where it is satisfied that the tenant needs, rather than wishes, to move for work related reasons.

### *Discharge into the private rented sector*

The Localism Act allows local authorities to bring their main homelessness duty to an end by discharging the duty into the private rented sector. The PRS offer must be an assured shorthold tenancy of a minimum of 12 months. If there is a further incidence of homelessness occurring within two years of accepting the offer, there may be an ongoing duty to provide accommodation.

### *Reside and Affordable Rent housing options*

Recognising the need to create a range of solutions to deliver housing options the Council as a landlord and in partnership with other providers and lenders is delivering affordable rent options at 65%-80% of the rental market value.

Reside, a joint purpose vehicle, was created to recognise the need for the provision of affordable housing of working households. It currently offers 477 dwellings across sites such as the William Street Quarter and Thames View East. Abbey Road Phase 2 is set to join the portfolio with an additional 144 homes. Properties are let, managed and maintained by the London Borough of Barking & Dagenham and

offered on longer term assured shorthold tenancies, subject to satisfactory management of an initial 12 month tenancy.

To be eligible the working applicant must have sufficient households income to afford rental payments. The income threshold will vary across developments around the borough as well as the size of the properties available.

***Overcrowding, Under Occupation and the Bungalows Scheme***

The need to be more efficient with housing stock led to dedicated efforts to reduce overcrowding and under occupation by the Choice Homes team. This has become even more important with the advent of welfare reform. As part of preventing growing homeless numbers, the Council has identified those likely to be impacted and where possible encouraged downsizing to free up larger homes.

The team facilitated 435 moves between 2010 and 2015, 72 of which were under the Seaside and Country Home scheme for those aged 60 or over, thereby freeing up more than 650 bedrooms. 33 households were directly affected by the reduction in the Spare Room Rate in housing benefit[33].

An additional 37 households were moved to bungalows designed for pensioners with a second phase of thirty four newly built bungalows due for occupation. Households which gave up the largest properties were prioritised.

Additionally the Council has used its Mutual Exchange service to encourage households to move out of under-occupation. 622 households have utilised the service since 2009/14:

***Fig.28: Mutual exchanges in Barking and Dagenham 2009/15***

| Mutual exchanges | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|---|---|
| Total dwellings let through mutual exchanges | 68 | 61 | 107 | 128 | 183 | 75 |

Source: P1E form on homelessness

### 3.7.2 Private Rented Sector (PRS):

Not unlike the rest of the capital, Barking and Dagenham's PRS sector has seen a remarkable surge in the last decade, quadrupling from a base of 4,220 in 2003 to 12,000-14,000 dwellings today representing 17% of total housing stock[34].

Burgeoning growth and evidence of significant levels of sub-standard rental accommodation flowing into the private lets market required the Council to take

[33] Internal records, Choice Homes team 2010-2015
[34] Internal records, Private Sector Licensing team, 2015 and Strategic Housing Market Assessment 2011 by Ecorys

action. Our Private Sector Stock Condition Survey in 2010[35] estimated that 41% of PRS tenants were vulnerable households in receipt of benefit; 15% of dwellings were considered to be fuel poor due to poor thermal comfort and 47% of stock was deemed to be non-decent with a quarter suffering from disrepair, hazards or inadequate warmth.

The borough values the essential resource PRS properties bring to the local housing market but equally stresses the need for local residents to be assisted in living in safe and well managed homes, especially with substantial numbers being used as emergency and temporary accommodation for homeless households.

To facilitate an improved market in quality accommodation the Council used the Housing Act 2004 to introduce a borough-wide mandatory licensing scheme in September 2014 requiring all landlords operating in the borough to be registered as fit and proper persons eligible to manage stock and letting accommodation which met basic decency. This was paralleled with a growth in landlords registered as accredited to the London Landlords Accreditation Scheme (LLAS), the creation of a proactive Landlords Forum and the conduct of quarterly surveys of letting agents in which to gauge an analysis of trends, prices and problems in the local private rental market.

This corresponds with the Mayor of London's Housing Covenant for Private Renters in 2012 and the adoption of the Mayor's London Rental Standard into the London Landlords Accreditation Scheme in 2013.

In terms of homelessness, the strategy and review have already referenced the contraction in supply caused by a decline in landlords interested in supporting temporary accommodation. It will be important in the next five years for the Council to take a lead role in working with private sector landlords to ensure that a balance is met between the demands of a buoyant private sector market and the duty in relation to homelessness.

Recent surveys of the local letting agents suggest that this will become ever more acute even before the second phase of welfare reform has begun to take effect. The September 2015 surveys showed that average median rent for private sector properties was up to £1,231 per month, an 8% rise since the beginning of the year and the highest the borough has recorded since it started the surveys in 2010 with 64% of letting agents expecting rents to rise again over the next quarter. The length of most tenancies has shifted markedly to over three years with 68% of tenants opting for security of their existing accommodation rather than looking for new premises.

Letting agents also reported an entrenched decline in landlords accepting housing benefit claimants explaining that 92% of recent lets were to in-work tenants clearly

[35] Barking and Dagenham Private Sector Housing Stock Condition Survey by CPC Ltd

pitching to the higher rental bracket. The survey continued to illustrate the existing pattern of lack of supply with 50% of landlords having no void properties on their books and the remaining 50% having four or less awaiting repairs for the next occupation. Ninety two per cent recorded acceleration in demand for rental accommodation[36].

### 3.7.3 New Affordable Housing

The borough's Draft Local Plan[37] estimates that Barking and Dagenham has the capacity to provide 35,000 new homes over the next 15 years and has already been set the target to deliver 1,236 properties a year in the Mayor's London Plan[38]. 40% are should be affordable splitting in tenure with 60% at market rent level, 24% at social rent and 16% at intermediate.

2011 Housing Needs Survey identified the need for an additional 1,333 new affordable homes every year, particularly around family-sized accommodation. By 2013 the Council committed to projects which over the next four years aim to have delivered 1,636 new affordable homes of mixed tenure ranging from social, intermediate and affordable rents as well as shared ownership dwellings.

Since 2009/10 the borough has produced 1,976 new affordable homes including the following flagship schemes since 2012:

***Fig.29: Council new-build affordable homes schemes 2012/15***

| Scheme | No. of units | Tenure breakdown |
|---|---|---|
| William Street Quarter | 201 | 65%-80% Market Rent |
| Thames View East | 276 | 50%, 65%-80% market rent |
| Alex Guy Gardens | 26 | 50% market rent |
| Luke Alsop Square | 12 | 50% market rent |
| Abbey Road Phase 1 | 134 | 57% and 80% market rent |
| Goresbrook Village | 98 | 50% market rent |
| Rainham Road South | 29 | 65% market rent |

[36] Barking and Dagenham Quarterly Letting Agents Survey – September 2015
[37] https://www.lbbd.gov.uk/residents/planning-and-building-control/planning-guidance-and-policies/local-plan-review/one-borough-one-community-one-plan/
[38] https://www.london.gov.uk/what-we-do/planning/london-plan/current-london-plan

Barking Riverside has become the Council's most ambitious growth opportunity delivering one of the UK's largest housing developments with planning approval for 10,800 new homes. Further estate renewal is expected to widen housing choice across the following schemes by 2016:

***Fig.30: Affordable housing schemes pipeline***

| Scheme | No. of units | Tenure breakdown |
|---|---|---|
| Leys Estate Phase 1 | 70 | 50%-65% market rent |
| Marks Gate Site 1 | 56 | 50% market rent |
| Marks Gate Sites 2-3 | 28 | 65% market rent |
| Bungalow portfolio (assorted sites) | 34 | 50% market rent |
| North Street | 14 | Potential shared ownership |
| Leys Estate Phase 2 | 69 | Shared ownership and 50%-65% rent |
| Abbey Road Phase 2 | 144 | To be confirmed |
| Gascoigne Phase 1 | 421 | Mixed for sale, shared ownership and 50%-80% market rents |

Up to 14% of the new homes target has been identified for the Barking Town Centre area. As a result the GLA has designated Barking Town Centre as a Housing Zone and awarded £42.3m of funding to assist this. The Council is committed to deliver 1,000 new homes by 2018 and over 4,000 within a 10 year period from this area.

The Draft Local Plan's Options and Issues Paper is currently out for public consultation and seeks to address the number of dwellings built and types of affordable housing the borough should produce in the next fifteen years and this will significantly broaden the offer of housing choice for residents.

# 5.Homelessness Strategy Objectives 2016/21

The Homeless Review 2015 set out context, identified trends in homelessness and examined the services and interventions employed to prevent homelessness in the first instance and tackle crisis presentations when they occurred.

However planning services for the next five years requires an appreciation of the current and emerging trends:

- Second phase of welfare reform is likely to create greater demand
- Loss of private rented sector accommodation is squeezing available supply
- Parental ejection from the home is on an upward trajectory
- Rough sleeping appears to be on the rise
- Lone parent households in priority need have increased dramatically
- Demand for supported housing options and services is developing

Tackling these problems has to be balanced against diminishing resources and the cultivation of a different ethos to housing crisis resolution. This has to recognise:

- Local authority resources are likely to be squeezed much further
- Prevention initiatives and self-resolution will be critical in managing demand
- Housing advice services will have to be creative and integrated
- That resources and support has to be targeted at the most acute circumstances
- Partnerships with external providers and the voluntary sector needs to become robust
- Innovation in housing supply and choice is essential

Despite the financial constraints, the borough aspires to continually improve its housing advice services and ensure that our approach to homelessness is fit-for-purpose and creates a customer journey that provides appropriate housing solutions.

As part of this process, the Council will be seeking Gold Standard accreditation for its services in 2016, of which this homelessness review and the strategic actions below form the strategy going forward.

The borough seeks to entrench initiatives and approaches which work well in reducing, preventing or attending to homelessness while modernising services, approaches and tackling gaps where more can be done to improve outcomes.

# OBJECTIVE ONE:
# Reducing demand through prevention

| Outcomes: | |
|---|---|
| 1.1 | Homelessness prevented through housing support, advice and initiatives for vulnerable and at risk households |
| 1.2 | Encouraging self-resolution of housing crises |
| 1.3 | Co-ordinated multiagency interventions to assist households affected by the second phase of welfare reform |
| 1.4 | Increased access to employment support for families and young people |

## 1.1 Homelessness prevented through housing support, advice and initiatives for vulnerable and at risk households

- **Maintain Rent Deposit/Rent Advance funding for suitable tenants**

The Rent Deposit Scheme has assisted 758 households since 2008 and allows Barking and Dagenham to act as an introductory agent with landlords offered up to four weeks rent as a deposit and up to four weeks rent in advance in agreement for a year long tenancy. To encourage landlords, a cash incentive for renewing the tenancy or extending it is offered to keep the household in situ for two years or more. The Council intends to maintain the scheme as an active and proven tool of homelessness prevention but will continue to review the scheme in light of market changes.

- **Continue to monitor the court duty representation scheme which assists home owners and tenants at risk of possession**

Barking and Dagenham previously funded the role of a court advocacy advisor who attended court to protect vulnerable homeowners subject to possession proceedings, from eviction. This was transferred to Edward Duthie Solicitors in partnership with the Citizen's Advice Bureau and the Council wish to continue its support for the service and the role it plays in the prevention of homelessness.

- **Marry up support between the voluntary sector and Private Sector Housing services to deliver swifter remedial action and support against illegal evictions and harassment**

The significance of PRS as a housing choice and homeless solution was recognised with the introduction of the Landlords Mandatory Licensing Scheme in 2014. Driving up standards of management and the quality of accommodation is an essential part of ensuring a sustainable supply of private rented accommodation.

However with rising homelessness attributed to the loss of assured shorthold tenancies, the Council's private sector housing services will have to forge a closer relationship with the voluntary sector organisations which are often the first to be contacted for advice on illegal evictions and harassment. Official Council interventions are small, but many clients, threatened with loss of security of tenure and a risk of homelessness, have presented themselves to the Citizens Advice Bureau and its Community Legal Action Centre.

Referrals pathway needs to be developed between the voluntary sector and the local authority, even if the Council has no statutory role to fulfil. It should be made aware of alleged bad practices and can log and investigate landlords as part of its Licensing regime and potentially enforce an Interim Management Order (IMO) upon the property.

- **Agree a RSL eviction protocol setting out how the council and RSLs take every measure to prevent evictions**

The Council is seeking to develop a protocol with fellow housing associations setting out the triggers and measures taken in the first instance to prevent eviction following the second phase of welfare reform. As a key element of homeless prevention the protocol will require our partners to evict only in the last resort and only where the tenant refuses to seek support or advice from the Council, the RSL or a relevant voluntary sector pathway. The protocol will allow those requiring assistance on debt, income maximisation, addiction or other suitable housing pathways to maintain at-risk tenancies.

- **Develop an innovative Homelessness Prevention Fund**

Trusting staff to be innovative and creative in tackling homelessness allows for blue skies thinking and the borough will develop a small homelessness innovation fund to allow front-line staff to prepare business cases for preventative solutions which can be trialled.

- **Increase the 'Dispelling the Myth' programme on housing options and lettings**

  The Housing Options team will roll-out their 'Reality Check' programme across secondary schools, Sumerfield House and The Vineries to encourage youngsters to think of wider housing solutions, debunking the myths surrounding pregnancy and access to social housing, issues around parental exclusion and encouraging self-reliance.

- **'Early Rent Alert' scheme in partnership with Children's Services**

  Working with Landlord Services, the Rent Arrears Eviction Panel seeks to prevent homelessness before a crisis presentation becomes imminent however this tends not be the case with some families who end up in arrears but are owed a duty by Children's Services. It is proposed that those families are identified early by the Rents team as being at risk of serious arrears and are supported and advised on how to avoid losing their accommodation.

- **Development of Homeless Prevention Improvement Plan**

  To compliment the overarching themes and strategic objectives of the Homelessness Strategy, the Housing Options team will devise an annual Homeless Prevention Improvement Plan to monitor performance and implement innovative ways to tackle the risk of homelessness.

  The team is already revising its approach to dealing with tenants who lose their abode due to the service of section 21 notices and parental ejection; working with charitable providers and liaising more strongly with the private rented market in relation to shared accommodation

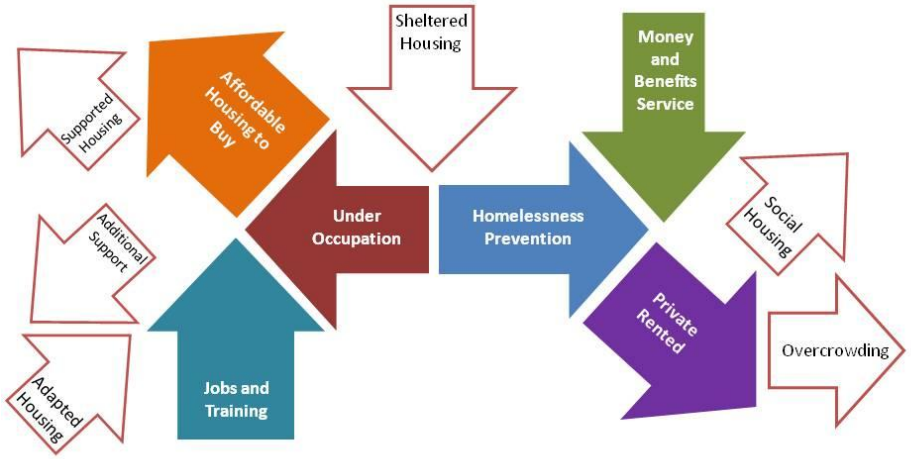
## 1.2 Encouraging self-resolution of housing crises

- **Delivery of an Enhanced Housing Options tool to allow clients to self-help**

Barking and Dagenham is developing an Enhanced Housing Options tool to create a far more effective and efficient customer gateway for households who may be at risk of homelessness, particularly young persons. Clients will be able to find housing options personalised to their own circumstances without having to wait for an appointment or applying to the Choice Homes scheme.

An online assessment will allow the client to assess the full suite of housing choices available to them including homelessness prevention, affordable housing to buy, private rent, social housing, jobs and training advice and income maximisation support.

***Fig.31: Referral routes through the enhanced housing options tool***




The tool acts as a first port-of-call which will mitigate against increasing volumes of approaches to John Smith House and makes it clear from the outset that social housing is not the first and only choice

- **Continue to promote the BanD Together Routemaster service**

  The borough will continue to support the BanD Together routemaster of services which allows residents to seek their own education, employment and training solutions through the suite of general and specialist providers such as the Richmond Fellowship for mental health clients, Bridges into Work run by East Thames and the Osborne Partnership for residents with learning disabilities

## 1.3 Co-ordinated multiagency interventions to assist households affected by the second phase of welfare reform

- **Prepare for universal credit and the second phase of welfare reform and identify those most likely to be impacted**

Ensuring housing officers and lettings teams understand the implications of the new system will put them in a stronger position to identify tenants at risk. Under the first phase of welfare reform the Council and its RSL partners identified those most likely to be impacted by welfare reductions and the introduction of Universal Credit. It has already recognised the risk around tenants juggling multiple priorities in their budgets during the impending second phase of welfare reform.

To prevent the risk of homelessness, the Council will continue to prepare staff, landlords and residents for the wider implementation of Universal Credit and further benefit reductions as legislation passes through Parliament.

## 1.4 Increased access to employment support for families and young people

- **Improve information on skills, learning and jobs and help more residents into sustainable employment**

Ensuring access into the jobs market and sustaining employment helps residents build their financial resilience, well-being and increases the likelihood of keeping up with rental and mortgage payments. The borough's Employability Partnership is the forum for joint planning between the Council and educational providers like the Adult College and Barking and Dagenham College and advisors such as Jobcentre Plus to provide training offers and clear pathways to employment and career progression. Tackling youth unemployment, long-term unemployment and enhancing support for claimants of income support or disability benefits are key areas of joint activity.

The borough also intends to maintain a network of employment support and job brokerage based on JobShop actively supporting tenants and residents including those in receipt of Discretionary Housing Payments who continue to assist and develop themselves. The employment and skills team is actively working with a wide range of local and sub-regional partners to secure European Social Fund monies to enhance local support for key priority groups.

# OBJECTIVE TWO:
# Enabling pathways away from homelessness

| Outcomes: | |
|---|---|
| **2.1** | **Re-established Homelessness Forum** |
| **2.2** | **A successful partnership with external providers and the voluntary sector providing financial resilience, mediation and support for those suffering from homelessness** |
| **2.3** | **Greater tenancy sustainment across all tenures** |
| **2.4** | **More effective identification of hidden homelessness, in particular rough sleepers and LGBT persons** |
| **2.5** | **Utilised sub-regional partnerships such as the ELHP to tackle vulnerable single persons homelessness** |

## 2.1 Re-established Homelessness Forum

- **Re-establish the Homelessness Forum facilitated by the Council but run independently**

The Homelessness Forum, comprised of statutory, voluntary and health partners, was previously the essential body which oversaw the implementation of the Homelessness Strategy and explored key areas for work and development. Originally established in 2004, it faltered through lack of resources and no consistent guidance.

The Council will identify key voluntary sector partners who are willing to independently chair the Forum and give it the external scrutiny and the leadership it requires. The Forum will meet in early 2016 and is seen as a key driver for the borough's commitment to continuous improvement of the homelessness service and in obtaining and retaining its anticipated Gold Standard accreditation.

## 2.2 A successful partnership with external providers and the voluntary sector providing financial resilience, mediation and support for those suffering homelessness

- **Develop clear voluntary sector referral pathways for vulnerable clients identified as at risk**

A key purpose of the Homelessness Forum will be the creation of a much stronger bond between the council's services and the voluntary sector which often cater for those who are most at risk of homelessness or rough sleeping. Organisations like the Citizens Advice Bureau, the CVS, Hope 4 Barking and Dagenham and Oasis night shelter projects, the Independent Living Agency, the Credit Union and DADB to name but a few provide essential advice and immediate support for vulnerable clients. Running many of the borough's social support programmes such Warmer Homes Healthy People, the voluntary sector has first contact when dispensing warm packs, income and debt support, private rented tenancy advice and night shelters.

However there is a need for a co-ordinated referral network where third sector partners can reliably forward individuals or households deemed as vulnerable and at risk to the appropriate teams and services available in the Council. There is evidence that in some cases this is beginning to happen but services need to be universally mapped and referral routes need to be developed and agreed to ensure appropriate systems are in place to assist those with complex needs at risk of homelessness.

- **Develop RSL partnerships to deliver cost effective supported accommodation**

Housing associations remain a key stakeholder in the borough's strategic delivery of housing including the provision of supported accommodation and associated services. During 2016, adult social care commissioning are to review existing arrangements in the provision of housing support for mental health, extra care, learning disabilities and young people. This review may have clear implications for homeless prevention.

The reviews are to take into consideration the Council's commitment to enabling social responsibility and independent living. Examining the role of providers, floating support packages and move-on arrangements the Council is looking for cost effective supported accommodation which emphasises the importance of personalisation of budgets where relevant.

As a result the Council is to:

- Review sheltered accommodation and extra care
- Develop a paper of housing options for persons with learning disabilities
- Examine floating support provided to younger persons
- Investigate innovative housing solutions for mental health clients including modular build and shared accommodation

## 2.3 Greater tenancy sustainment across all tenures

- **Ingrain 'good tenancy' practices for social tenants, rent deposit clients and PRS tenants to help clients manage their finances and sustain their tenancies**

Understanding a tenancy and how to manage it during times of financial difficulty or personal hardship is often the critical element of sustaining a tenancy and ultimately preventing homelessness. The Council has developed a 'how to be a good tenant' mandatory training session for those it offers a rent deposit or rent in advance too. This ensures that a landlord receives tenants who are fully appraised of their rights and responsibilities and are equipped to manage tenancy problems should they ever arise.

The borough will explore the development of a tenant training package, possibly with the voluntary sector to support landlords who house PRS tenants and TA tenants on behalf of the Council for guidance about their responsibilities. If the pilots work, the scheme could be opened up to council and housing association tenants deemed suitable for guidance.

- **Draft tenancy guides produced for the private rented sector**

Barking and Dagenham is working in partnership with a leading building society to market a new tenants guide specifically to encourage good tenancy sustainment and easy access to advice for those seeking private rented accommodation for the first time. The borough will specifically use this guide to encourage wider housing solutions for those who have traditionally just preferred social housing as the only available option.

## 2.4 More effective identification of hidden homelessness, in particular rough sleepers and LGBT persons

- **Early identification of the risk to Lesbian, Gay, Bisexual and Transgender (LGBT) persons at risk of becoming homeless**

Growing anecdotal evidence suggests that there is rising homelessness linked to lesbian, gay, bisexual and transgender discrimination. This is particularly pertinent to young people and also in some BME communities. At risk are those where families have rejected or found it hard to come to terms with the gender identification or sexual orientation of the individual.

This is a new area of identification for the Council which will work with the voluntary sector and approach registered providers and appropriate charities to examine how best to identify this vulnerable group in the first instance. This will allow the borough to explore the commissioning implications of providing support which could take the pressure off housing and social services.

- **Minimise rough sleeping through partnership interventions to ensure No Second Night Out (NSNO) for single homeless people**

  In light of the anecdotal evidence of increasing rough sleepers in Barking and Dagenham the borough is to review its approach to tackling the problem and how it interacts with partners delivering refuge and support at the sharp end. Rough sleeper identification is a key issue to be addressed, providing for a robust process of referral where move-on can be encouraged and support for complex needs administered.

  The borough will use the new Homelessness Forum to prioritise the ad hoc work of the rough sleepers group and conduct a fresh analysis of rough sleeping in the borough inclusive of the work provided by Thames Reach, No Second Night Out, London Street Rescue, Independent Living Agency, the Salvation Army, Hope 4 Barking and Dagenham night shelters and the dedicated police team. A new street count will be authorised in late 2015 and future work will include specific emphasis upon mental health, LGBT issues and international reconnection. The Council will evaluate the multi-agency outcomes of the Operation Alabama approach used in neighbouring boroughs in partnership with Thames Reach, the police and UK Border to assess what learning Barking and Dagenham can employ.

## 2.5 Utilised external partnerships to support vulnerable single persons who are homeless

- **Support the East London Housing Partnership bid for single homeless project**

Resources for single homelessness across the capital have been diminishing for some time and with growing numbers making approaches to housing advice services, initiatives by partner organisations to provide assistance must be encouraged.

Barking and Dagenham will continue to support East London Housing Partnership bids for external resource and in particular its bid for Big Lottery Funding for a new single homelessness project.

- **Debt management and mentoring project for single homeless persons**

LESS crisis funding ceased this year but part of the remaining budget has been approved for a pilot debt management and monitoring project run by CAB to help single homeless young persons cope with crisis and create a pathway to independent living throughout 2016.

# OBJECTIVE THREE:
# Create Integrated Services at First Contact

| Outcomes: | |
|---|---|
| **3.1** | **Gold Standard accreditation for Housing Options** |
| **3.2** | **Co-ordinated 'single pathways' protocols, procedures and mapping between housing, adult commissioning, children's services and health services** |
| **3.3** | **Development of one-stop shop approach to housing services such as Housing+ model** |
| **3.4** | **Joint commissioning of services to provide seamless housing options to all clients** |

## 3.1 Gold Standard accreditation for housing options services

- **Aim for Gold Standard accreditation for housing options services**

To achieve the continuous improvement of our housing advice function, we are committed to developing a Gold Standard Housing Options service recognised by the National Practitioner Support Service (NPSS). The borough needs to meet ten local challenge targets which thread multiagency actions to tackle homelessness, support vulnerable households, work with the private sector, engage with the voluntary sector and provide pathways out of homelessness for all client groups affected. The service is seeking to bench-marking its provision using the Gold Standard self-assessment toolkit in January 2016.

- **Review housing advice structure and prevention services to improve customer journey and ensure fit for purpose**

To ensure that the housing advice service is responsive to the ever changing market, remains fit for purpose and seeks to continually improve the customer journey, the Council is reviewing its current structure through the Housing Transformation Programme with recommendations for reform to be made in early 2016.

- **Consider more invest-to-save bids to improve the service**

An invest-to-save bid in 2014 allowed for the recruitment of staff to collect rent arrears from residents in temporary accommodation. The adoption of a robust collection procedure through visits and utilising technology to receive payment online and by telephone significantly reduce the 50% arrears rate of those in temporary accommodation. The Council will explore further invest-to-save initiatives to deliver quality services and create savings for the General Fund.

| **3.2** | **Co-ordinated 'single pathways' protocols, procedures and mapping between housing, adult commissioning, children's services and health services** |
|---|---|

- **Review all protocols and procedures between NELFT, mental health, adult commissioning, children's services and housing options to create a seamless integrated process for clients**

Across the board of adult and children social care services, protocols were agreed to provide effective referral routes and quotas of social housing for adults, families and young people assessed as priority need or at risk but who could be supported to live independently free of specialised support – including those suffering from chronic mental illness, severe learning disabilities and persons recovering from long-term substance misuse.

Elements of these protocols need to be reviewed and refreshed to reflect their effectiveness in delivering outcomes as part of wider strategy looking at housing-related services for vulnerable and supported households.

- **Mandatory attendance at a bi-annual conference between children's, adults and housing staff to explore processes, cases and legal changes to provide consistent service**

The complexity and ever changing nature of social care legislation has occasionally led to a disconnect between commissioning services and housing, with the unintended consequence of leaving vulnerable clients in inappropriate housing situations at great cost to the Council.

There is a service wide agreement that mandatory bi-annual conferences should be held between mental health, adult social care, children's services and housing staff to prepare, brief and engage frontline workers in policy and

legislative changes which may impact upon their personal delivery of seamless services to clients.

- **Consider appointing a referral officer who understands all of the social services links, assessments and legislation to ensure seamless approach to complex cases**

A key disconnect in present service delivery exists between housing and social care services when it comes to who is owed a duty, when, by whom and under which legislation. Housing support is a duty owed under different circumstances by different services under disparate laws ranging from the Housing Act 1996 as amended, the Children's (Leaving Care) Act 2000, the Children's Act 1989, the Mental Health Act 1983, Care Act 2014 and the National assistance Act 1948.

There is currently not a seamless service between housing and children's services in particular despite multi-agency engagement through the MAF assessment panels. Greater understanding of the assessment and referral processes between housing and social services would drastically reduce overspend on accommodation budgets used for TA if the approach could be co-ordinated.

The Council will look to resource a link officer versed in the social services links, assessments and legislation to ensure seamless approach to complex cases.

- **Reinstate homeless access to primary care health**

Until the reorganisation of the primary care model into the Clinical Commissioning Group, the borough had a concordat which provided a referral route for homeless people to appropriate health services and registration with GP surgeries. This arrangement ceased following the reorganisation of primary health care in 2010.

The Council will seek to re-establish this referral pathway with the Clinical Commissioning Group.

- **Further client panels mapping and consider the establishment of single assessment/referral panel to deal with high risk, complex needs clients in one meeting**

A desk-top mapping exercise has identified nine different operational and client panels where there is likely duplication in assessing the needs of the

same high-risk clients and offenders in isolation from other sub-groups. The borough will explore whether a comprehensive single assessment panel which considers the full range of issues concerning the individual can be developed, leading to an efficient and seamless service delivery for the client.

## 3.3 Development of one-stop shop approach to housing services such as the Housing+ model

- **Roll-out a pilot of HousingPlus approach to one-stop shop housing support and advice**

The potential role of HousingPlus in delivering rudimentary advice and lower level prevention work could be a critical development in tackling the risk of homelessness and sustaining tenancies.

The model is being developed as part of the Housing Transformation Programme to ensure frontline housing staff are in the position to advise on basic employment, public health and life skill issues to encourage residents to resolve problems early and by themselves as opposed to relying on further Council services. Where circumstances are acute HousingPlus officers would be equipped with making appropriate referrals to specialists, local networks and support.

- **Utilise the new OnSide Youth Zone and Integrated Youth Services to provide housing options advice**

The approval of a £6million state-of-the-art Youth Zone at Parsloes Park will offer more than 20 activities on offer every session for young people aged 8 to 19, or up to 25 for those with a disability. The aim of the Youth Zone is to raise the aspirations, enhance prospects and improve the health and wellbeing for young people in Barking and Dagenham, by providing affordable access to a wide range of programmes, services and activities including sports, arts, music, employability and mentoring. Integrated Youth Services already run a variety of activities through its three youth centres at The Vibe, Gascoigne and Sue Bramley, as well as ‘pop-up’ provision in areas of high need, such as Marks Gate. This creates an opportunity for housing advice and youth services to provide outreach support on parental ejection, rough sleeping and housing options and choice.

## 3.4 Joint commissioning of services to provide seamless housing options to all clients

- **Joint commissioning strategy for accommodation for people with supported needs**

The Council has already identified the need for a more integrated and seamless provision of housing-related support and plans to address the gaps with a set of accommodation reviews around mental health, older persons and learning disabilities in particular. A joint commissioning approach will be unveiled in 2016.

- **Create an Older Persons Housing Pathway**

The Council is currently experiencing high demand for sheltered housing with over five hundred people on the waiting list, with minimal voids and no hard to let stock. The sheltered schemes and what they offer vary greatly and this needs to be considered in light of the borough's need to create an effective and reappraised older persons housing pathway.

The Council is to commission some analysis in 2016 on how the older people's housing pathway currently works, particularly the interface between sheltered housing, extra care housing, residential care and nursing care. This analysis will consider how individuals move between different types of accommodation and whether the current system is achieving the goal of ensuring that older people can live independently and in the community for as long as possible.

- **Maximise nomination rights on housing association properties**

The Housing Advice team is dependent upon housing associations in alerting them of properties which are due for nomination by the Council, especially when they become vacant for relet. However there is no robust protocol in place or monitoring to ensure this happens effectively.

The Council is to review all previous nomination agreements and schemes to ensure that obligations are being fulfilled and that the Council receives its correct share of properties.

- **Lobby for reform of IBAA data collection to obtain data on social care placements and more information on placements in TA**

The implementation of the IBAA has allowed Barking and Dagenham to monitor the numbers and levels of placements in the locality by other boroughs however it does not currently indicate the costs that those placements can bring to wider services. For strategic planning purposes it would be useful for the host borough:

- to know more details about the placements and their needs
- the number of social care placements made which are not currently covered by the agreement

Barking and Dagenham will lobby London Councils and sub-regional neighbours in the East London Housing Partnership to make this information an integral part of the quarterly reporting.

- **Continue to work with the Landlords & Letting Agents Forum**

Continue to develop the trust and co-operation of landlords and letting agents in the borough which has been critical for the Council's introduction of mandatory licensing and overseeing the implementation of welfare reform and energy efficiency measures in the PRS.

The Council will continue to facilitate the Landlord & Letting Agents Forum as a bilateral platform for consultation and engagement over policy and operational issues. This will be complimented by working with local letting agencies in the production of quarterly surveys which act as a temperature check on rent levels, fees, level of supply and emerging trends in the PRS market.

# OBJECTIVE FOUR:
# Provide appropriate accommodation options

| Outcomes: | |
|---|---|
| **4.1** | **Creation of new affordable housing supply** |
| **4.2** | **Maximised use of own assets for temporary accommodation** |
| **4.3** | **Reconfigured portfolio of hostel accommodation** |
| **4.4** | **Professional private sector housing solutions including the potential for a local lettings agency** |
| **4.5** | **Increased housing choice for supported people** |
| **4.6** | **Reviewed accommodation needs of gypsy and traveller communities** |

## 4.1 Creation of new affordable housing supply

- **Aim to create 1,236 new homes per year to increase housing supply**

With Barking and Dagenham promoted as east London's growth opportunity, the Council is committed to housing regeneration, estate renewal and new supply to meet the population and housing challenges of the next fifteen years. The Borough has an existing requirement to provide 1,236 new homes under the Mayor's London Plan but the draft Local Plan for the area discusses the potential to deliver 2,333 and will map out its supply over the next fifteen years through a new Housing Implementation Strategy.

- **Develop new affordable housing options on key development sites through the Local Plan**

The draft Local Plan examines the challenges in delivering new supply on major sites and questions the viability of providing 40% affordable homes on each as required by the Mayor's London Plan. As part of the options appraisal the draft Local Plan is consulting on the provision of either 25% or 30% of affordable homes on key sites as better target of delivery than the London Plan offers.

The draft Local Plan targets would provide between 583-700 affordable units a year with 233-280 being shared ownership, sub-market rent or low cost homes for sale and 350-420 delivering social rents.

- **Work with Haig Housing on affordable housing options for ex-forces personnel**

Barking and Dagenham has pledged to assist the armed forces and their families adapt to a return to normal life following service in the field. The Council signed an Armed Forces Community Covenant in 2012 and prioritised those who had been in service under the new Allocations Policy in 2014.

The Council is now exploring how it can assist the strategic partner of the Help for Heroes campaign, ex-services charity Haig Housing, in delivering new supply of general needs rental accommodation in east London for returning servicemen at risk of homelessness.

## 4.2 Maximised use of own assets for temporary accommodation

- **Centralise accommodation decision-making at one point of control**

Services with clients at risk of homelessness have suffered from a significant budget squeeze and in some cases overspends due to the lack of a centrally agreed accommodation procurement strategy which would have allowed the Council as one to identify, procure and provide appropriate housing. To be cost effective, avoid duplication and streamline the provision of temporary housing solutions the Council will explore the set-up of a single point of procurement for all temporary accommodation for housing, children's services and teams dealing with NRPF clients.

- **Maximise use of own assets for alternative temporary accommodation and continue to reduce our reliance on PRS**

The borough will continue to audit its property portfolio to utilise suitable buildings for housing and temporary accommodation purposes. This could include turning vacant and redundant commercial and non-domestic assets into dwellings, utilising decommissioned premises or using regeneration schemes as short-life temporary accommodation

- **Explore the use of modular build for temporary accommodation**

Barking and Dagenham is to explore the feasibility of modular build low-cost temporary social housing, for homeless residents or other residents in urgent need, developed as an alternative to poor quality B&B and hostel accommodation. Modular build can be delivered and assembled at a low cost and much faster than traditional

new build structures and are designed to be placed on unused council land for upto 10 years.

It could be used to plug the gap between the current housing shortage and other, permanent building schemes which are in the pipeline.

## 4.3 Reconfigured portfolio of hostel accommodation

- **Review the use of hostel facilities to match them to appropriate client-based accommodation with floating hostel support staff**

Housing advice services are to review the provision of hostel support following an assessment of vulnerable placements and high risk clients with complex needs to tailor accommodation appropriately to specific cohorts.

The Council is reviewing the opportunity to utilise the smallest hostel site with a view to working in partnership with various agencies to assist those customers with high and complex needs requiring supported interventions.

- **Review of Boundary Road hostel**

As part of its reconfiguration of hostel services, the borough will test the feasibility of using the Boundary Road hostel for high-risk, complex needs clients.

## 4.4 Professional private sector housing solutions including the potential for a local lettings agency

- **Review Article 4 direction restricting Houses in Multiple Occupation (HMOs)**

The borough introduced an Article 4 Direction in 2011 withdrawing permitted development rights to convert family-sized accommodation into Houses in Multiple Occupation. HMOs are only permitted where:

-The number of houses that have been converted to flats or HMOs in any road does not exceed 10% of the total number of houses in the road

- No two adjacent properties apart from dwellings that are separated by a road should be converted.

However with the growth of the PRS sector, the private sector housing team have indentified noticeable levels of HMOs being registered for a license which do not comply with the Article 4 criteria and are potentially prevented from letting. This problem needs to be viewed in the context of fresh demand for HMO and shared facility housing for young persons, care leavers and mental health

clients to assist in the Council's duties to provide reasonable move-on accommodation.

With this housing pressure in mind the Council will review the current effectiveness of the Article 4 Direction.

- **Use of Interim Management Orders (IMOs) to improve poor quality PRS**

  As part of the mandatory licensing regime of the private rented sector, the Council will begin to issue Interim Management Orders (IMOs) to take control of the most problematic properties and HMOs and acts as temporary landlord for up to a year. The Council can remedy hazards and defects and implement a management scheme. This returns vacant dwellings back to use either as fresh housing supply or suitable managed lets which could encourage landlords to engage with the Council in future provision.

- **Encourage growth of professional private rented accommodation**

  The Reside model has already used institutional investment to provide social rented stock and already the mandatory licensing regime in Barking and Dagenham is driving up accommodation standards while taking action against disreputable landlords. However there is a threat from landlords who wish to disinvest and it is important that institutional private rented investment (IPRI) is encouraged to add a dependable supply to PRS.

  The London Plan suggests that 12% of all stock in Barking and Dagenham should be institutional private rent and the Draft Local Plan looks at developing these targets further

- **Develop a local lettings agency to reduce procurement costs of PRS and offer a management and repairs service to encourage landlords to provide suitable private lets**

The success of the Reside model in producing affordable accommodation to working families for 80% market rent has prompted the council to test the feasibility of establishing a local lettings agency. The aim is for it to procure PRS properties which could be managed by the Council and used to supply housing for households need or to discharge the homelessness duty.

The lettings market is highly competitive and PRS properties are becoming harder to procure. The Council is keen to explore ways to secure a steady stream of affordable accommodation to support its own housing needs. A feasibility study is to be completed by the end of 2015 evaluating the business case and providing insight into the viability of such a model in the current local market.

- **Utilise GLA Empty Homes funding to bring trickle supply on five year leases**

The borough has a commendable record in returning long-term private sector empty properties back into use, reducing the number from 750 in 2010 to 199 in 2015 – the lowest recorded number. The Empty Property Unit has used a mix of advice, incentive, encouragement and enforcement to persuade owners to return their vacant dwellings to occupation instead of being wasted assets causing neighbourhood blight.

One particular strand of the strategy has been to utilise empty homes grant from the Greater London Authority and encourage owners to repair their properties and rent the accommodation on a five year lease to the Council's temporary accommodation unit. Between 2012 and 2015, 43 dwellings were returned to use in this fashion using £523,000 of grant funding through the Mayor of London's Affordable Housing Programme. The borough is aiming to make a fresh bid for funding to bring upto ten more units back into use.

## 4.5 Increased housing choice for supported people

- **Develop a KeyRing scheme**

The council is exploring the KeyRing living support network model for clients who have learning disabilities. The aim of the model is to create a viable local network allowing persons with learning disabilities who live in close proximity to encourage and support each other and assist in sustaining their tenancies and independent living.

There are more than 100 networks across the UK supporting nearly 1,000 vulnerable adults and it has proven to be resourceful for clients moving onto personal budgets.

- **Explore Street Purchasing scheme for supported needs accommodation**

Street purchases can be a cost-effective way of obtaining accommodation which can be utilised for general needs or supported housing. The Council is evaluating a proposal to use a portion of the Housing Revenue Account to administer a small purchase programme of cheaper properties which could be utilised for the supported needs of single households or in some instances shared accommodation.

## 4.6 Reviewed accommodation needs of gypsy and traveller communities

- **Explore potential sites for future traveller pitches**

The Local Plan 2010/15 and the Housing Strategy 2012/17 committed the Council to safeguarding the existing Chase gypsy site and for permitting new sites subject to rigorous site-specific planning policy conditions. Need for traveller and gypsy pitches in the borough is exceptionally low and previous studies suggested the long-term need for between 2-9 extra pitches. As part of the Draft Local Plan the Council will monitor need and consider further provision where appropriate sites arise.

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# 5.Consultation Schedule

To ensure that we have the broadest and widest consultation with service users, the public and external stakeholders the Council is inviting comment and responses to the review and preventative strategy between 16 November and 16 December 2015. The draft homelessness strategy will be accessible on our website at the following address: with a final revised document expected to be approved by the Council's Cabinet in January 2016.

**Draft Schedule of Internal Consultation**

| Board/Consultation Action | Date |
|---|---|
| Draft consultation with Housing Advice | 27 October 2015 |
| Housing DMT | 06 November 2015 |
| Draft consultation with internal services | 09 November-13 November 2015 |
| Draft consultation with Cllr Ashraf | 13 November 2015 |
| Public consultation | 16 November-16 December 2015 |
| Papers/draft prepared for all boards | 27 November 2015 |
| Adult Care Services DMT | 03 December 2015 |
| Community Safety Partnership | 07 December 2015 |
| Health & Wellbeing Board | 08 December 2015 |
| Children's Services DMT | 10 December 2015 |
| Corporate Strategy Group | 26 January 2016 |
| Papers prepared for Cabinet | 18 February 2016 |
| Cabinet | 09 March 2016 |

**Draft Schedule of External Consultation**

| Board/Consultation Action | Date |
|---|---|
| Draft consultation with the public | 16 November-16 December 2015 |
| • Social media | 16 November |
| • E-newsletter | 27 November |
| Draft publication to voluntary sector groups | 16 November 2015 |
| Draft publication to registered providers | 16 November 2015 |
| Draft publication to CCG/NHS groups | 16 November 2015 |
| Strategic Volunteers Forum | 14 December 2015 |
| Voluntary sector stakeholder workshops | February 2016 |
| Draft publication to Landlords Forum | January 2016 |
| | |

# 6.Homelessness Strategy Action Plan 2016/23

## OBJECTIVE 1: Reducing demand through prevention

**Outcome 1.1: Homelessness prevented through housing support, advice and initiatives for vulnerable/at risk household**

| | Strategic Action | Lead | Resource | Timescale | Target |
|---|---|---|---|---|---|
| **1** | Maintain rent deposit/advance scheme | Housing Advice | Homeless Prevention Grant and existing resources | On-going | |
| **2** | Monitor court representation scheme | Housing Advice | Existing resources and Legal Aid/Housing Possession Court Duty Scheme | On-going | |
| **3** | Voluntary sector/PSH referral route against illegal evictions/harassment | Private Sector Housing | Existing resources | On-going, starting in Year 1 | |
| **4** | Agree RSL eviction protocol | Housing Advice | Existing resources | Year 1 | |
| **5** | Develop an Homeless Prevention Fund | Housing Advice | Homeless Prevention Grant and existing resources | On-going, starting in Year 1 | |
| **6** | Continue ‘dispelling the myth’ programme | Housing Advice | Existing resources | On-going | |
| **7** | Early rent alert scheme with children’s services | Housing Advice | Existing resources | On-going, starting in Year 1 | |

| | | | | | |
|---|---|---|---|---|---|
| **8** | Homeless Prevention Improvement Plan | Housing Advice | Existing resources | On-going, starting in Year 1 | |

**Outcome 1.2: Encouraging self-resolution of housing crises**

| | Strategic Action | Lead | Resource | Timescale | Target |
|---|---|---|---|---|---|
| **1** | Delivery of enhanced housing options tool | Housing Advice | Existing resources | End of Year 1 | |
| **2** | Continue to promote BanD Together routemaster service | Housing Advice | Existing resources | On-going | |

**Outcome 1.3: Co-ordinated multiagency interventions to assist households affected by welfare reform**

| | Strategic Action | Lead | Resource | Timescale | Target |
|---|---|---|---|---|---|
| **1** | Prepare for universal credit, second phase of welfare reform and identify those impacted | Housing Advice/Elevate | Existing resources | On-going | |

**Outcome 1.4: Increased access to employment support for families and young people**

| | Strategic Action | Lead | Resource | Timescale | Target |
|---|---|---|---|---|---|
| **1** | Improved information on skills, learning and jobs | Employability Partnership | Existing resources | On-going | |

| OBJECTIVE 2:Enabling pathways away from homelessness | | | | | |
|---|---|---|---|---|---|
| **Outcome 2.1: Re-established Homelessness Forum** | | | | | |
| | **Strategic Action** | **Lead** | **Resource** | **Timescale** | **Target** |
| **1** | Re-established independently run Homelessness Forum | Housing Strategy and Housing Advice | Existing resources | On-going, starting in Year 1 | |
| **Outcome 2.2: Successful partnership with voluntary sector and external providers supporting those suffering homelessness** | | | | | |
| **1** | Develop voluntary sector referral pathways | Housing Advice | Existing resources | End of Year 1 | |
| **2** | Develop RSL partnerships for cost effective supported accommodation | Housing Strategy | Existing resources | On-going | |
| **Outcome 2.3: Greater tenancy sustainment across all tenures** | | | | | |
| **1** | Ingrain good tenancy practices for all tenants | Housing Advice | | On-going | |
| **2** | Draft tenancy guides for PRS | Housing Advice | Existing resources | On-going, | |

| | | | | | |
|---|---|---|---|---|---|
| | | | with additional support from building society | starting in Year 1 | |
| **Outcome 2.4: More effective identification of hidden homelessness, in particular rough sleepers and LGBT persons** | | | | | |
| **1** | Early identification of LGBT homelessness risk | Housing Advice | Existing resources | On-going, starting in Year 1 | |

| | | | | | |
|---|---|---|---|---|---|
| **2** | Minimise rough sleeping through partnership interventions to ensure NSNO | Housing Advice | Existing resources | | |
| **Outcome 2.4: Utilised external partnerships to support vulnerable single persons who are homeless** | | | | | |
| **1** | Support ELHP bid for single homelessness project | Housing Strategy/ELHP | Existing resources in ELHP | Year 1 | |
| **2** | Debt management project for single homelessness | Adult Community Services (AC) | Existing resources - £60,000 from ACS | Completed by Year 1 | |

## OBJECTIVE 3:Create integrated services at first contact

**Outcome 3.1: Gold Standard accreditation for housing options service**

| | Strategic Action | Lead | Resource | Timescale | Target |
|---|---|---|---|---|---|
| **1** | Aim for Gold Standard accreditation for | Housing Advice | Existing resources | Start in | |

| | | | | | |
|---|---|---|---|---|---|
| | housing options | | | Year 1 | |
| **2** | Review housing advice structure and prevention services to ensure fit for purpose | Housing Advice | Existing resources | Year 1 | |
| **3** | Consider further invest-to-save bids | Housing Advice | Existing resources | Begin in Year 1 | |
| **Outcome 3.2: Co-ordinated 'single pathways' protocols, processes and mapping between services** | | | | | |
| **1** | Review all processes/protocols between housing, health, adult/children's services | Housing Advice | Existing resources | Year 1 | |
| **2** | Mandatory staff attendance at bi-annual conference on single pathways policy | Housing Advice | Existing resources | On-going, starting in Year 1 | |
| **3** | Consider appointment of referral link officer for all complex need cases | Housing Advice | | | |
| **4** | Reinstate homeless access to primary health care | Housing Advice | | Year 1 | |
| **5** | Further client panels mapping and consider a single assessment panel for high risk clients | Housing Advice | | Year 1 | |
| **Outcome 3.3: Development of one-stop shop approach to housing services such as HousingPlus model** | | | | | |
| **1** | Roll-out a pilot of HousingPlus approach to one-stop shop housing support and advice | Landlord Services | | Year 2 | |
| **2** | Utilise the Onside Youth Zone and Integrated Youth Services | Integrated Youth Services | Existing resources and funding from Jack Petchey Foundation and the Queen's Trust | | |
| **Outcome 3.4: Joint commissioning of services to provide seamless housing options to all clients** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **1** | Joint commissioning strategy for supported people accommodation options | Housing Strategy/AC | Existing resources | Begin in Year 1 | |
| **2** | Create an Older Persons Housing Pathway | Housing Strategy/AC | Existing resources | Begin in Year 1 | |
| **3** | Maximise nomination rights on housing association properties | Housing Strategy | Existing resources | Complete by end of Year 1 | |
| **4** | Lobby for reform of IBAA data collection to obtain data on social care placements | ELHP | Existing resources | On-going | |
| **5** | Continue to work with the landlords and letting agents forum | Private Sector Housing (PSH) | Existing resources | On-going | |



## OBJECTIVE 4:Provide appropriate accommodation options

**Outcome 4.1: Creation of new affordable housing supply**

| | Strategic Action | Lead | Resource | Timescale | Target |
|---|---|---|---|---|---|
| **1** | Aim to create 1,236 new homes per year to increase housing supply | Regeneration/Housing Strategy | | On-going | |
| **2** | Develop new affordable housing options on key development sites through the Local Plan | Planning Policy/Housing Strategy | | On-going | |
| **3** | Work with Haig Housing on affordable housing options for ex-forces personnel | Housing Strategy | Existing resources | On-going | |

| Outcome 4.2: Maximised use of own assets for temporary accommodation | | | | | |
|---|---|---|---|---|---|
| | **Strategic Action** | **Lead** | **Resource** | **Timescale** | **Target** |
| **1** | Centralise accommodation decision-making at one point of control | Housing Advice | | Year 1 | |
| **2** | Maximise use of own assets for alternative TA and continue to reduce reliance on PRS | Housing Advice | Existing resources | On-going | |
| **3** | Explore use of modular build for TA | Housing Advice | | Year 2 | |



| Outcome 4.3: Reconfigured portfolio of hostel accommodation | | | | | |
|---|---|---|---|---|---|
| | **Strategic Action** | **Lead** | **Resource** | **Timescale** | **Target** |
| **1** | Review use of hostel facilities to match them to appropriate client-based accommodation | Housing Advice | Existing resources | Year 1 | |
| **2** | Review of Boundary Road hostel | Housing Advice | Existing resources and GLA grant | Complete by Year 2 | |
| **Outcome 4.4: Professional private sector solutions including a local lettings agency** | | | | | |
| | **Strategic Action** | **Lead** | **Resource** | **Timescale** | **Target** |
| **1** | Review of Article 4 Direction on HMOs | Planning | Existing resources | Year 1 | |

| | | | | | |
|---|---|---|---|---|---|
| | | Policy/PSH | | | |
| **2** | Use of IMOs to improve poor quality PRS | PSH | | On-going | |
| **3** | Encourage growth of professional PRS | Planning Policy | Existing resources | | |
| **4** | Develop a local lettings agency | Housing Advice | | | |
| **5** | Utilise GLA empty homes funding | Housing Strategy | Existing resources and GLA grant of £300,000 | Begin in Year1 and completed by Year 3 | |

**Outcome 4.5: Increased housing choice for supported people**

| | Strategic Action | Lead | Resource | Timescale | Target |
|---|---|---|---|---|---|
| **1** | Develop Keyring scheme | AC | | | |
| **2** | Explore street purchasing scheme for supply of supported needs accommodation | Housing Strategy | £2.0m from Housing Revenue Account | | |

**Outcome 4.6: Reviewed accommodation needs of gypsy and traveller communities**

| | Strategic Action | Lead | Resource | Timescale | Target |
|---|---|---|---|---|---|
| **1** | Explore potential sites for future traveller | Planning Policy | Existing resources | Evaluated | |

| | | | | | |
|---|---|---|---|---|---|
| | pitches through the Local Plan | | and potential external funding | by Year 5 | |

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# HEALTH AND WELLBEING BOARD

## 26 January 2016

| **Title:** | Prevention Approach Update |
|---|---|

**Report of the Cabinet Member for Adult Social Care and Health**

| | |
|---|---|
| **Open Report** | **For Decision** |
| **Wards Affected: All wards** | **Key Decision: No** |
| **Report Author:**<br>Lewis Sheldrake, Prevention Manger, Integration and Commissioning | **Contact Details:**<br>Tel: 0208 724 8109<br>Email: lewis.sheldrake@lbbd.gov.uk |

**Sponsors:**

Cllr M Worby, Cabinet Member for Adult Social Care and Health, London Borough of Barking and Dagenham

Glynis Rogers, Lead Divisional Director, Adult and Community Services, London Borough of Barking and Dagenham

**Summary:**

The paper titled "***Prevention: A Local Framework for Preventing, Reducing and Delaying Care and Support Needs In Adults***" reported to the Health and Wellbeing Board on 12 May 2015. This report introduced the local Prevention Approach with an accompanying Prevention Framework which proposed a way in which the Council and its partners should respond to the statutory obligation laid out in the Care Act 2014.

This report is to update the Board on the progress of embedding the Prevention Approach locally. This includes:

- the formation of a Prevention Steering Group, with a range of partners, which works to influence and harness existing local prevention activities which prevent, reduce or delay the development of needs for social care and support.
- The alignment of policy approaches through the NHS Five Year Forward View and the Barking and Dagenham Joint Health and Wellbeing Strategy.
- A number of engagement activities have taken place across the Borough to support embedding the principle of adopting a holistic approach to wellbeing and understanding how needs may be prevented, reduced or delayed by others within the community, rather than by public sector services.

The report also recommends the following next steps:

- Develop a Prevention and Information and Advice Workshop for front line professionals across Barking and Dagenham.
- Review the Prevention Scheme within the Better Care Fund for 2016/17 to align future work to identified programme outcomes.
- Enhance understanding and support for the approach within the voluntary sector

via further engagement and mapping sessions.

- Implement the agreed 'Commissioning for Prevention' approach into existing and future contracts.

- Continue to develop the Prevention Approach to align with and support Ambition 2020 projects going forward.

**Recommendation(s)**

The Health and Wellbeing Board is recommended to note the content of this report and agree the proposed next steps

**Reason(s)**

The Prevention Approach supports the Borough's overall vision of One borough; One community; London's growth opportunity, and provides a practical framework to realise key elements of the underpinning priorities. The application of the approach makes real the priority of Enabling Social Responsibility by supporting residents to take responsibility for themselves, their homes and their community. This also contributes to ensuring there are support mechanisms to enable our residents to live more independently, whilst still offering a safety net of support for our most vulnerable.

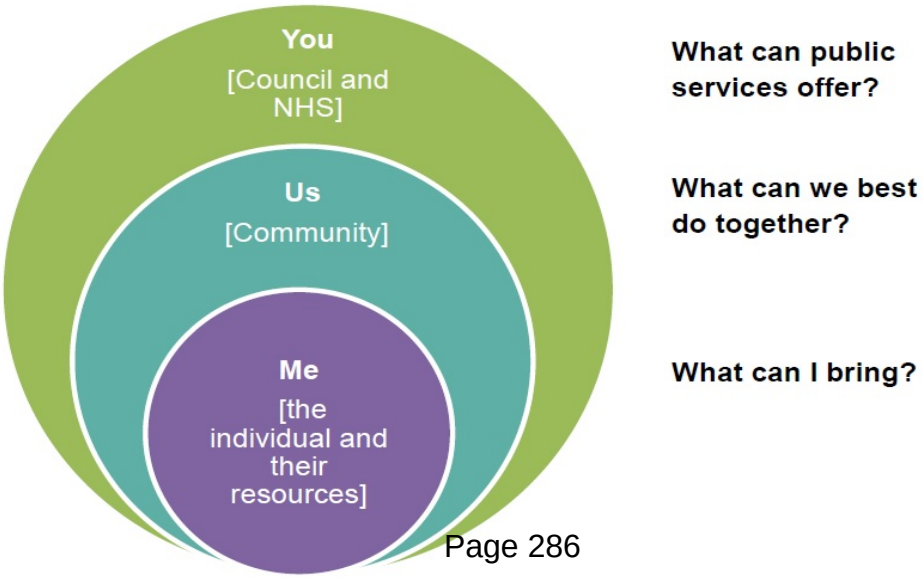
Section 2 of the Care Act 2014 requires that a local authority must provide or arrange for services, facilities or resources which would prevent, reduce or delay individuals' needs for care and support, or the needs for support to carers. Local authorities should develop a clear, local approach to prevention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

## 1. Introduction and Background

1.1 The local Prevention Framework adopted in May 2015 has three guiding principles.

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

1.3 The diagram below illustrates the approach.



1.4 **Principle 1:** Prevention starts with every individual (**Me**). The approach starts with the individual – the person who may have needs. This may include the contribution of friends and relatives who are providing care for someone with needs. The starting point is considering what the individual can do for themselves and already has to help meet their needs, and what is potentially available.

1.5 **Principle 2:** Prevention is a job for the community (**Us**). The next step is for the individual to consider what the wider community might be able to offer. Putting Me and Us together helps to create a community that underpins effective social responsibility. By bringing together civic pride, individual responsibility and local growth, neighbourhoods across the borough can recreate a sense of community wellbeing.

1.6 **Principle 3:** Prevention and the role of statutory agencies (**You**). The statutory agencies, for example, the NHS, Council, police, employment agencies, colleges and schools continue to have duties of care. However, their role may be focused on specific population groups, or on people with high levels of need. Nonetheless, the principle of prevention that can delay or reduce the impact of needs must be ever-present.

1.7 This approach is informed by and seeks to develop the Council's priority of Enabling Social Responsibility. This means that individuals, with support where necessary from communities and local networks, will be primarily responsible for making their own decisions about their own life choices and for seeking the advice and information they need to achieve the outcomes they desire.

1.8 The local Prevention Approach is aligned and contributory to outcomes and targets of the Better Care Fund as well as themes and priorities within the Joint Health and Wellbeing Strategy which was agreed by the Health and Wellbeing Board on 7 July 2015. This was reemphasised in the key recommendations of the Joint Strategic Needs Assessment 2015 which reported to the Health and Wellbeing Board on 8 September 2015.

1.9 These shared outcomes support the objective of ensuring that individuals with the highest levels of need will continue to receive support from statutory agencies such as the NHS and, for those who meet the national eligibility criteria, from the local authority, whilst seeking to prevent the need for such interventions wherever possible.

## 2. Embedding the approach

2.1 A number of initiatives have taken place across a range of partners to seek to embed the Prevention Approach within the broader context of the Council's priority of Enabling Social Responsibility.

2.2 A key first step was the widening of the existing BCF prevention group to encompass a wider range of partners and embed the Prevention Approach locally. The group is currently focused on services for adults and therefore the current membership of the Prevention Steering Group includes:

- Adult Social Care
- Clinical Commissioning Group

- Culture and Sport
- Housing
- Public Health and programme leads
- NELFT
- Pharmacies
- Commissioners
- Care City

2.3 The diversity of partners and services represented at the Prevention Steering Group highlights the breadth and significance of the prevention agenda locally. The remit of the Group is to harness existing local prevention activities across the borough, and ensure that consistent working practices are employed, which complement those of other services. This works to encourage a seamless pathway that helps to prevent, reduce or delay the development of needs for social care and support.

2.4 The role of prevention across the partners has been recognised and is increasingly referenced or driven through both policy direction and practical approaches.

2.5 The prevention approach was a significant plank in the refreshed Health and Wellbeing Strategy which was agreed by the Health and Wellbeing Board on 7 July 2015. The 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

2.6 The Prevention theme is defined in the Barking and Dagenham Joint Health and Wellbeing Strategy 2015-2018 as *"Supporting local people to make lifestyle choices at an individual level which will positively improve the quality and length of their life and overall increase the health of the population."*

2.7 The local prevention agenda is aligned with a number of national guidelines across the health and social care economy. For example, the NHS Five Year Forward View acknowledges that the future sustainability of the NHS hinges on a radical upgrade in prevention. It acknowledges that the health service can't do everything that's needed by itself, but affirms that the health service needs to be a more activist agent of health-related social change, leading where possible, or advocating when appropriate, a range of new approaches to improving health and wellbeing.

2.8 The NHS Five Year Forward View also shares the seven priorities from Public Health England's five year plan *From Evidence Into Action*: obesity; smoking, harmful drinking and alcohol-related hospital admissions; ensuring every child has

the best start in life; dementia; antimicrobial resistance; and tuberculosis. It specifically calls on the NHS to offer more proactive prevention activities through primary care. A first step will be a new national diabetes prevention programme establishing a model of care that can be expanded to other conditions and linked with the NHS Health Check.

2.9 Following the publication of NHS planning guidance in December 2015 health commissioners are required to produce a five year Sustainability and Transformation Plan (STP) to drive forward the Five Year Forward View. The planning and commissioning process will be place-based, rather than organisation based. It must also cover all areas of CCG and NHS England commissioned activity including specialised services and primary medical care. The STP must also cover integration with local authority services including prevention, reflecting local health and wellbeing strategies.

2.10 An example of a service aligned with the prevention approach is the Improving Access to Psychological Therapies (IAPT) programme which supports people suffering from mild to moderate depression and anxiety disorders. The programme offers patients a realistic and routine first-line treatment, combined where appropriate with medication which traditionally had been the only treatment available. By targeting those people within primary care, it reduces the need for dependence upon medication alone. IAPT further promotes independence by giving consideration and weighting to support people in job retention for those in work and struggling with a mental health condition, and for those seeking work with such a condition.

2.11 One of Barking and Dagenham CCG's initiatives that embeds a prevention approach is "Everyone Counts" which designs and delivers schemes of care directed at residents over the age of 75. The cohort has also been extended to also include residents over the age of 65 who have two or more long term conditions. A comprehensive assessment framework has been developed to screen a number of areas including the risk of falls. These assessments allow clinicians to discuss conditions with patients and deepen their understanding of how they can better self manage their conditions.

## 3. Engagement

3.1 A number of engagement activities have taken place across the Borough to highlight the role that various services can play in engaging with and supporting individuals and communities to take a more preventative/enabling approach. This has supported embedding the principle of adopting a holistic approach to wellbeing and understanding how needs may be prevented, reduced or delayed by others within the community, rather than by public sector services.

3.2 This principle reinforced that there is no single organisation or sector that can take sole responsibility for achieving the intended outcomes of the Prevention Approach. Rather this is a golden thread that needs a joined up response at local, regional and national levels across health, care, public health, wider local government, the community and voluntary sector, education, skills and employment support, as well as other areas.

3.3 Consistent themes and culture / process shifts which have emerged through the engagement process are as follows:

- A focus on capitalising on individuals' resources and strengths rather than needs and deficiencies

- Identifying ways of promoting independence rather than reinforcing dependence

- Enabling people to do things for themselves rather than always deferring to public sector services

- The importance for effective and appropriate signposting to other services – see Section 4 below.

3.4 The Integration and Commissioning Team supported two workshops for individuals with Learning Disabilities who had recently been impacted by a change in their circumstances due to eligibility thresholds. The Prevention Approach was used to help the individuals to consider their own strengths and resources and promote independence. The workshop simply used a weekly diary and facilitated/supported conversations between individuals and community based providers about the activities they would like to do. This workshop helped a number of individuals and their carers to look at the opportunities that were available in changing circumstances and make informed decisions about the next steps.

3.5 Engaging with social workers and other key professionals has helped to ensure that prevention is applied from the first point of contact with an individual or carer to promote strengths-based Care and Support planning. The workforce development and training programme was supplemented by giving staff 'Quickcards' to reinforce learning and prompt them on key points of policy and procedure. The Prevention Quickcard is attached at Appendix B.

3.6 The Voluntary and Community Sector are integral to the adoption of the Prevention Approach and officers have met with a number of key local providers to explore synergies between services and to identify how the approach impacts on service delivery locally.

3.7 Part of this engagement included an informal review of existing working practices in order to identify how these align with the principles of the Prevention Approach. This was generally conducted using case study examples relevant to the provider. A number of the themes highlighted at 3.3 were reflected in the work of the organisations that were engaged with. This has led to better joining up of provision and support for residents with regard to wellbeing.

## 4. The role of Information and Advice

4.1 A consistently emerging theme throughout the adoption of the Prevention Approach has been the importance of providing high quality, impartial information and advice to residents about local preventative services, resources or facilities.

4.2 From April 2015 the Care Act placed a statutory duty on councils to provide information and advice to the whole population that is both accessible and relevant. Specifically, the Care Act 2014 highlights that providing accurate and timely information and advice is *'… vital in preventing or delaying people's need for care and support.'*

4.3 Barking and Dagenham have developed the Information and Advice Plan 2015-2018 in line with the Care Act 2014. This strategy is aligned to the Community Network Strategy which builds on the 'digital by design' approach providing local access points where it is intended that residents can find a wide range of information.

4.4 Key to the provision of information and advice are the digital platforms that provide the information. There has been continued development of the Care and Support Hub as the borough's local online directory for adult social care services and wider information. In addition the development of BanD Together Routemaster provides residents and practitioners with tools that take account of multiple or complex needs and delivers relevant and accurate signposting to appropriate services including benefits, local agencies and other support organisations.

4.5 The provision of high quality reliable information and advice to residents is integral to the promotion of wellbeing, and is fundamental to enabling people and families to make well-informed choices about their own wellbeing. Building a stronger, more resilient and engaged community should also help reduce demand on Council services in the longer term enabling us to continue to support the most vulnerable.

## 5. Development of 'Commissioning for Prevention'

5.1 The local Prevention Approach is shaping the local strategy on a number of commissioning issues, including information and advice provision; carers support services, supported living, learning disability day services and an imminent review of extra care housing. The formalisation and embedding of these steps into an agreed approach is an on-going piece of work that is being shaped by the practical experience of implementing the prevention approach.

5.2 The Integration and Commissioning team has been part of the working group, reviewing a number of Public Health funded Health and Activity based projects which aim to prevent, reduce or delay health and social care needs from developing. The purpose of this piece of work is to achieve efficiencies and bring future commissioning for 2016/17 in line with local strategic objectives. The prevention approach has informed this process and promotes joint-working.

5.3 The Prevention Approach is already reflected in the Market Position statement which aims to develop a market that offers a choice of affordable, locally available responsive services that people want. The vision of the Market Position Statement is for '*people to be active citizens; able to live a meaningful life and make positive contributions to the community they are part of, whilst not losing sight of the relationships and interests that are important to them.'*

5.4 A Commissioning for Prevention learning event is being delivered on 11 January 2016 by the London Health and Care Integration Collaborative (LHCIC) and the Healthy London Partnership Prevention Programme (HLP), working closely with Public Health England. This event will support the identification of local commissioning priorities and areas for high return on investment and will be attended by the Integration and Commissioning team.

5.5 A Commissioning for Prevention Workshop is planned to take place in February 2016 within Integration and Commissioning and Public Health. The objective of the

workshop is to establish a “commissioning for prevention” methodology along with a simple process for partners to use to apply to commissioning and contracting. This will also support the revision of current contracts to emphasise the preventative approach throughout the care or service pathway. A second workshop for other services and partners will take place in March 2016.

## 6. Better Care Fund

6.1 Prevention, combined with other schemes within the Better Care Fund contributes towards helping local people to stay healthy and well for as long as possible and reducing avoidable demand for services across health and social care.

6.2 The key focus for the Prevention scheme is on falls reduction/prevention, in order to address the associated significant number of admissions to acute care, loss of independence and negative impact on long term health and disability. The Prevention Scheme has commissioned two pilot projects which seek to prevent, reduce or delay occurrences of falls:

- Barking and Dagenham Handyperson Scheme provides practical support into individuals own homes to reduce environmental hazards that may contribute to falls or ill health.

- Whole Body Therapy delivered a 12 week community based progressive evidence based falls management exercise programme. Including targeted, personalised and progressive strength and balance exercise sessions.

6.3 An evaluation of the Whole Body Therapy programme has evidenced an improvement in participants’ mobility and functional strength. Participants also said that the course had a positive impact on their confidence and wellbeing. These outcomes will help to reduce or delay health and social care needs from developing further by supporting participants to live more fulfilled and independent lives, with an improvement in performing daily living activities. A paper on this project will report to the Better Care Fund Delivery Group in February 2016 to inform future commissioning decisions.

## 7. Care City Test Bed Application

7.1 The Integration and Commissioning Team have established close links with Care City given a number of complementary work streams, including prevention. The Integration and Commissioning Team supported Care City in their bid to become a ‘test bed’ site by supporting the short listing process to identify innovators offering new concepts in health and social care. A number of these outcomes can be achieved through innovations which prevent, reduce and delay health and social care needs from developing.

7.2 NHS England has defined one of the priorities of the programme to be achieving the prevention of illness and improvement of health and wellbeing through innovations which support behaviour change as well as approaches to whole population health management. The meeting of this priority was supported by the embedding of the local Prevention Approach to ensure alignment with other local initiatives and priorities.

## 8. Visbuzz

8.1 Barking and Dagenham has recently been successful in applying to become a London Ventures Visbuzz pilot borough funded by the Capital Ambition Board of London Councils. The Borough has been awarded £41,000 for the pilot.

Visbuzz is an extremely simple way for people who do not use computers to make and receive video calls. This project is aligned with the local Prevention Approach and works to overcome the barriers which exacerbate social isolation such as family and friends not living within a manageable distance to meet in person. This project helps to empower our most vulnerable residents to maintain or re-establish their individual support networks, thus reducing demand on public services.

8.2 The Borough has 100 units for this project, which will be implemented across a number of cohorts including:

- Socially isolated older people (via Cluster Teams)
- Carers
- Long term needs – Asian Communities
- Voluntary Sector cohorts via DABD
- Sensory Impairment

## 9. Ambition 2020 and The Growth Commission

9.1 The Council and its partners face significant challenges in the next few years with the continued reduction in local government funding. This is being addressed locally through the Growth Commission and Ambition 2020.

9.2 The prevention approach is becoming a golden thread that expresses, in its widest sense, some of the future direction of travel in working with residents and partners in the borough. The adoption and implementation of the approach will present practical challenges but many of these are reflected by both the initial headlines of both the Growth Commission and Ambition 2020.

## 10. Next Steps

10.1 The proposed next steps to further embed the local Prevention Approach are as follows:

- Develop a Prevention and Information and Advice Workshop for front line professionals across Barking and Dagenham.
- Review the Prevention Scheme within the Better Care Fund for 2016/17 to align future work to identified programme outcomes
- Enhance understanding and support for the approach within the voluntary sector via further engagement and mapping sessions
- Implement the agreed ‘Commissioning for Prevention’ approach into existing and future contracts

- Continue to develop the Prevention Approach to align with and support Ambition 2020 projects going forward.

## 11. Mandatory Implications

### 11.1 Joint Strategic Needs Assessment

The implementation of the Prevention Approach will further support the priorities identified in the JSNA for our residents' health and social care.

### 11.2 Health and Wellbeing Strategy

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

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

http://moderngov.barking-dagenham.gov.uk/documents/s90333/JHWS%20Refresh%202015%20V3.pdf

### 11.3 Integration

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

### 11.4 Financial Implications - completed by Carl Tomlinson, Group Finance Manager

Activities undertaken in delivering the prevention approach are been managed within existing resources held in the Better Care fund (BCF). The allocation set aside in 2015-16 is circa £1.6m mainly funded from the Public Health grant, the Adult Social Care capital grant and the Adult Social care new burdens grant. The Council was successful in bidding to be a London Ventures Visbuzz pilot borough and has been awarded £41,000 which is also aiding the delivery of the prevention approach.

Going forward, the BCF funding arrangements would need to be reviewed and agreed for 2016-17 and any other requirements arising in future years would need to be incorporated into the Ambition 2020 agenda.

### 11.5 Legal Implications – completed by Dawn Pelle, Adult Care Lawyer

There are no legal implications for the following reasons:

- The prevention strategy is being developed with the Care Act 2014 in mind;
- Note has been taken of 2.34 of the statutory guidance;
- It notes the important of integration between statutory services, i.e. housing and health who are deemed partners;
- Recognition that the process is a holistic one and that the service user can access assistance from their network as well as statutory services.

The report goes further and sets goals specific to LBBD and what needs improving for example, the life expectancy of its residents.

## 12. Non-mandatory Implications

### 12.1 Safeguarding

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

### 12.2 Contractual Issues

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

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

### 12.3 Procurement Implications – completed by Adebimpe Winjobi, Category Manager

The Care Act 2014 requires that local authorities must provide or arrange for services, facilities or resources which would prevent, reduce or delay individuals' needs for care and support, or the needs for support to carers.

This papers sets out how the local Prevention Approach is shaping the local strategy on a number of commissioning issues, including information and advice provision; carers support services, supported living, learning disability day services and an imminent review of extra care housing.

The formalisation and embedding of these steps into an agreed approach is an on-going piece of work that is being shaped by the practical experience of implementing the prevention approach to achieve efficiencies and bring future commissioning for 2016/17 in line with local strategic objectives.

Once the commissioning plans for these services are finalised, the procurement team would support commissioners throughout the process to ensure service models are aligned to strategic aims; services are procured in full compliance with

the Council's Contract Rules and Public Contracts Regulations 2015 depending on the contract values.

Individual tenders will be designed to ensure that contracts are awarded to the bidder or bidders submitting the most economically advantageous tender(s), taking account of economy, efficiency and effectiveness.

**List of Appendices:**

**Appendix A –** Prevention Quickcard
**Appendix B –** Prevention Framework – available at http://moderngov.barking-dagenham.gov.uk/documents/s90370/Prevention%20framework%20DRAFT%20v5%20Appendix.pdf

# 3.P.c Prevention

Prevention is not a single act or activity. It has many aspects and may change or develop over time. It is closely allied to good wellbeing. It is key in ensuring the assessment is centred on the needs of the individual and is appropriate and proportionate to their circumstances. A preventative approach should be taken from the point of initial contact onwards, and at all stages throughout someone's life and circumstances. Effective and early prevention prevents, reduces and delays more complex health risks, enhances quality of life and saves time and costs in the longer term.

| Prevention has three main aims: | | |
|---|---|---|
| **Prevent** | **Reduce** | **Delay** |
| People who may have no current or specific health or care and support needs | People with an increased risk of developing needs | People with established or complex health needs |

**It's never too late for prevention and early help**

It is important at any time in the information, assessment and reviewing process:

- promoting wellbeing e.g. access to universal services
- early intervention e.g. targeted support to provide a few hours of support to a carer, or adaptations at home to reduce the likelihood of falls
- intermediate care e.g. support to regain specific skills or to improve a carer's life
- aids and adaptations for supporting independent living

**Information and advice**

Easy access to good quality information and advice at the right time and in the right place is critical in helping individuals to prevent, delay or reduce the escalation or impact of care needs.

Example: The LinkAge [www.linkagebristol.org.uk] programme brings together older people who feel socially isolated and lonely. Evaluation showed a significant improvement on a friendship scale from very low to very or highly socially connected.

# 3.P.c Prevention

Prevention is effective only when individuals (**Me**), communities (**Us**) and public services (**You**) work together.

This promotes the strengths based approach to assessing needs and supporting people.

**Prevention starts with the individual**

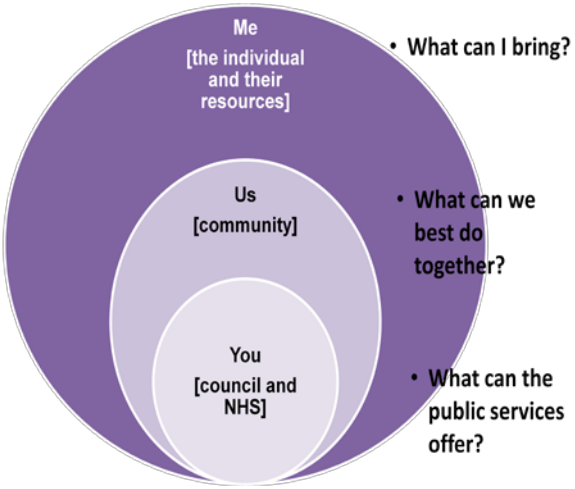
- What do they want?
- What can they bring?

**The community has a role to play**

- What is available locally, from voluntary and community organisations, or from friends and neighbours?

**Statutory services are the final link**

- If more is needed, then what can the local authority or NHS do that the individual and the community cannot provide or manage?




**Link to NHS choices website**
**www.nhs.uk**

**Further information:**
Section 2, Care Act 2014
Chapter 3, Care and Support Statutory Guidance

# HEALTH AND WELLBEING BOARD

## 08 December 2015

| | |
|---|---|
| **Title:** | **Overview of Complaint Handling** |
| **Report of the Barking and Dagenham Healthwatch** | |
| **Open Report** | **For Information** |
| **Wards Affected:** ALL | **Key Decision:** No |
| **Report Author:**<br>Marie Kearns, Contract Manager, Healthwatch Barking and Dagenham | **Contact Details:**<br>Tel: 0208 526 8200<br>E-mail: mkearns@harmonyhousedagenham.org.uk |
| **Sponsor:**<br>Frances Carroll, Chair of Healthwatch Barking and Dagenham | |
| **Summary:**<br>This report is an overview of the how complaints are managed across a variety of public agencies that serve Barking and Dagenham residents. The report considers the ways in which the expectations of complainants can be become more central to the complaints process. | |
| **Recommendation(s)**<br>The Health and Wellbeing Board is recommended to note and comment upon the recommendations of the report. | |
| **Reason(s)**<br>Healthwatch Barking and Dagenham was asked by the Public Heath Team to undertake some primary research as to how the complainants to a variety of local public services, found their experience. We were then asked to put the research into a wider context. | |

## 1 Introduction and Background

1.1 Healthwatch Barking and Dagenham was asked by the Public Health Team to undertaken primary research into the experiences of local people when they have had cause to complain about the delivery of health or social care services.

1.2 In order to put the experiences of complainants in to a fuller context Healthwatch looked at the annual complaints reports of six local organisations.

1.3 It is clear that those raising concerns view the stages of making a complaint in a different way to the organisations that are receiving and investigating the complaint. For the public services involved it is a process driven exercise, usually with three clear stages and timescales. For the complainant however, their stages are more likely to be: shall I make a complaint, how easy will they make it for me, will anyone listen and understand what I'm saying and will it make any difference to me or anyone else in the end?

1.4 This report looks at ways in which both current national and local research can help put the experiences of patients and users at the heart of complaints procedures.

## 2 Proposal and issues

2.1 This report proposes that individual agencies find ways of engaging with complainants to their services on an annual basis. Feedback from complainants should be regularly included in organisational annual complaints reports

2.2 That the annual complaints reports of agencies and organisations are clearer about what changes are to be implemented as a result of patients and users raising concerns

2.3 It will be a challenge to shift the perspective of complaints handling away from the organisational understanding of the need to measure only categories and timescales. However, if the journey of the complainant can also be captured and valued, the complaints procedure can become a more relevant and enlightening experience for all those involved in it.

**List of Appendices:**

**Appendix A** Overview of Complaints Handling

**Appendix B** Healthwatch Barking and Dagenham: *Your voice counts.*

healthwatch Barking and Dagenham

# Overview of Complaints Reporting 2014—2015

# Contents

## Introduction

Healthwatch Barking and Dagenham are the voice of local people, groups and networks. We are independent and therefore do not have a pre-set agenda or a pre-determined interest in influencing the outcome of the results of a consultation.

Copies of this report are available by contacting Healthwatch on 020 8596 8200 or by emailing **info@Healthwatchbarkinganddagenham.co.uk**

**If you would like a hard copy of this report please contact**

**Healthwatch Barking and Dagenham**

**Healthwatch Barking and Dagenham**

Overview of Complaints Reporting 2014—2015

This report has been undertaken by Healthwatch Barking and Dagenham at the request of the Public Health Department of Barking and Dagenham.

We have been asked to compare and contrast the outcomes for complainants in a variety of organisations.

In order to complete this report we have had sight of the Annual Complaints Reports from the following organisations:

- Adult Social Care, Barking and Dagenham
- Children's Services, Barking and Dagenham
- Patient Advice and Liaison Service and Complaints Service (BHURT)
- North East London NHS Foundation Trust (NELFT)
- Barking and Dagenham Clinical Commissioning Group (CCG)
- The Metropolitan Police Service

Healthwatch Barking and Dagenham have also conducted primary research amongst complainants from a variety of services, the outcomes from which are referred to in this report. The complete report is attached as an appendix to this report.

In writing this report I have referenced the work of the Complaints Programme Board that was set up in 2013 by the by the Department of Health following the inquiry into the Mid-Staffordshire NHS Foundation Trust, the Clwyd--Hart Review and the Government's response to both, *Hard Truths.*

The report of the Complaints Programme Board is titled *My expectations for raising concerns and complaints.*

## The National Context

The report produced by the Complaints Programme Board: *My expectations for raising concerns and complaints*, outlines a vision for good complaints handling across both the health and social care sectors. It was lead by the Parliamentary and Health Service Ombudsman who worked in partnership with Healthwatch England and the Local Government Ombudsman.

These national, authoritative and current research and findings could be considered as a blueprint for managing local complaints well.

The development of the vision was driven by four key principles:

- The need for a tool that will ensure that patient and service user expectations lie at the heart of any system or approach to complaint handling;

- The need to define what the outcomes of good practice should look like for patients and service users;

- The need for a complaint handling framework that is relevant and practical for providers of both health and social care;

- the need for a set of expectations of complaint handling that makes sense to patients and service users themselves, so that they can hold complaint handling services to account

Using these principles a comprehensive guide was developed showing what good outcomes for service users would look like when complaints were handled well. The path of a complainant's journey is followed through the various stages. The stages are defined by what are called "I statements". These statements and stages of the journey have been developed directly from patient and service user testimony. The experiences of the public consulted for this national research are echoed in the experiences gathered from local patients and service users.

The following sets out the user-led vision for raising complaints from the Complaints Programme Board as outlined in the *My expectations for raising concerns and complaints* report.

There are 5 steps identified in the complainants' journey: each being populated by a series of statements that patients and service users should be able to make when reflecting on their experience of making a complaint.

## 1. CONSIDERING A COMPLAINT

- I felt confident to speak up
- I knew I had the right to speak up
- I was made aware of how to complain (when I first started to receive the service)
- I understood that I could be supported to make a complaint
- I knew for certain that my care would not be compromised by making a complaint

## 2. MAKING A COMPLAINT

- I felt that making my complaint was simple
- I felt that I could have raised my concerns with any of the members of staff I dealt with
- I was offered support to help me make my complaint
- I was able to communicate my concerns in the way that I wanted
- I knew that my concerns were taken seriously the very first time I raised them
- I was able to make a complaint at a time that suited me

## 3. STAYING INFORMED

- I felt listened to and understood
- I always knew what was happening in my case
- I felt that responses were personal to me and the specific nature of my complaint
- I was offered the choice to keep my details anonymous and confidential
- I felt that the staff handling my complaint were also empowered to resolve it

## 4. RECEIVING OUTCOMES

- I felt that my complaint made a difference
- I received a resolution in a time period that was relevant to my particular case and concern
- I was told the outcome of my complaint in an appropriate manner, in an appropriate place, by an appropriate person
- I felt that the outcomes I received directly addressed my complaint(s)
- I felt that my views on the appropriate outcome had been taken into consideration

## 5. REFLECTING ON THE EXPERIENCE

- I would feel confident making a complaint in the future
- I would complain again, if I felt I needed to
- I felt that my complaint had been fairly handled
- I would happily advise and encourage others to make a complaint, if they felt they needed to
- I understand how complaints help to improve services

"This report and the vision it represents flip the perspective away from concentrating solely on the bureaucratic challenge of how to provide a complaint handling service, to focus on the real experiences of patients and service users themselves in making complaints. Placing these at the front and centre of a construction is an example of what "good" looks like"

From the concluding chapter of *My expectations for raising concerns and complaints*

## The Local Context

In preparation for this report Healthwatch Barking and Dagenham conducted its own primary research. In doing so we were assisted by the Public Health Team Barking and Dagenham, who identified 10 services who were approached to take part in the review.

Owing to data protection issues Healthwatch could not directly approach complainants to these services as we did not have their details and the services involved could not release them to us.

The original proposal was for each service area to contact complainants to their service and ask them to complete the Healthwatch survey. In all we were asked to gather feedback from 60 complainants.

In the event 6 service areas were able to make contact with their complainants on behalf of Healthwatch. The Public Health Team then sent an e-version of our questionnaire to contacts form each organisation, together with a covering letter explaining the purpose of the survey. There were 27 respondents to the Healthwatch questionnaire. This is a small number: just over a quarter of the 100 people who took part in the Healthwatch England primary research which subsequently drove the vision behind the *My expectations for raising concerns and complaints* report.

Despite our smaller numbers the findings of the Healthwatch Barking and Dagenham report do reflect many of the issues brought up in the larger report, and can be matched to the stages of the complainant's journey.

These remarks are from the summary from the Healthwatch Barking and Dagenham report: *Your voice counts* and from comments made by individual respondents. These extracts are not meant to indicate that all responses were negative but rather that this was the opinion of some people.

- From the complainants across all 6 provider services, none of them was offered any advice or information about advocacy and support services that could assist them with their complaint
  **(1.Considering a complaint: I felt confident to speak up)**

- "The staff attitude over the phone was good. I could not arrange a face to face appointment, nor could I directly get in touch with the lady I was due to meet. I left a message which was never replied to"
  **(2. Making a complaint: I felt that making my complaint was simple)**

- "The complaints team communicated with me extremely well and kept me informed of the process. The response I received was full of errors: spelling and grammar mistakes. I got the impression that the communications department did not fully understand why I was making a complaint"
  **(3.Staying informed: I felt listened to and understood)**

- When asked if they had seen or heard about anything different happening as a result of their complaint, 24 people (89%) said they were not aware of any difference their complaint had made, 3 (11%) said their complaint had made a difference.
  **(4. Receiving outcomes: I felt that my complaint made a difference)**

- Despite some disappointments with the system, 85% of participants said they would complain again. Some qualified this by saying it may only be as a way of getting their case escalated higher.
  **(5. Reflecting on the experience: I would feel confident making a complaint in the future)**

The similarity between the findings of, and comments from, both the national and our local primary research indicates that all complaints pass through the same stages as far as complainants are concerned. These are not of course the same stages as the complaints officer will be thinking about: informal resolution, stage one, stage two, stage three and the Ombudsman.

The complainant's stages are more likely to be: shall I make this complaint, how easy will they make it for me, will anyone listen and understand what I'm saying, and will it make any difference to me or anyone else in the end? Finally, when the process is over the complainant may consider if it was all worthwhile and would they ever go through it again.

Our thanks go to the local service areas that sourced the complainants who were willing to take part in our research: North East London Foundation Trust, Barking, Havering and Redbridge University Trust, Barking and Dagenham Corporate Services, Barking and Dagenham Adult Social Care, Barking and Dagenham Children's Services and the Metropolitan Police Service.

## The Content of Local Annual Complaints Reports

Healthwatch next wanted to see how the local format of complaints collation and reporting compared with the vision of the Complaints Programme Board, and their conclusion that service user expectations should lay at the heart of any system or approach to complaint handling.

To gain an understanding and see a cross section of approaches we looked at the annual complaints reports from the following service areas:

- North East London NHS Foundation Trust (NELFT) 2013-14
- Pals Advice & Liaison Service (PALS) & Complaints Annual Report 2013-14 (BHURT)
- Barking and Dagenham Adult Social Care Report 2014-15
- Barking and Dagenham Children's Services Report 2013-14
- Commissioning Complaints Report, Quarters 1,2 &3 Barking and Dagenham Clinical Commissioning Group (CCG) 2014-15
- Monthly Summary Report for Public Complaints and Conduct Matters, Metropolitan Police Service (MPS) June 2015

All of these reports have concerned themselves with gathering broadly the same kinds of information:

- The numbers of complaints made
- A comparison with the numbers made in previous years
- The nature of the complaint
- The directorate or department responsible for the service delivery
- At what stage the complaint is resolved
- Outcomes: was the complaint upheld or not
- The length of time taken to address the complaint
- The geographical location by ward where the complaint has come from (sometimes)
- The source of the complaint e.g. M.P. Local Councillor

All the above information is useful to both policy makers and providers of front line services. Analysis of these statistics however is limited and the improvements made through having this information are unclear from the reports. Many of the recommendations are really reminders for workers about what they should be doing anyway. Good examples are found in the NELFT report which details the specific changes that have resulted from patient complaints.

Most reports have a final section entitled "The year ahead", "What to expect in 2016" or "Future areas for development." Issues mentioned here are new software

packages to help monitor complaints and capture outcomes, new posters and leaflets for advertising the complaints procedure and more training for front line staff and complaints handlers. (The terms handling or managing complaints are often used as opposed to investigating complaints) Whilst all improvements are welcome and useful, some will undoubtedly be of more direct benefit to those dealing with complaints than those making them.

Compliments are mentioned in three of the reports with quotations given from complimentary letters in two of the reports. Neither of these reports quotes the remarks of complainants.

Four of the annual complaint reports have sections that refer to customer satisfaction. This had been tested by giving questionnaires to complainants after they had been through the complaint process. It is clear from the reports that it has been difficult to engage with patients and service users at this point. NELFT report 100% customer satisfaction, but do not say the number of respondents that this refers to. Most report writers talk about re-vamping this system to enable them to better engage with the views of patient and service users.

This may provide the opportunity to develop a tool that follows the patient or service user's journey through the complaints system and reflects their needs at each stage, as outlined in the vision of the *My expectations for raising concerns and complaints*

## Considerations for putting patients and service users at the heart of complaints

Along with the "I statements" that identify the complainant's journey, the *My expectations for raising complaints and concerns* report has considerations that complaint investigators might keep in mind. These are described as four "facets" of making and replying to a complaint. They are the Process, Emotion, Environment and Culture. These facets can all be fitted to the stages of the complainants' journey.

Here, the expectations of the complainant are matched to ways in which the organisations could meet those expectations.

### PROCESS

Examples of "I statements", describing the expectations of complainants include:

"I was given updates about the progress of my complaint at regular intervals" and

"I feel that staff are pro-active in dealing with my complaint and I was not asked to do more than I should"

To make these expectations happen organisations might consider:

- Do we place too much burden on a complainant to produce evidence, fill in forms or write extensive amounts of detail?
- Are we transparent about the way we are handling a specific complaint, or only about our processes in general?

### EMOTION

Examples of "I statements" here include:

"I feel that the organisation wants to make things better for me and for others, and that I can help to do that"

"I was told the outcome of my complaint in an appropriate manner, in an appropriate place, by an appropriate person"

The make these expectations real organisations might consider:

- Do our complaints processes take account of the emotional impact of the perception of something having gone wrong in service delivery? For example, the death of a patient or the mistreatment of a loved one?
- Are the tone and setting of our communications in keeping with the nature of the complaints being made?

**ENVIROMENT**

Examples of "I statements" in this category are:

"I was made aware of my right to complain when I first started using the service"

"I knew that information on the outcomes of previous complaints was easy to find"

The considerations for organisations here might include:

- Do we communicate our openness to receiving complaints from the moment we first receive a patient or service user?
- Are our complaints handling and support services highly visible? Is our complaints service easily accessible from service user waiting areas and public entrances?

**CULTURE**

Examples of "I statements" here include:

"I was able to raise my concern with a neutral third party"

"I knew for certain that my care would not be compromised by making a complaint"

"I felt that my complaint was being taken seriously"

Considerations for organisations here might include:

- Can we ensure that those who wish to make a complaint can do so privately and anonymously if they wish to do so?
- Do all our staff encourage people to complain without fear for themselves?
- Are all complaints handled equally and treated with equal respect and dignity?

The expectations raised here by complainants in both the larger national research and the local Barking and Dagenham research present a challenge to those who are managing complaints across all areas of local service delivery.

In order to develop a complaints process that patients and service users feel okay to be part of, their journey and their experiences should be at the heart of its design.

It will be a challenge to shift the perspective of complaints handling away from the bureaucracy of categories and timescales, but if it can be done it will create a more relevant and enlightening process for all who find themselves involved in the complaints system.

## Conclusion

In completing this report Healthwatch Barking and Dagenham has looked at the latest National Research through the work of the Complaints Programme Board and their report *My expectations for raising concerns and complaints*, conducted our own primary research with complainants to six local services and have taken an overview of the annual complaints reports of six local services.

In doing so we have found that the stages of the complaints procedure are thought of very differently by the complainants as opposed to the organisations receiving and investigating the complaints. For organisations it is a procedure driven activity, as reflected in the type of information gathered for annual reports. For complainants however, it is an emotional journey. A patient or service user generally has to feel offended or wronged on their own behalf , or that of a loved one, before they even consider making a complaint. The issues arise when the complainant is already in a vulnerable or traumatic situation: they are, to varying degrees, already in crisis by needing the help of public services. Where a situation is ongoing people may also be conflicted as to whether it is in their own best interests to make a complaint.

Both making a complaint and investigating a complaint can be emotionally laden and time consuming experiences. It therefore seems important that both sides should find it a satisfying process. For the service user they want their experience to be acknowledged, for it to bring about change and contribute to an overall greater good. Service providers want complaints to be positive way of identifying weaknesses in their service provision or a way of identifying pressure points due to lack of resources. Inevitably however, there are times when both parties will experience it as a confrontational process with no valuable outcomes.

Organisations, attempting to engage with complainants about their experiences have found it difficult to do.

For organisations wanting to make the complaints process a more positive experience all round, their starting point should be putting the patient and service users experience at the heart of its design.

## Recommendations

- That service providers make it a priority to engage with complainants at least once a year,

- That the views and experiences of complainants contribute to any re-design of complaints procedures.

- That organisations wishing to make their complaints procedures more user friendly follow the advice given in the report of the Complaints Programme Board *My expectations for raising concerns and complaints.*

- Organisations should consider including in their annual complaints reports more testaments from complainants as to how the process worked for them.

- Organisational annual complaints reports should be clearer about what their analysis is saying and what changes will be brought about as a result. This should be fed back to complainants who have contributed through highlighting the situation.

- Complainants should be advised of agencies or advocates who can help them with their complaint.

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# How Do Local Service Providers Handle Their Complaints?

# Contents



**Copies of this report are available by contacting Healthwatch Barking and Dagenham on 020 8596 8200 or by emailing to: Richard@Healthwatchbarkinganddagenham.co.uk**

**If you require this report in an alternative format please contact us.**

# Introduction and Background to the Survey

Healthwatch Barking and Dagenham are the voice of local people, groups and networks. We are independent and therefore do not have a pre-set agenda or a pre-determined interest in influencing the outcome of the results of consultations and surveys we undertake.

This document represents a response to a survey and is a random sample of individuals that have used local services. This has been conducted impartially - Healthwatch Barking and Dagenham have no organisational view, however seek to represent the views of people who have given their feedback.

Working together with the Public Health Team at Barking and Dagenham council, Healthwatch carried out a survey of what happens when local organisations; serving local people; handle complaints about their services from the public.

The findings from the survey will feed into a wider project; to be undertaken by the Public Health Team on behalf of Barking and Dagenham Health and Wellbeing Board.

The scope of the survey was to gather up to 10 responses from complainants that used services provided by the following local organisations:

- North East London Foundation Trust (NELFT)
- Barking, Havering and Redbridge University Trust (BHRUT)
- Barking and Dagenham Corporate Service (LBBD Corp)
- Barking and Dagenham Adult Social Care (LBBD ASC)
- Barking and Dagenham Children's Services (LBBD CS)
- Barking and Dagenham Housing Services (LBBD HS)
- Metropolitan Police (MPS)
- National Health Service England (NHSE)
- Barking and Dagenham Primary Care Services (B&D PCS)
- Barking and Dagenham Clinical Commissioning Group (NELCSU)

# Methodology

Healthwatch developed a survey questionnaire with 11 questions:-

- *To which service did you make your complaint?*
- *How long did it take to resolve your complaint from start to finish?*
- *Were you offered help or advocacy to make your complaint?*
- *If you had an advocate to assist you, did you find it useful?*
- *Was your complaint upheld; partially upheld or not upheld?*
- *What outcome did you want from the complaint?*
- *Were you satisfied with the outcome? (I.e. did you understand and agree with the reason given?)*
- *Have you seen or heard of anything different happening as a result of your complaint?*
- *Were you made aware of the next steps to take if you needed to?*
- *What was your overall experience of making a complaint? (I.e. staff attitude; how well the process was explained to you and if you were kept informed and communicated with)*
- *Would you make another complaint should the need arise again?*

For each of the participating service providers, the option was available for them to ask their complainants to complete the questionnaire using an online survey monkey or to send written responses to be posted back to Healthwatch.

The Public Health Team sent an e-version of the questionnaire to contacts within each organisation, with a covering letter, that explained the purpose of the survey. Each organisation was asked to encourage their most recent complainants to respond to the survey.

Data protection and current information sharing policies prohibited Healthwatch from having access to any personal customer information in relation to this survey.

## Summary of Findings

- A disappointing small number of people replied to the survey. The project would have benefitted from having more time to run. The key findings however, are still interesting.

- Of the outcomes for complaints – 24 (89%) said they were not satisfied, as they did not understand or agree with the reason(s) given for the decision – 3 (11%) said that they were satisfied.

- When asked if they had seen or heard about anything different happening as a result of their complaint – 24 (89%) said they were not aware of any difference their complaint had made – 3 (11%) said their complaint had made a difference.

- For the time it took for complaints to be investigated – 3 (11%) said it took up to 4 weeks; 11 (42%) 1 to 3 months; 4 (15%) said it took 4 to 6 months and 1 (3%) said it took 18 months.

- Despite some disappointments with the system, 85% of participants said they would complain again, even if only to get their case escalated higher.

Of the 10 local service provider organisations requested to participate in the survey, the following is a breakdown of the responses.

| Organisation | Number of Complainant Responses | Feedback |
|---|---|---|
| NELFT | 1 | |
| BHRUT | 13 | |
| LBBD Corp | 1 | |
| LBBD ASC | 4 | |
| LBBD CS | 5 | |
| LBBD HS | 0 | |
| MPS | 0 | Advised they would not participate |
| NHSE | 0 | Advised they would not participate |
| B&D PCS | 3 | |
| B&D CCG (NELSCU) | 0 | Advised they were unable to participate due to time constraints |

The operating policies concerning the sharing of sensitive and personal data was deemed to be a barrier for the Metropolitan Police Service (MPS) to ask their complainants to participate in the survey.

National Health Service England (NHSE) declined to take part in the survey, citing that there is an imminent national survey

they are undertaking which has the potential to overlap with this work. In addition, when complainants contact them, they provide details that they are unable to pass onto others without the informed consent of that individual. It has since emerged that NHSE are to consider ways, via their patient experience lead, how to request consent from patients to facilitate sharing information to understand and improve services.

The CCG Commissioning Unit (NELSCU) expressed their interest in wanting to participate – however due to staff absence, they were not able to put arrangements in place to meet the timescale for returns.

In total there were **27 responses** received from **6 organisations**.

| | |
|---|---|
| **BHRUT** | 13 (48%) |
| **LBBD CS** | 5 (18%) |
| **LBBD ASC** | 4 (15%) |
| **B&D PCS** | 3 (11%) |
| **LBBD Corporate** | 1 (4%) |
| **NELFT** | 1 (4%) |

- From the complainants across all 6 providers, none of them was offered any advice or information about advocacy and support services that could assist them with their complaint.

- Of the outcomes for complaints – 24 (89%) said they were not satisfied, as they did not understand or agree with the reason given for the decision – 3 (11%) said that they were satisfied.

- Of the outcomes, 4 (15%) complaints were upheld; 10 (37%) were partially upheld and 8 (30%) were not upheld. Of the remaining cases, 5 (18%) were not resolved or ongoing.

| | Upheld | Partially Upheld | Not Upheld | Unresolved |
|---|---|---|---|---|
| LBBD Corp | | 1 (100%) | | |
| LBBD CS | 1 (20%) | 3 (60%) | 1 (20%) | |
| LBBD ASC | | 1 (25%) | 3 (75%) | |
| BHRUT | 3 (23%) | 3 (23%) | 4 (31%) | 3 (23%) |
| B&D PCS | | 2 (67%) | | 1 (33%) |
| NELFT | | | | 1 (100%) |

- When asked if they had seen or heard about anything different happening as a result of their complaint – 24 (89%) said they were not aware of any difference their complaint had made – 3 (11%) said their complaint had made a difference.

- If they needed to – 12 (44%) of complainants said they were made aware of the next steps they could take to escalate their complaint – 15 (56%) said they were not made aware.

- For the time it took for their complaints to be investigated – 3 (11%) said it took up to 4 weeks; 11 (42%) 1 to 3 months; 4 (15%) said it took 4 to 6 months and 1 (3%) said it took 18 months.

- Of the other responses, 7 (26%) were not resolved and 1 (3%) was not pursued.

| | Up to 4 weeks | 1-3 Months | 4-6 Months | Over 6 Months | Unresolved or Not Pursued |
|---|---|---|---|---|---|
| **LBBD Corp** | 1 (100%) | | | | |
| **LBBD CS** | 1 (20%) | 2 (40%) | 1 (20%) | | 1 (20%) |
| **LBBD ASC** | | 1 (25%) | | 1 (25%) | 2 (50%) |
| **BHRUT** | 1 (8%) | 7 (53%) | 1 (8%) | 1 (8%) | 3 (23%) |
| **B&D PCS** | | | 2 (67%) | | 1 (33%) |
| **NELFT** | | | | | 1 (100%) |

- Asked if they would make a complaint again, 23 (85%) said they would and 4 (15%) said they would not. Of the participants that said they would not complain again, none gave a reason. Of those that said they would, 3 people indicated that it was a way to escalate their complaint to get an independent decision.

## Conclusions

A greater number of responses from local people would be a better representation of the issues they are faced with when making complaints about local services.

There are clear differences between the way each service provider handle their complaints.

In undertaking this survey, we recognised that bringing together the complaints handling processes of each service in a meaningful way, are complex and wrapped up in organisations' protocols and practices. It has emerged that there are barriers to encouraging complaints sharing information for some of these services. For the purpose of this survey, some providers actively sought responses and have developed their practices from the beginning, to include public involvement and feedback about their experience of using the service.

Not all complaints were made by individuals; an example was raised by a representative from an external business.

From the responses, there is a clear indication that none of the provider organisations provide information to complainants about local services that can assist and support them with help to make a complaint.

The majority of complainants did not understand the reason for the decision about their complaint; whether it was the use of language on official letters or confusion about facts put forward concerning their complaint.

It has emerged that the majority of complaints are not followed up and communication about any changes the provider might have put in place as a consequence of it wasn't fed back to complainants.

Of the total number of responses, the majority of complaints were concluded within 1 to 3 months. It is not clear to Healthwatch what each provider's policy is for responding to complaints about their service and the standards they set for handling them.

There were a number of complaints that remain unresolved and in one example, the participant did not pursue their complaint any further; citing frustration about being made to feel their complaint was irrelevant and that it had been trivialised to a point that they were treated like a pest.

Most participants said they would make a complaint again if they needed to, with some recognising that they needed to complain to the provider organisations first before escalating it further; for example to an Ombudsman.

## Recommendations

- That all services who are asked to take part in a similar exercise in the future, are advised now to include some policy provision for data sharing within their complaints procedures.

- That complainant is informed of any subsequent changes in service delivery as a result of their complaint.

- That all complaints are answered in plain English, allowing the complainant to clearly understand what the outcome is and the reasoning behind it.

- That the local NHS, local Authority and others wishing to be part of any exercise such as this in the future, refer to the contents of this document.
  Source Document: *'My Expectations for Raising Concerns and Complaints'* – November 2014
  http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/vision_report_0.pdf

## Comments and Feedback about Making Complaints

### Participants were asked what outcomes they wanted from making their complaint – these were their responses:-

- *"A full explanation and apology to acknowledge the errors made."*
- *"An answer why it took 5 different visits to get 1 assessment done by an OT."*
- *"I wanted them to acknowledge that what I was told about my OT assessment wasn't true and why they have since denied their response to me about my complaint."*
- *"For people to learn not to bring down one care agency for the benefit of another to provide the services. Felt they were bias."*
- *"I wanted the needs of my child to be considered in the decisions made by the Social Worker."*
- *"What the department was going to do to make sure that the social worker responded to telephone calls or e-mails."*
- *"For social workers to be made accountable for their actions."*
- *"To amend false information."*
- *"Better overall training on 'before and after care' of patients."*
- *"For them to say sorry."*

- *“Why no one did anything about my dad’s shortness of breath that resulted in an embolism that killed him the next morning at home.”*

- *“Satisfaction and reassurance.”*

- *“Payment and a letter of apology.”*

- *“To accept responsibility for their incompetence and negligence.”*

- *“I would like to see the law working better after making this complaint.”*

- *“I want to know who sent my son home from hospital with no Warfarin.”*

- *“I expected some kind of apology from the Consultant.”*

- *“An explanation for the consultants conduct concerning statements he made; I want a sincere apology.”*

- *“The doctor got a slap on the wrist and I got a sorry.”*

- *“I want the surgery to get their appointments service working properly so that it is not constantly engaged ALL DAY!!”*

- *“I never want another patient to go through what my neighbour did with this GP. I wanted the GP to be held accountable for the terrible service he gave this man at the end of his life.”*

- *“I wanted the service to improve so no one else would get angry or stressed because they couldn’t get an appointment.”*

**People participating were asked for their overall view and experience of making their complaint - how well informed and communicated with they felt? How well the process was explained and the attitude of the staff?**

**Their feedback was as follows:-**

- *"The complaints team communicated with me extremely well and kept me informed of the process. The response I received was full of errors; spelling and grammar mistakes. I got the impression that the communications department did not fully understand why I was making a complaint."*

- *"It was mediocre - they talk a lot and manage to say nothing. Nothing was explained about each visitor's capacity to make a decision and which part of the assessment they were responsible for."*

- *"The commissioning team kept in communication. Since the response from the council initially, I have not heard anything more from them."*

- *"It proves to me these people think they are untouchable and not accountable."*

- *"The Complaints Officer at the Town Hall was very polite and helpful."*

- *"If I am an adult and being ignored then what hope does the children under this service have? Children's' social services for Barking and Dagenham need a good looking into."*

- *“It seems making a complaint gains nothing, even if the concerns are upheld. The situation has reverted back to the reason why the complaint was made in the first place! The social worker is still not responding to e-mails.”*

- *“The staff attitude over the phone was good. I could not arrange a face to face appointment, nor could I get directly in touch with the lady I was due to meet. I left a message which was never replied to.”*

- *“Making the complaint and getting a response was OK - up until the complaint, I felt I was being lied to.”*

- *“As a result of my complaint, there has been a change in direction and it made somebody listen to you.”*

- *“POINTLESS! Medical records were completed months after the incident. Cover up!”*

- *“Not being kept informed, having to constantly remind them at the complaints department that I was still awaiting payment.”*

- *“Took longer to respond than I was told to expect.”*

- *“The complaint was not handled very well. I had to stop the complaints process because I was discouraged and made to feel like a pest.”*

- *“Poor - the officer I saw in the first instance was excellent, but the investigation did not address all the issues I raised. The points about the consultants conduct were swept under the carpet. I was communicated with to an extent.”*

- *“I had to keep going back to the complaints team before they took it seriously.”*

- *“The staff attitude i.e. the reception staff was brilliant. The whole complaint process I feel has just been ignored - nobody has bothered to get back to me.”*

- *“It was not good, but from what I have experienced recently, there seems to be an improvement.”*

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# HEALTH AND WELLBEING BOARD

## 26 January 2016

| **Title:** | **Devolution through an Accountable Care Organisation in Barking & Dagenham, Havering, and Redbridge** |
|---|---|
| **Report of the Cabinet Member for Adult Social Care and Health** | |
| **Open Report** | **For Information** |
| **Wards Affected: ALL** | **Key Decision: NO** |
| **Report Author:**<br>Mark Tyson, Group Manager, Integration & Commissioning | **Contact Details:**<br>Tel: 020 8227 2875<br>E-mail: mark.tyson@lbbd.gov.uk |

**Sponsor:**

Anne Bristow, Strategic Director, Integration & Service Development, and Deputy Chief Executive

**Summary:**

Further to previous updates, this report summarises the current position with respect to the development of the business case to determine whether or not an Accountable Care Organisation is a viable form for future integrated health and social care delivery across Barking & Dagenham, Havering & Redbridge. This follows the announcement by the Chancellor on 15 December of a devolution pilot for Barking & Dagenham, Havering and Redbridge for health and social care.

The update is provided for Board members' information and comment, and in particular to introduce the governance arrangements that will oversee the development of the business case.

**Recommendation(s)**

Members of the Health and Wellbeing Board are recommended to note the update provided with this report, and to provide comments on the proposed approach to governance.

**Reason(s):**

The approach to devolution through an Accountable Care Organisation would be a very significant change to how health and social care services are planned and delivered across Barking &Dagenham, Havering and Redbridge. The development of the business case on which these decisions can be made is a substantial programme, and through this and the planned on-going reporting to the Board, Board members are invited to contribute to shaping the developing business case.

## 1. Background

1.1 On 15 December 2015, London Health and Care Collaboration Agreement was published by the London Partners (London's 32 Clinical Commissioning Groups, all 33 LA members of London Councils, the Greater London Authority, NHS England London Region and Public Health England London Region). It set out the overall commitment of the Partners to the transformation of health and social care through integration and devolution. Alongside it, five pilot projects were announced, one of which was for "*Barking & Dagenham, Havering and Redbridge [to] run a pilot to develop an Accountable Care Organisation, where primary and secondary care are more closely integrated and patient pathways are redesigned with a focus on intervening early and managing the chronically ill.*"

1.2 The announcement follows the submission of a bid to NHS England London Region for the support to develop a business case, focused on whether the model of an Accountable Care Organisation could deliver the next stage of integrated service delivery across the three boroughs, with the aim of delivering the improvements that are needed in the health of the population, the quality of care they receive, and the efficiency with which it is delivered.

1.3 Accountable Care Organisations are forms of joint health and social care delivery that emerged in the United States in response to the need to improve preventive care, and reduce the costs associated with poorly planned care. They were referenced in the *NHS 5-Year Forward View* as one of the possible mechanisms for improving joint working across health and social care. In essence, they involve groups of providers taking responsibility for all healthcare for a defined population, under agreements with a commissioner about the sharing of financial risk. In the UK context, it is expected that there will be a softening of the commissioner/provider split at a local level, as the new organisation takes on a shared responsibility for population-level health outcomes. It is intended that the health of population, as well as the services that are provided for it, are improved through fully integrated service delivery and an ability to ensure that greater levels of preventive activity are better targeted, both of which should release savings and efficiencies.

1.4 The exact details of how the organisation would be structured, the services that would be in scope, and the financial commitment and risk involved are all to be determined through the process of developing the business case. It is to be stressed that, at this stage, there is no decision on whether to proceed with an Accountable Care Organisation. All participating organisations will take a decision on whether to proceed, through their established governance processes, based on the business case that is developed by summer 2016.

## 2. General Approach to Developing the Business Case

2.1 Work on the business case, and the bid to NHS England, is being managed through the Integrated Care Coalition. The Coalition was formed in 2011 as a vehicle for bringing the three local authorities and three CCGs together with healthcare provider organisations, to jointly manage the transformation of health and social care services across Barking & Dagenham, Havering and Redbridge. It oversees a

range of key transformation programmes, including the Urgent & Emergency Care Vanguard Programme and improvements to primary care and planned care.

2.2 The focus of the business case development is therefore on whether the model of an Accountable Care Organisation can provide the right mechanism to help the partners of the Integrated Care Coalition to deliver the vision that they are already shaping for the future of health and social care services.

**Governance for the development of the ACO business case**

2.3 A formal governance structure has been developed which puts statutory decision makers at the forefront through the Democratic and Clinical Oversight Group (proposed membership is set out in the Governance Structure attached). Clinicians/ professionals will lead the design through the Clinical Leadership and Strategic Planning Group which will be comprised of clinicians and professionals from across health and social care in BHR. The public, clinicians and professionals will be engaged throughout the process to enable co-design of the emerging proposed model.

2.4 Beneath this will set the Accountable Care Organisation Executive Group into which the ACO programme team will report. The Senior Responsible Officers for the programme are Conor Burke, Accountable Officer for BHR CCGs, and Cheryl Coppell, Chief Executive of London Borough of Havering, and they jointly chair the ACO Executive Group. The programme's governance structure is attached at Appendix 1.

2.5 The Clinical & Democratic Oversight Group is to be comprised of Elected Members from the three local authorities and non-executives and senior clinicians from across the health system. This membership (as proposed) is included at Appendix 1. However, the first meeting of this group is currently being arranged in late January, and details of how it intends to operate will be shaped by the members through that first meeting.

2.6 Specifically for Barking & Dagenham, the representatives on these groups are:

- **Clinical & Democratic Oversight Group:**
  Cllr Darren Rodwell, Leader of the Council;
  Cllr Maureen Worby, Cabinet Member for Health & Adult Services, and Chair of the Health & Wellbeing Board
  Dr Waseem Mohi, Chair, Barking and Dagenham CCG
- **ACO Executive Group:**
  Anne Bristow, Deputy Chief Executive and Strategic Director of Service Development & Integration
- **ACO Steering Group:**
  Mark Tyson, Group Manager, Integration & Commissioning, and Deputy Programme Director for the ACO Programme

2.7 The Accountable Care Organisation Executive Group have developed a set of guiding principles for the programme. They are that the development of the ACO business case:

- Will be led by clinicians and professional groups;
- Will be owned by decision-making statutory bodies;
- Recognises that a radically new and innovative approach and commitment to working in different ways is required;
- Will include extensive engagement with staff, clinicians/professional groups and the public to shape proposals going forward;
- Will embed and adopt best academic practice;
- Has already brought together stakeholders form across Barking & Dagenham, Havering and Redbridge to shape the initial expression of interest and develop the business case; and
- Will learn from national and international best practice examples and guidance.

**Programme Management Office**

2.8 To undertake the work on the business case, a programme management office has been formed, led by Jane Gateley, Director of Strategic Planning for BHR CCGs, as Programme Director. All participating organisations are committing staff resources into the PMO, having committed to an equivalent of £100,000 per organisation to match a bid to NHS England for the additional resources needed to support the development of the bid. At the time of drafting this report, the detail of this bid is still subject to discussion with NHS England, but £750,000 of investment has been requested for the commissioning of external advice and support for the development of the business case, including a significant level of engagement with the public, staff and other stakeholders.

**Programme structure**

2.9 A programme structure is in the process of being developed, currently including workstreams around design of the model; communications and engagement; regulation; governance; financial modelling; estates; and workforce. Leads are being established, as well as contributors to the workstreams from across the participating organisations.

2.10 The programme is receiving substantial support from UCL Partners, the academic health sciences network which covers this area. They are providing policy and technical expertise, and playing a lead role in some areas, including discussions with regulators about the impact of the ACO development on the regulatory regime for health and social care.

## 3. Communications and Engagement

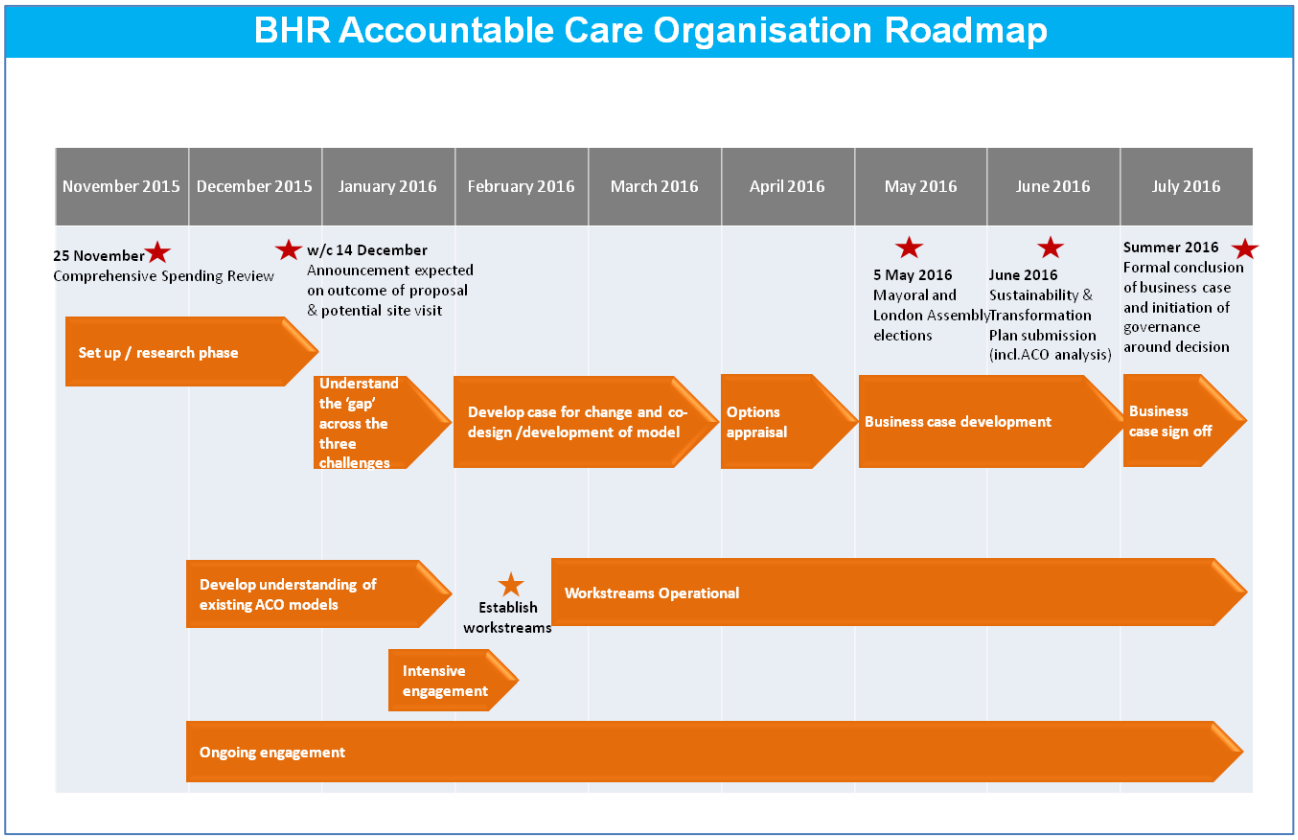
3.1 It is vitally important that the business case is informed by the views of the users and staff of local health and social care services. The programme therefore

includes substantial plans for engagement activities, commencing in January 2016. A baseline survey of service user and staff experience is planned, and officers from across the participating organisations are being invited to help shape the approach.

3.2 In order to ensure consistency in communications about the ACO business case development, both publicly and within organisations, a network of communications officers has been formed, co-ordinated by the Associate Director of Communications for NELFT.

## 4. Timeline and links to other programmes

4.1 An overview of the timeline for developing the business case is set out below, and further detail has been set out in programme documentation that has been reviewed by the ACO Executive Group.




4.2 It is recognised that the development of the business case will need to take account of a number of related programmes and begin to reflect their established ambitions. These include:

- The Urgent & Emergency Care Vanguard;
- Primary care transformation;
- Mental health service transformation and strategy;
- Work on prevention;
- Programmes designed to redesign and improve planned/integrated care, including those in the three boroughs' Better Care Fund programmes and

work to develop the various forms of integrated locality working across the three boroughs;
- Wider service transformation programmes such as through Ambition 2020, across adults' and children's social care in particular.

4.3 In the event that the business case does not evidence that the ACO model is a viable proposition for future devolution and integration of services, it is expected that the coming months will contribute strongly to future service planning across the three boroughs. This is consistent with the emphasis in the ACO programme being on testing whether this is a vehicle for delivering the combined ambition already scoped by the Integrated Care Coalition and its partners.

## 5. Next steps

5.1 The immediate priorities for the programme in the coming weeks are:

- To establish the Clinical and Democratic Oversight arrangements and to ensure that they have the support and buy-in of the clinicians and Elected Members;
- To commission and conduct the baseline survey of service user and staff experience and to understand perceptions of the opportunity for an ACO to improve population health and the delivery of care;
- To establish the programme workstreams and to clarify leads and participants from across the organisations;
- To develop a clear model for how the Accountable Care Organisation development relates to other transformation programmes in health and social care, for circulation to stakeholders.

# HEALTH AND WELLBEING BOARD

## 26 January 2016

| **Title: Agreement between the London Borough of Barking & Dagenham and North East London NHS Foundation Trust under Section 75 of the National Health Service Act 2006 for the provision of integrated mental health services** | |
|---|---|
| **Report of the Strategic Director for Service Development and Integration** | |
| **Open Report** | **For Decision** |
| **Wards Affected: ALL** | **Key Decision: YES** |
| **Report Author:**<br>Louise Hider, Principal Commissioning Manager | **Contact Details:**<br>Tel: 020 8227 2861<br>Email: louise.hider@lbbd.gov.uk |
| **Sponsor:**<br>Anne Bristow, Strategic Director for Service Development and Integration (LBBD)<br>Jacqui Van Rossum, Executive Director - Integrated Care (London) and Corporate Communications (NELFT) | |

**Summary:**

Section 75 of the NHS Act 2006 provides the framework within which the Council and health bodies can arrange to pool resources and delegate certain health-related functions to the other partner if it would lead to an improvement in the way those functions are exercised. This includes the integrated provision of services across health and social care.

Integrated mental health services are currently provided by North East London NHS Foundation Trust (NELFT) governed by a Section 75 partnership agreement. This was originally established in October 2011 and then updated with a further extension in April 2014, which was agreed by the Health and Wellbeing Board in March 2014. The extension in April 2014 was for one year (to 31 March 2015), with the option to extend for a further year from 1 April 2015 to 31 March 2016. This extension was enacted by the Section 75 Executive Steering Group.

Due to the fact that the 2014 agreement only had the provision for a one year extension, it is necessary to agree a new Section 75 arrangement between the local authority and NELFT. It is proposed that the Section 75 arrangement is put in place for one year to enable the local authority and NELFT to jointly approach the re-thinking of the future of the integrated service, particularly alongside the development of the Mental Health Strategy which is currently being undertaken by the Mental Health Sub-Group. The agreement will take a similar form to the 2014 version, with updates appropriate for the

2016/17 financial year.

The agreement affects the employment of 25 FTE members of the Council's staff, who will work under a secondment arrangement to NELFT, and pooled funding arrangements for both organisations; pooled funding currently totals £10.918m for 2016/17.

This report sets out the background to the agreement, and provides an overview of its terms.

**Recommendation(s)**

The Health and Wellbeing Board is recommended to:

- Approve the renewal of the partnership arrangement between the Council and NELFT in accordance with Section 75 of the NHS Act 2006, for a period of one year from April 2016, as detailed in this report;
- Delegate authority to the Strategic Director of Service Development and Integration in consultation with the Director of Law and Governance and the Strategic Director of Finance and Investment, on the Council's behalf, to conclude the negotiation and execute the Section 75 agreement, in consultation with the Cabinet Member for Adult Social Care and Health as necessary.
- Note that NELFT are making equivalent arrangements to ensure authorisation of the agreement through their own governance mechanisms.

**Reason(s)**

Integrated service delivery is a national policy direction and works to ensure the improved delivery of services with greater efficiency. Effective provision of secondary mental health services is a critical component in delivering priorities within the Health & Wellbeing Strategy and in particular works to deliver the third of the Strategy's outcomes:

- To improve health and social care outcomes through integrated services.

An integrated service also works to deliver the Council's vision of 'One Borough; One Community; London's Growth Opportunity', particularly the priority of 'enabling social responsibility'. In particular an integrated service helps to:

- Support residents with mental health needs to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults with mental health needs healthy and safe
- Ensure everyone can access good quality healthcare when they need it, which addresses both mental and physical health needs.

## 1. Background and Introduction

1.1 Powers to enable health and local authority partners to work together more effectively came into force on 1 April 2000. These were outlined in Section 31 of the 1999 Health Act, which has since been repealed and replaced, for England, by Section 75 of the National Health Service Act 2006.

1.2 A Section 75 is a partnership agreement of equal control whereby one partner can act as a "host" to manage the delegated functions, including statutory functions of both partners who remain equally responsible and accountable for those functions being carried out in a suitable manner.

1.3 The Section 75 agreement proposed for the delivery of integrated mental health services sets out a partnership agreement between the Council and North East London NHS Foundation Trust (NELFT), demonstrating how both organisations are contributing to the delivery of mental health services in the borough. Partners have agreed on the pooled funds option to deliver this partnership arrangement.

### Context

1.4 The continued operation and development of integrated mental health services across health and social care remains central to the borough's overall strategy for the improvement of services and support to those with mental health problems. In February 2014, the Government published *Closing the Gap*, containing 25 recommendations designed to achieve 'parity of esteem' between mental health services and services designed to improve physical health. Integrated services have also continued to be championed in 2015 through Simon Steven's *Five Year Forward View* and NHS England's *New Models of Care*.

1.5 However, over the last 12 months there have been substantial changes in the way that we run services with health colleagues and we now need to look at whether our mental health services are integrated in the right way. We have started these discussions through the Summer and Autumn 2015 workshops which focused on the future of mental health services and this will be continued by the working up of the Mental Health Strategy through the Mental Health sub-group. The arrangement of a further year of the Section 75 arrangement for the integrated service between the local authority and NELFT will enable both partners to work together to jointly plan for the future of integrated mental health services in Barking and Dagenham.

### Development of the Revised Agreement

1.6 In approaching the refresh of the Section 75 agreement, members of the Mental Health Executive Steering Group agreed that the existing Section 75 agreement (agreed in 2014) would be a sufficient basis for the new agreement for 2016/17. Members of the Executive Steering Group ensured that the schedules were updated for the 2016/17 financial year, particularly ensuring that the budget and the staffing structure were updated from 2014, and also ensured that the agreement made reference to legislative changes, particularly the Care Act 2014.

## 2. Terms of the Proposed Agreement

### Scope of Services

2.1 NELFT currently provide health care services which include community-based family health services and a broad range of specialist mental health services to people living in Barking & Dagenham. These include:

- Mental Health Initial Contact Assessment Service
- Barking and Dagenham Community Recovery Teams (CRT)
- Barking and Dagenham Crisis Resolution and Home Treatment Team
- Barking and Dagenham Assertive Outreach and Intensive Case Management
- Improving Access to Psychological Therapies (IAPT) service
- Older People's Mental Health Team
- Barking and Dagenham Psychology Service

2.2 A fuller description of the scope of services can be found in the 2014 Health and Wellbeing Board report: http://moderngov.barking-dagenham.gov.uk/documents/g7091/Public%20reports%20pack%20Tuesday%2025-Mar-2014%2018.00%20Health%20and%20Wellbeing%20Board.pdf?T=10

### Outcomes and Performance Management

2.3 The Council has refreshed the existing Section 75 to further strengthen the focus on the Adult Social Care Outcomes Framework and in particular, the data and reporting requirements are more fully aligned to the new statutory annual returns which came into effect in 2014/15.

2.4 A matter of on-going discussion has been to ensure that an appropriate level of recording is taking place on the Council's SWIFT system so that data is available for the Council to undertake core analysis alongside other social care datasets and is Care Act compliant. It is also essential that the Council are able to access basic case information for the management of complaints. The agreement is clearer on the requirements about staff access to IT systems to ensure that work activity is captured according to the Council's social work requirements

2.5 There is an on-going need to improve the recording of safeguarding information around mental health service users, and the schedules set out the minimum requirements, in line with the national focus on investigations (rather than alerts) going forward.

2.6 Outcomes and performance measures are discussed at each of the Executive Steering Group meetings.

**Staffing**

2.7 In terms of the Council's contribution, this includes 25 FTE members of staff who are currently employed by LBBD. The existing Section 75 Agreement had already formalised these arrangements through a secondment of the staff to NELFT. The staff members remain as LBBD employees with no changes to their terms and conditions.

2.8 Discussions on performance against the existing agreement have also highlighted that it is necessary to strengthen the support for seconded staff to ensure that they can maintain their social work professional discipline. Over the course of the current agreement, NELFT and the Council have worked together to strengthen social work leadership, and facilitate better information flows between the staff and the Council.

**Finance**

2.9 The provisional total of the pooled fund for 2016/17 is £10.918m.This includes funding contributions of:

| **Organisation** | **Contribution to Pooled Fund** |
|---|---|
| North East London NHS Foundation Trust | £7.492m |
| London Borough of Barking and Dagenham | £3.426m |
| | **£10.918m** |

2.10 Over the past two years, discussions between the Council and NELFT have focused on an increasing overspend in the placement budgets for mental health residential care. For the financial year of 2015/16, the Council's element of mental health budgets contributed to the pooled fund is currently forecast to overspend by £267k.

2.11 Although the budget is overspent, this is a decreasing picture and NELFT have worked in partnership with the local authority to reduce the budget pressure. Work that has contributed to this has included:

- A policy in which a residential placement can only be made if two discharges have been undertaken. This policy has led to some delayed transfers of care but has been an essential intervention to manage the pressures of the Council's budget. From December 2015, this policy has changed to two residential placements being made for every three discharges.
- A dedicated team have undertaken reviews of all service users in placements and assurance has been given that all service users are in a placement which is appropriate to their needs or have move-on plans in place ready to step-down their support when an appropriate placement is procured.
- Improvements in brokerage and financial tracking systems.

**Duration**

2.12 As noted above, the Section 75 agreement will be entered into for a period of one year in order that both partners can jointly approach the re-thinking of the future of

the integrated mental health service in the context of both the current approach to integrated services across health and social care, and the developing mental health strategy.

**Governance**

2.13 A Section 75 Executive Steering Group is established with senior officer representation from both organisations to monitor arrangements relating to the agreement. This arrangement will continue, with the Executive Steering Group meeting on a monthly basis.

2.14 In terms of formalising the agreement, this report is inviting the Board to authorise signature on behalf of the Council. NELFT are making their own arrangements, within their governance framework, so that the formal authority to sign the agreement is secured.

## 3. Recommendation

3.1 This report therefore recommends delegated authority to the Strategic Director of Service Development and Integration in consultation with the Director of Law and Governance and the Strategic Director of Finance and Investment to conclude negotiation on final outstanding matters of detail and to take steps to formalise the agreement between the Council and NELFT.

3.2 In doing so, where any further significant decisions arise, the Strategic Director will consult with the Cabinet Member for Adult Social Care and Health, and the Board is further being asked to note and confirm this arrangement.

3.3 Should authorisation not be provided, the Council would have to take immediate steps to withdraw the seconded staff and re-establish direct management of the team and its functions. This would be destabilising for service delivery and run counter to national directives on integration as a key mechanism for improving efficiency and service user experience.

## 4. Consultation

4.1 As this is a continuation of the current Section 75 agreement, no consultation has been undertaken with staff. However, when changes are proposed to the integrated service, full consultation will be undertaken.

## 5. Mandatory Implications

### 5.1 Joint Strategic Needs Assessment

The priorities for consideration in this report align well with the strategic recommendations of the Joint Strategic Needs Assessment. It should be noted, 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.

### 5.2 Health and Wellbeing Strategy

The recommendations of the report align well with Health and Wellbeing Strategy which sets shared priorities to improve people's mental health and wellbeing and improve services for people with mental health problems.

### 5.3 Integration

Mental ill-health is a cross cutting need which spans across both health and social care. Integrated care is when both health and social care services work together to ensure individuals get the right treatment and care that they need that help them remain in control and live independent lives. The Section 75 agreement governs how specialist mental health services will be integrated to improve the health and well being of local people and reduce health inequalities.

This is a cornerstone of delivering the 25 recommendations set out in *Closing the Gap*, the Department of Health's set of priorities for improving mental health service provision, which they published in February 2014.

### 5.4 Financial Implications

Implications completed by Carl Tomlinson, Group Finance Manager

This report seeks to approve the renewal of the partnership arrangement between the Council and NELFT. If this is agreed, the proposed contribution from the Council to the Mental Health pooled funds for 2016/17 will be £3.426m subject to Cabinet approval of the proposed Budget Framework for 2016/17. This budget also includes £500k funding from the Adult Social care grant held within the Better Care fund (BCF). The total value of the pooled funds following NELFT's contribution of £7.492m will be a total of £10.918m.

Against the Council's element of the pool, there have been significant budget pressures which are reducing as a result of remedial action taking by the service. Pressures have reduced from a 2014/15 outturn of £357k overspend, to a projected outturn for 2015/16 of £267k overspend. This reduction has been as a result of action taken as listed in paragraph 2.11 of this report. These measures would need to continue to reduce the current pressure and ensure that the service going forward is managed within existing funds.

### 5.5 Legal Implications

Implications completed by Bimpe Onafuwa, Solicitor

This report is seeking that the Health and Wellbeing Board approve the renewal of the Section 75 arrangement between the Council and the North East London Foundation Trust (NELFT).

Section 75 of the National Health Services Act 2006 allows local authorities and NHS bodies to enter into partnership agreements for the pooling of resources and delegation of certain NHS and local authority health related functions to the other partner, if this would lead to an improvement in the way those functions are exercised.

There is currently in place a S.75 Agreement governing the partnership between the Council and NELFT, in respect of the delivery of Mental Health services within the London Borough of Barking & Dagenham. This report sets out how the Council has worked to date in collaboration with NELFT to improve the delivery of the mental health related functions of both parties within the Borough.

Details of the current arrangements for the pooling of funds and staff resources, as well as the governance structure for the provision of the integrated service have been outlined in this report, as relevant.

Legal Services are working with the Council's Adult and Community Services on the re-negotiation of the Section 75 Agreement. Legal Services are also available to assist with the execution of the same, once negotiations have been concluded.

**6. Background Papers Used in Preparation of the Report:**

- Mental Health Section 75 Agreement, 25 March 2014: http://moderngov.barking-dagenham.gov.uk/documents/g7091/Public%20reports%20pack%20Tuesday%2025-Mar-2014%2018.00%20Health%20and%20Wellbeing%20Board.pdf?T=10

# HEALTH AND WELLBEING BOARD

## 26 JANUARY 2016

| **Title:** | **Systems Resilience Group Update** |
|---|---|
| **Report of the Systems Resilience Group** | |
| **Open Report** | **For Information** |
| **Wards Affected: ALL** | **Key Decision: NO** |
| **Report Author:**<br>Andrew Hagger, Health and Social Care Integration Manager, LBBD | **Contact Details:**<br>Tel: 020 8227 5071<br>E-mail: Andrew.Hagger@lbbd.gov.uk |
| **Sponsor:**<br>Conor Burke, Accountable Officer, Barking and Dagenham Clinical Commissioning Group | |
| **Summary:**<br>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 meeting held on 8 December 2015. | |
| **Recommendation(s)**<br>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):**<br>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 A**: 8 December 2015

| System Resilience Group (SRG) Briefing | Meeting dated – 8 December 2015 |
|---|---|
| | Venue – Bellows room, Imperial Offices, Romford |
| **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 |
|---|---|
| **Planned Care** | Members were updated on the RTT and Cancer improvement plans.<br>Further update to come back to the next meeting. |
| **Performance reporting** | Key areas from the dashboard were highlighted. |
| **Trust Improvement Plan** | Members received a brief update on the latest developments of the Trust Improvement Plan. |
| **Plan for 2015/16** | Members received an update on progress of key areas of the 2015/16 plan and key actions being taken ahead of the Christmas and New Year period. |
| **Strategic Development** | Members noted the latest position of the Urgent and Emergency Care Vanguard . |
| **Next meeting:** | 1st February 2016<br>2pm – 4pm<br>Bellows room, Imperial Offices<br>2-4 Eastern Road, Romford Essex RM1 3P |

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# HEALTH AND WELLBEING BOARD

## 26 JANUARY 2016

| | |
|---|---|
| **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:**<br>Andrew Hagger, Health and Social Care Integration Manager, LBBD | **Contact Details:**<br>Telephone: 020 8227 5071<br>E-mail: Andrew.Hagger@lbbd.gov.uk |
| **Sponsor:**<br>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 Mental Health Sub Group and Integrated Care Sub Group as they have not held a meeting since the last Health and Wellbeing Board.

The Learning Disability Partnership Board met on 15th December 2015 but no report is included here as a full update is on the agenda as a separate item.

**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: Public Health Programmes Board
- Appendix 2: Children & Maternity Group

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## Public Health Programmes Board

Chair: Matthew Cole, Director Public Health

**Items to be escalated to the Health & Wellbeing Board**

(a) None.

**Performance**

**Programme Performance**
Performance is outlined in the quarterly performance report detailed earlier in the Board Papers.

**Health Protection Committee**
Maternity services for the residents of Barking and Dagenham are provided by Barts Health NHS Trust (Barking Hospital) and Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT). The Programmes at both NHS Trusts are critical interventions to improve care during pregnancy, childbirth and the postnatal period as well as feeding is likely to improve the immediate and longer-term health and well-being of the individual infant and have a significant impact on neonatal and infant mortality at a population level. The key points to note for our main provider BHRUT (Queens Hospital) are:

- BHRUT has the lowest rate of completion of the laboratory request form antenatal screening for Down's syndrome of all trusts in London. There is no measure of screening coverage or uptake for this programme, but cohort tracking should mean that 100% of women who accept screening receive screening eventually. The problem with inadequately completed forms is that this may lead to an inaccurate risk assessment, and so further investigation and management may be delayed.
- BHRUT has been achieving well above the achievable standard for antenatal HIV screening (of 90.0%) though, with screening being at over 99.6% throughout the last two years, and at 99.8% in 2014/15 Q4. This compares to 99.8% throughout London and 98.8% in England.
- BHRUT has also been consistently achieving above the achievable standard of 99.0% coverage for sickle cell and thalassaemia antenatal screening. Although coverage is good, timeliness is not good, with only 11.5% of women in BHRUT having a result available by 10 weeks. Improving this, and promoting early booking in collaboration with the Maternity Strategic Clinical Network, are priorities for 2015/16.
- Hearing screening is a problem for BHRUT, and from the community audiology provider we know that many babies who need further assessment are not followed up with audiology assessment in a timely manner (within 4 weeks). This is down to staffing issues and staff retention, and the community provider is giving monthly updates to the commissioning manager.

With around a 1000 of our deliveries per annum at Barts Health we need to keep a check on their quality and performance. The issues and challenges faced at BHRUT and Barts are very different. Barts have a recognised issue in ensuring all women accepting screening then attend screening appointments for Down's syndrome screening. They have brought in a one stop clinic to address this, so that women are screened at the time they accept the offer. This has helped with the problems but has made their sickle cell and thalassaemia screening performance worse as the one stop arrangements bed in.

**Meeting Attendance**

Good – CCG representative not present.

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

(a) Work to develop our new early years integrated model is progressing and outline business case is being scoped up.

(b) Work to achieve efficiency savings and modernisation of sexual health services is ongoing and progressing well. Discussions with our Pan London partners are continuing in relation to Pan London procurement and modernisation plans for GUM and family planning. Currently we are not part of the Pan London procurement, as the benefits and quality offered are not equivalent to or better than our current arrangements, but these are being kept under constant review as the Pan London team work up and quantify their savings and capacity assumptions.

(c) Plans to redesign a single smoking programme to improve performance and achieve efficiency savings is almost at a point of a headline business case with the refresh of the Tobacco Strategy on track to be completed by March. Some e-cigarette products have been licensed for use in the specialist smoking services.

(d) Plans to redesign our childhood obesity programme into a single programme are progressing with a six month implementation date.

**Action and Priorities for the coming period**

1. Implement the In year savings plan
2. Monitor recovery plans on areas of poor performance.
3. Immunisation improvement report

## Children & Maternity Group

Chair: Sharon Morrow, Chief Operating Officer

**Items to be escalated to the Health & Wellbeing Board**

None

**Performance**

The focus of this meeting was on the interim findings from the Children and Young People's mental health and wellbeing needs assessment and as such there was no review of wider performance indicators. These were reviewed at the last meeting and have helped to inform the work plan and meeting agendas for future sessions.

**Meeting Attendance**

8 attendees/deputies out of 16 members (50%)

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

The Sub-Group met to take a detailed review of the draft findings from the Children and Young People's mental health and wellbeing needs assessment. This was a very useful session which enabled those working with children and young people to test the data against local experience. Various issues were discussed including

- The difference between school and residential population particularly in B&D where many children school out of borough.
- Some of the difficulties in assessing prevalence particularly where co-morbidity and taking into account the effect of deprivation and ethnicity – again significant issues in B&D
- Acute hospital admission data and how this relates to unmet need/impact of effective outreach services – this may well be an example of early intervention services giving B&D a better than national average position.
- Risk factors in B&D for poor mental health in children and young people – many of which are present in B&D population
- Capacity and confidence in workforce in general in working with children and young people with mental health needs.

A number of actions were agreed to test out the data further. The final report is due at the end of March and will be reviewed again by the CMG and the Mental Health Sub-Group.

The Sub-Group were also invited to comment on the draft Healthy Weight Strategy. The detailed action plan will come back to a future meeting to ensure local ownership and work through areas where joint partnership input needed.

At the last meeting infant mortality was raised as a particular issue. Some information is available as to how this might be impacted and further work is needed to weave this into current plans – in particular infant feeding.

**Action and Priorities for the coming period**

The following items will be reviewed in March 2016 meeting by the Group

- Infant Mortality
- Breastfeeding strategy
- Healthy Weight Plan

**Contact**: Dawn Endean, Locality Admin Support

**Tel:** 020 3644 2378 **Email:** bdccg@barkingdagenhamccg.nhs.uk

# HEALTH AND WELLBEING BOARD

## 26 JANUARY 2016

| **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:**<br>Andrew Hagger, Health and Social Care Integration Manager | **Contact Details:**<br>Tel: 020 8227 5071<br>Email: Andrew.Hagger@lbbd.gov.uk |
| **Sponsor:**<br>Councillor Maureen Worby, Chair of the Health and Wellbeing Board | |
| **Summary:**<br>Please see the Chair's Report attached at **Appendix 1**. | |
| **Recommendation(s)**<br>The Health and Wellbeing Board is recommended to:<br>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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# Chair's Report

26 January 2016

*In this edition of my Chair's Report, I talk about the success of the bid for the Accountable Care Organisation, the CCG's drop in event as well as an update from 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***

## Accountable Care Organisation

As many of you are aware, there has been a lot of work over the last few months to put together a submission to NHS England London Region for support to develop a business case for an Accountable Care Organisation across Barking & Dagenham, Havering and Redbridge.

So I was very pleased that on December 15 it was announced that we will be one of the 5 pilot projects that formed part of the health devolution agreement. Our pilot is to develop an Accountable Care Organisation, where primary and secondary care are more closely integrated and patient pathways are redesigned with a focus on intervening early and managing the chronically ill.

The bid that was submitted focused on whether the model of an Accountable Care Organisation could deliver the next stage of integrated service delivery across the three boroughs, with the aim of delivering the improvements that are needed in the health of the population, the quality of care they receive, and the efficiency with which it is delivered. The exact details of how the organisation would be structured, the services that would be in scope, and the financial commitment and risk involved are all to be determined through the process of developing the business case.

The London Health and Care Collaboration Agreement was published by the London Partners (London's 32 Clinical Commissioning Groups, all 33 LA members of London Councils, the Greater London Authority, NHS England London Region and Public Health England London Region). It set out the overall commitment of the Partners to the transformation of health and social care through integration and devolution and the full agreement can be viewed here.

As well as the Accountable Care Organisation pilot, there were a further 4 devolution pilots launched across London, each focused on different areas:

- Haringey will run a prevention pilot exploring the use of flexibilities in existing planning and licensing powers to develop new approaches to public health issues
- North Central London (Barnet, Camden, Enfield, Haringey, Islington) will run an estates pilot to test new approaches to collaboration on asset use
- Lewisham will run a pilot seeking to integrate physical and mental health services alongside social care
- Hackney will run a health and social care integration pilot, aiming for full integration of health and social care budgets and joint provision of services. This will also have a particular focus on prevention

These pilots could provide valuable insights into making further improvements to health and social care integration

There is a full update and report on the agenda, but I wanted to offer my congratulations and thanks to all those who have worked so hard on putting together the successful bid. However a lot more hard work will be required to develop the business case for the Accountable Care Organisation.

## CCG Commissioning Café Drop-in event

Barking and Dagenham CCG is planning on holding a public engagement event on the afternoon of 16th February and I would ask that all those involved in the Health and Wellbeing Board publicise this event and encourage people to attend.

The CCG has a responsibility to engage with local people and its stakeholders on an ongoing basis as it develops its commissioning strategy and plans. The CCG already has a range of mechanisms in place to do this, which includes a regular annual event in January/February which particularly focuses on the CCG's commissioning priorities for the coming year.

A range of approaches have been tried over the last few years including workshop events and a market place style event in 2015. Although these have been well received, the CCG wants to do more to engage with local people who don't normally attend formal engagement events.

Therefore the plan this year is to stage The Great Staying Healthy Drop In at Relish Café and in the BLC atrium. Given that many people will have made New Year's resolutions to be healthier in 2016, the aim will be to showcase what is on offer to support people but also on listening to how health might commission more effectively.

The event will be have themed zones where members of the public can access information about services and feedback on how they have experienced services as well as what they think about the CCGs priorities. The zones will include:

- Be Clear on Cancer
- New year's resolutions rebooted
- Banish the winter blues
- Staying well in winter
- Children's health

There will also be free drinks and healthy snacks as well as children's activities.


The event will take place in Relish Café on 16th February 2016 and run from 2.30 pm to 5 pm.

## News from NHS England

### NHS Five Year Forward View – One year on

Just over a year ago the NHS Five Year Forward View was launched, providing a vision for the future of the health system in England. The Five Year Forward View proposed that to achieve the triple aim of improved population health, quality of care and cost-control, this needed to be matched by triple integration, removing the boundaries between mental and physical health, primary and specialist services, health and social care.

Dr Mahiben Maruthappu, Senior Fellow to the CEO of NHS England and adviser on NHS England's innovation, technology and prevention portfolio, highlights three tensions that will need to be resolved. First, current pressures need to be balanced with the longer-term vision. Second, the traditional focus on individual organisation performance and accountability needs to be shifted to place-based whole systems and population health, incorporating broader components of the care system, including prevention and social care. Third, local initiatives need to be supported while also improving capabilities to spread these nationally, balancing bespoke approaches with ambitions to reduce countrywide variation of care.

### Patients using online services to access local GPs

Patients in England are on course to use online services offered by their local GPs to arrange more than 10 million appointments and order more than 15 million prescriptions in this financial year. Based on HSCIC activity figures six months into the year, it is also expected that patients will use new systems to view test results and letters about their care more than half a million times each.

NHS England's Patient Online programme has updated the interactive Support and Resources Guide to help GP practices implement their contractual requirements for 2015/16, including online booking of appointments, ordering repeat prescriptions and by the 31st of March 2016, access to detailed coded information held in patients' records. NHS England has worked closely with practice managers, practice staff and GPs from across the country to ensure the guide addresses their concerns, shares learning and supports them to offer high-quality online services to their patients. Last year's guide was positively received by GP practices, and accessed more than 10,500 times.

### Independent report on Southern Health

Just before Christmas NHS England published an independent report into the deaths of people with a learning disability or mental health problem at Southern Health NHS Foundation Trust, and highlighted a system-wide response. The report was commissioned by NHS England (South) following the death of Connor Sparrowhawk in July 2013 in a unit in Oxford run by Southern Health NHS Foundation Trust.

Some of the report's main findings included:

- Many investigations were of poor quality and took too long to complete
- There was a lack of leadership, focus and sufficient time spent in the Trust on carefully reporting and investigating deaths
- There was a lack of family involvement in investigations after a death
- Opportunities for the Trust to learn and improve were missed.

Both Southern Health NHS Foundation Trust and the clinical commissioning groups (CCGs) that commission services from them have accepted the recommendations.

## News from NHS England continued…

NHS Improvement (Monitor, as the regulator of Foundation Trusts), NHS England and the Care Quality Commission have set out a joint response to the recommendations which relate to national policy. NHS England has now forwarded the report to Monitor, who will consider as a matter of urgency whether regulatory action is required. The report will feed into the National Learning Disability Mortality Review Programme which was announced in June.

This three-year project is the first comprehensive, national review set up to get to the bottom of why people with learning disabilities typically die much earlier than average, and to inform a strategy to reduce this inequality.

## Update from Care City

Care City will be officially opening its Barking based new Healthy Ageing Innovation Centre on 18th January. From 4pm, Care City will throw open its doors to introduce this new centre for innovation, research and education. It will showcase how it aims to meet its dual mission of delivering measurable improvements in healthy ageing for the local population and acting as a catalyst for regenerating one of London's most deprived regions.

With the health and social care sector facing remarkable challenges as the population increases and ages, it is recognised that innovation and service redesign are essential if we are to continue to deliver world class health and social care services. The aim is to establish Care City as a place where innovation is accelerated and where system partners are supported to work alongside the community to improve health outcomes.

## Leisure centres receive prestigious award

Congratulations to staff at Becontree Heath and Abbey Leisure Centres who have been awarded the prestigious Chartered Institute for the Management of Sport and Physical Activity (CIMSPA) European pool safety award. Becontree now holds this 'quality mark' for high standards of pool safety for the third year running, while Abbey secured it in its first year of opening at the end of 2015.

## Health and Wellbeing Board Meeting Dates

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

## 26 January 2016

| **Title:** | **Forward Plan** |
|---|---|
| **Report of the Chief Executive** | |
| **Open** | **For Comment** |
| **Wards Affected: NONE** | **Key Decision: NO** |
| **Report Authors:**<br>Tina Robinson,<br>Democratic Services, Law and Governance | **Contact Details:**<br>Telephone: 020 8227 3285<br>E-mail: tina.robinson@lbbd.gov.uk |
| **Sponsor:**<br>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. The draft contains details of future agenda items that have been advised to Democratic Services at the time of the agenda's publication.

**Recommendation(s)**

The Health and Wellbeing Board is asked to:

a) Note the draft Health and Wellbeing Board Forward Plan and that partners need to advice Democratic Services of any issues or decisions that may be required, in order that the details can be listed publicly in the Board's Forward Plan at least 28 days before the next 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) Note that the next issue of the Forward Plan will be published on 9 February 2016. Any changes or additions to the next issue should be provided before 6.00 p.m. on 3 February.

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

**List of Appendices**
**Appendix A** – Draft Forward Plan

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# HEALTH and WELLBEING BOARD
# FORWARD PLAN

March 2016 Edition

Publication Date: 3 February 2016

# THE FORWARD PLAN

**Explanatory note:**

Key decisions in respect of health-related matters are made by the Health and Wellbeing Board. Key decisions in respect of other Council activities are made by the Council's Cabinet (the main executive decision-making body) or the Assembly (full Council) and can be viewed on the Council's website at http://moderngov.barking-dagenham.gov.uk/mgListPlans.aspx?RPId=180&RD=0. In accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 the full membership of the Health and Wellbeing Board is listed in Appendix 1.

**Key Decisions**

By law, councils have to publish a document detailing "Key Decisions" that are to be taken by the Cabinet or other committees / persons / bodies that have executive functions. The document, known as the Forward Plan, is required to be published 28 days before the date that the decisions are to be made. Key decisions are defined as:

(i) Those that form the Council's budgetary and policy framework (this is explained in more detail in the Council's Constitution)
(ii) Those that involve 'significant' spending or savings
(iii) Those that have a significant effect on the community



In relation to (ii) above, Barking and Dagenham's definition of 'significant' is spending or savings of £200,000 or more that is not already provided for in the Council's Budget (the setting of the Budget is itself a Key Decision).
In relation to (iii) above, Barking and Dagenham has also extended this definition so that it relates to any decision that is likely to have a significant impact on one or more ward (the legislation refers to this aspect only being relevant where the impact is likely to be on two or more wards).

As part of the Council's commitment to open government it has extended the scope of this document so that it includes all known issues, not just "Key Decisions", that are due to be considered by the decision-making body as far ahead as possible.

**Information included in the Forward Plan**

In relation to each decision, the Forward Plan includes as much information as is available when it is published, including:

- the matter in respect of which the decision is to be made;
- the decision-making body (Barking and Dagenham does not delegate the taking of key decisions to individual Members or officers)
- the date when the decision is due to be made;

**Publicity in connection with Key decisions**

Subject to any prohibition or restriction on their disclosure, the documents referred to in relation to each Key Decision are available to the public. Each entry in the Plan gives details of the main officer to contact if you would like some further information on the item. If you would like to view any of the documents listed you should contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@lbbd.gov.uk.

The agendas and reports for the decision-making bodies and other Council meetings open to the public will normally be published at least five clear working days before the meeting. For details about Council meetings and to view the agenda papers go to http://moderngov.barking-dagenham.gov.uk/ieDocHome.asp?Categories and select the committee and meeting that you are interested in.

The Health and Wellbeing Board's Forward Plan will be published on or before the following dates during the 2015 / 2016 Council year, in accordance with the statutory 28-day publication period:

| Edition | Publication date |
|---|---|
| March 2016 edition | 9 February 2016 |
| April 2016 edition | 29 March 2016 |
| June 2016 edition | 17 May 2016 |

**Confidential or Exempt Information**

Whilst the majority of the Health and Wellbeing Board's business will be open to the public and media organisations to attend, there will inevitably be some business to be considered that contains, for example, confidential, commercially sensitive or personal information.

This is formal notice under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 that part of the meetings listed in this Forward Plan may be held in private because the agenda and reports for the meeting will contain exempt information under Part 1 of Schedule 12A to the Local Government Act 1972 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it. Representations may be made to the Council about why a particular decision should be open to the public. Any such representations should be made to Alan Dawson, Democratic Services Manager, Civic Centre, Dagenham, Essex RM10 7BN (telephone: 020 8227 2348, email: committees@lbbd.gov.uk).

**Key to the table**

Column 1 shows the projected date when the decision will be taken and who will be taking it. However, an item shown on the Forward Plan may, for a variety of reasons, be deferred or delayed.



It is suggested, therefore, that anyone with an interest in a particular item, especially if he/she wishes to attend the meeting at which the item is scheduled to be considered, should check within 7 days of the meeting that the item is included on the agenda for that meeting, either by going to http://moderngov.barking-dagenham.gov.uk/ieListMeetings.aspx?CId=669&Year=0 or by contacting contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@lbbd.gov.uk .

Column 2 sets out the title of the report or subject matter and the nature of the decision being sought. For 'key decision' items the title is shown in **bold type** - for all other items the title is shown in normal type. Column 2 also lists the ward(s) in the Borough that the issue relates to.

Column 3 shows whether the issue is expected to be considered in the open part of the meeting or whether it may, in whole or in part, be considered in private and, if so, the reason(s) why.

Column 4 gives the details of the lead officer and / or Board Member who is the sponsor for that item.

| Decision taker/ Projected Date | Subject Matter<br><br>Nature of Decision | Open / Private (and reason if all / part is private) | Sponsor and Lead officer / report author |
|---|---|---|---|
| **Health and Wellbeing Board: 8.3.16** | **Barking and Dagenham Sport and Physical Activity Strategy** : Community<br><br>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.<br><br>• Wards Directly Affected: All Wards | Open | Paul Hogan, Divisional Director of Culture and Sport (Tel: 020 8227 3576) (paul.hogan@lbbd.gov.uk) |
| **Health and Wellbeing Board: 8.3.16** | Health and Wellbeing Board Performance Report 2015/16 - Quarter 3<br><br>The report will provide an update on key performance indicators, as requested previously agreed by the Board.<br><br>The Board will be asked to consider the performance issues to be monitored and agree any actions.<br><br>• Wards Directly Affected: All Wards | Open | Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk) |

**APPENDIX 1**

**Membership of Health and Wellbeing Board:**

Councillor Maureen Worby, Cabinet Member for Adult Social Care and Health (Chair)
Councillor Laila Butt, Cabinet Member for Crime and Enforcement
Councillor Evelyn Carpenter, Cabinet Member for Education and Schools
Councillor Bill Turner, Cabinet Member for Children's Social Care
Anne Bristow, Strategic Director for Service Development and Integration and Deputy Chief Executive
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)