Notice of Meeting

HEALTH & WELLBEING BOARD

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

Date of publication: 18 April 2016

Chris Naylor
Chief Executive

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

Membership

Cllr Maureen Worby (Chair)	(LBBD) Cabinet Member for Adult Social Care and Health
Dr W Mohi (Deputy Chair)	(Barking & Dagenham Clinical Commissioning Group)
Cllr Laila Butt	(LBBD) Cabinet Member for Crime and Enforcement
Cllr Evelyn Carpenter	(LBBD) Cabinet Member for Education and Schools
Cllr Bill Turner	(LBBD) Cabinet Member for Children's Services and Social Care
Anne Bristow	(LBBD) 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)
	(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 March 2016 (Pages 3 - 10)**

BUSINESS ITEMS

4. **Draft Primary Care Transformation Strategy (Pages 11 - 63)**

5. **Better Care Fund 2016/17 (Pages 65 - 123)**

6. **Referral to Treatment (Pages 125 - 129)**

7. **London Ambulance Service NHS Trust Improvement Plan (Pages 131 - 173)**

8. **Care City Programme Update (Pages 175 - 187)**

9. **Public Health Programme Board Strategic Delivery Plan Update (Pages 189 - 205)**

10. **Contracts: Procurement and Commissioning Plans 2016/17 (Pages 207 - 216)**

STANDING ITEMS

11. **Systems Resilience Group - Update (Pages 217 - 221)**

12. **Sub-Group Reports (Pages 223 - 230)**

13. **Chair's Report (Pages 231 - 235)**

14. **Forward Plan (Pages 237 - 246)**

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

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

Private Business

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

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

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London Borough of Barking & Dagenham
lbbd.gov.uk

Our Vision for Barking and Dagenham

One borough; one community; London's growth opportunity

Encouraging civic pride

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

Enabling social responsibility

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

Growing the borough

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

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MINUTES OF
HEALTH AND WELLBEING BOARD

Tuesday, 8 March 2016
(6:00 - 7:26 pm)

Present: Cllr Maureen Worby (Chair), Dr Waseem Mohi (Deputy Chair), Dr Muhammed Ali, Chief Superintendant Sultan Taylor, Conor Burke, Cllr Laila Butt, Frances Carroll, Matthew Cole, Helen Jenner, Cllr Bill Turner and Melody Williams

Also Present: Sarah Baker

Apologies: John Atherton, Anne Bristow, Dr Nadeem Moghal, Cllr Evelyn Carpenter and Jacqui Van Rossum, Cllr Eileen Keller, Terry Williamson

75. Declarations of Interest

NELFT declared a Pecuniary Interest in agenda item 9 (Contract – Procurement of Healthy Child Programme 5-19 Programme (School Nursing and National Child Measurement Programme)) and took no part in the discussions or decision.

76. Minutes - 26 January 2016

The minutes of the meeting held on 26 January 2016 were confirmed as correct.

77. Better Care Fund - End Of Performance Year 2015 Assessment and Plans For 2016/17

Mark Tyson, Group Manager, Integration and Commissioning, LBBD, and Sarah de Souza jointly presented the report, which gave a re-cap of the performance during 2015/16 and also built upon the details reported in December 2015. The eleven schemes within the Better Care Fund (BCF) had delivered most of the key milestones that had been set out in the BCF plans submitted to NHS England, however, there had been some under achievement on a number of metrics, the full details of which were set out in the report.

The BCF plans for 2015/16 and the associated Section 75 Agreement and pooled budget arrangements would come to an end on the 31 March 2016. The Policy Framework for 2016/17 had been released in January 2016 and the further technical guidance had been received in February, which had enabled work to start on the development of BCF plans for submission to NHS England. Mark drew the Board's attention to its role in approving the BCF plans before submission and to the timeframe that set out the final BCF plan submission date for 2016/17 as the 25 April. As the Board was not scheduled to meet until the 26 April, officers had suggested that NHS England is informed that the BCF 2016/17 Plan will be formally signed off by the Board on 26 April and submitted on 27 April rather than being approved through delegated authority.

Mark drew the Boards attention to the expected financial arrangements for 2016/17, set out in Appendix A of the report, and explained that this together with the Ambition 2020 Programme, planning guidance from NHS England and the emphasis in shift towards delay transmission of care would all impact on the final

2016/17 plans and targets.

Discussion was held in regards to a number of areas of performance concern and the actions that would be needed to address those and other issues, including:

- The need to be realistic about what could be achieved with reducing budgets when there was both an increase in population numbers and a growing ageing population.

- That only half of people discharged felt significantly supported to manage their own conditions, with mental health discharge being a significant part of the non achievement target. Consideration needed to be given by Partners into what could be done in regards to aftercare that would then enable people to feel safe and supported enough to manage their own condition.

- The overspend last year was indicated at around £600,000 but this was now expected to be a £200,000 overspend. Consideration would need to be given to the permanent base budget and the effect of this on services.

- The Healthwatch review had raised the issue of the four to six month wait for suitable housing for people being discharged and the effect that this could have on their health and rehabilitation. The Chair reminded the Board that this was discussed at the last Board meeting. There was pressure on the local housing market because of the lack of suitable housing stock / social housing and cost of private rental. This pressure was being looked at as part of the Housing and Homelessness Strategies.

- The need to ensure that data was robust to enable proper planning and monitoring and the work that was being undertaken with BHRUT to ensure that individuals were being identified. The Chair drew the Board's attention to self-funders and how they could be identified and included, so that true comparators and trends could be assessed.

- Wider integration approaches, including the Sustainability and Transformation Plan (STP) and the need to ensure that partner priorities and requirements were reflected in the development of the Accountable Care Organisation (ACO) business case. Whilst the BCF was a national programme it is developed and delivered locally and should become part of the ACO business case.

The Board:

(i) Noted the progress made in 2015 and the process for drawing up the 2016/17 Better Care Fund (BCF) plan, including the Board's role in approving the BCF plan;

(ii) Noted that the Policy Framework for the 2016/17 BCF had been released in January 2016 and the technical guidance had been received in February 2016, which had had a significant effect on the timetable for producing the BCF plan;

(iii) Endorsed, in principle, the current draft BCF plan, extension of the current Section 75 Agreement into 2016/17 and budget for 2016/17, which was set

out in the Finance report to Joint Executive Management Committee attached as Appendix B to the report, and agreed this should be used for the initial submission, albeit that some amendment would be likely as the plan was finalised; and

(iv) Agreed that in view of the timetable constraints, the Draft Final Plan should be submitted to NHS England on 25 April 2016 and that NHS England would be advised that the Plan was to be considered by the Board at its 26 April 2016 meeting, with the aim that the final Plan would be provided to NHS England on 27 April 2016.

78. Transforming Care for People with Learning Disabilities

Connor Burke, Accountable Officer, Barking and Dagenham Clinical Commissioning Group presented the report and explained how the Winterbourne View scandal of the abuse of young adults with learning difficulties had resulted in a review and subsequent recommendations on transforming the lives of young people with learning difficulties, Autism or mental health issues. In October 2015, NHS England, the Association of Directors of Adult Social Services (ADASS) and the Local Government Association announced a national plan called 'Building the Right Support'. The plan, agreed by all national partners, aims to develop 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. To implement the national plan locally, the Barking and Dagenham, Havering and Redbridge Transforming Care Partnership (TCP) had recently been established.

The Board's attention was drawn to section 2 of the report and in particular to the governance, ambition and vision statements and delivery plan development. Further reports would be presented to the Board in due course on those issues and on the programme delivery. The Board was also advised that the feedback from NHS England had been positive on the work undertaken to date.

The Board discussed a number of issues, including the need to look at provision and support on a broader level and to undertake consultation with safeguarding boards, young people, parents and other appropriate voluntary sector stakeholders and services users. The Board noted that the Partners would provide the appropriate stakeholder contact details to Connor enable the consultation to be undertaken.

The Board:

(i) Noted the progress that had been made in developing the BHR Transforming Care Partnership vision to date;

(ii) Discussed and agreed the proposed actions and consultation activity that would be undertaken to finalise the vision and plan before 11 April 2016; and that this would include consulting service users such as the Just Say parents forum, BAD Youth Forum Disability Group and the Safeguarding Adults Board and Safeguarding Children's Board;

(iii) Delegated authority to the Strategic Director for Service Development and Integration (LBBD) and the Accountable Officer (BHR CCGs) to sign off the

final submission before the 11 April 2016 deadline.

79. London Ambulance Service Quality Improvement Plan

The Chair advised that the London Ambulance Service (LAS) were unable to attend the Board and had sent their apologies for this. The Board received the report and considered the general details within it and the Improvement Plan.

The Chair asked Partners if they had any comments or questions to be passed back to the LAS. The Chair also asked Partners what they were doing within their organisations to support the LAS in delivering their Improvement Plan. The Board raised the following issues:

- The data had indicated that demand for ambulance services had increased year on year across the country. The demand on the LAS had increased by 4.7% in the last year in London.

- How processes would need to be looked at to enable both the current and projected increase in demand to be met.

- There was clearly a need to identify why people are turning up at BHRUT hospital A&E departments and why ambulances were the method of transport to those hospitals. The Chair commented that people knew they wanted a service, but if that was not easily attainable from GPs or other health professionals then they would default to a place where they could get medical treatment, and that would almost certainly be A&E and potentially an ambulance attendance and journey. Cllr Turner said that he would like to see the latest data on ambulance calls to LBBD wards, as this might show if demand could be due to insufficient local medical treatment provision / options locally.

- Re admissions to hospital was already a local performance reduction target for the Board. Therefore, any actions the Partners could take to reduce those would also ameliorate demands on the LAS.

The Board:

(i) Noted the report and comprehensive quality improvement Plan attached to the report;

(ii) Would welcome an update from LAS at a future meeting on the implementation of the Plan and how the LAS intended to achieve the improvements when demand levels were increasing year-on-year; and

(iii) Requested that data on LAS performance at a LBBD ward level be provided to Cllr Turner.

80. Health and Wellbeing Board Performance Report - Quarter 3 (2015/16)

Matthew Cole, Director of Public Health, LBBD, presented the report which provided the overarching dashboard and performance on specific indicators for Quarter 3. Matthew drew the Board's attention to a number of issues that had

improved or required improvement, the details of which were set out in the report.

The Board discussed a number of issues, including:

- The validation of the Referral-to-treatment (RTT) figures, which were still not completed and the action being taken to address the backlog of treatment numbers. Dr Ali, provided insight into the history behind this issue, the current performance rates, prioritisation of the backlog by need and the aim was to get the service back on an even keel by next financial year. The Board noted that a report on this issue would be brought to the next meeting.

- The significant fall in Breast Screening rates, especially as the Borough was the second worst nationally for Breast Cancer survival rates. The Chair and Francis Carroll, Healthwatch, both raised concern about people from Dagenham not accessing the Breast Screening centres at Harold Wood and King George Hospital due to their location and transport connections.

- The non-elective admissions rate and action being taken to address this.

- BHRUT's progress and when it hoped to be out of special measures. Noted that a report would be brought to the Board in due course

- The improving achievement rate for surgeries returning information on Learning Disability Health Checks.

- Passport for learning disabilities clients / patients.

- CQC had given King Edwards Centre a 'Good' rating.

- The number of children and young people accessing CAMHS tiers 3 and 4 was not R.A.G. rated as there was no national target for this indicator. Consideration was being given to whether a local target should be applied for such services and what it should look like.

- The wait between assessment and treatment for young people with mental health issues. NELFT advised that patients undergo triage assessment and initial treatment would be put into place whilst they were waiting for particular intervention / specialist treatments.

- Healthwatch commented that the 'Handyperson Project' was beginning to reduce the number of falls that were occurring.

The Board:

(i) Noted the overarching dashboard;

(ii) Noted the detail provided on specific indicators, and remedial actions being taken to sustain good performance;

(iii) Noted the concerns raised in regard to the public transport accessibility issues from the Dagenham area to the Breast Screening Services in Harold Wood and King George Hospital; and

(iv) Noted that work was continuing on validating the data in regard to both the hospital referral-to-treatment (RTT) and the non admitted backlog targets and requested BHRUT to report to a future meeting in order that the Board could have assurance that the data accuracy problems had been fully resolved and that an action plan is in place to ensure the backlog is being dealt with so that patients are not waiting too long for treatment.

81. Devolution Through an Accountable Care Organisation in Barking and Dagenham, Havering, and Redbridge

Mark Tyson, introduced the report, which provided a further update in respect of the development of the business case to determine whether or not an Accountable Care Organisation (ACO) was the best viable option for future integrated health and social care for Barking and Dagenham, Havering and Redbridge. On the 15 December the Chancellor of the Exchequer had agreed to a devolution pilot for health and social care for those areas. Planning would now need to be undertaken to ensure that the Urgent and Emergency Vanguard and other transformation initiatives fit with the work on the ACO. With this in mind the Clinical and Democratic Oversight Group (CDOG) held a workshop on 3 March to look at the scope, opportunities and ambition options and on 17 March a second workshop would be held, supported by external legal advice, which would enable the CDOG to get a more detailed perspective on the risks, challenges and organisational forms involved in approaches to establishing an ACO. Each organisation would then need to obtain their own legal and governance advice. Mark drew the Board's attention to the next steps, set out in the report, and also pointed out that the Ipsos MORI surveys were due to start shortly.

Discussion was held in regards to other ACOs that had already been established, or were in the process of being established, and the potential to capitalise on their learning. The focus at present needed to be on what the partners want the ACO to achieve and how those aims could be delivered. Mark confirmed that as documents were developed they would be shared and be made available on the website.

It was also noted that there are often assumptions that joint and integrated working will cost less, but that may not be the case, and there would need to be both further investigation and assurance on such concerns in due course.

The Board:

(i) Received the update on the development of the business case for the Accountable Care Organisation;

(ii) Noted that there was potential learning available on the setting up an ACO from ACOs elsewhere in the UK and that clarity would be obtained, in due course, on the how the Urgent and Emergency Care Vanguard may interlink with the ACO;

(iii) Noted that Ipso MORI surveys and data analytical work was due to start imminently; and

(iv) Noted the 'next steps', as set out in section 3 of the report, and that two

workshops had now been arranged for the 3 and 17 March.

82. Contract- Procurement of Healthy Child Programme 5-19 (School Nursing and National Child Measurement Programme)

NELFT declared a Pecuniary Interest in this item and took no part in the discussions or decision.

Further to Minute 70, 26 January 2016, the Board received the report from Matthew Cole, which explained that the Healthy Child 5 to 19 Programme was a mandated public health programme, the responsibility for which was transferred to the Council on 1 April 2013. The Programme offered school aged children a schedule of health and development reviews, screening tests, immunisations and health promotion. The services also provided tailored support for children and families.

Matthew explained that by Minute 70 the Board had agreed to the extension of the existing contract until the 30 September 2016 and that they were now being asked to agree to the formal commencement of tendering for the new contract, which was intended to start on 1 October 2016, as set out in the procurement strategy in the report.

The Board:

(i) Noted the procurement strategy set out in this report;

(ii) Authorised the procurement of a new contract for the provision of the Healthy Child Programme 5-19, via an open tender process, for the period 1 October 2016 to 30 September 2017, with the option for the Council to extend the contract for a further one year period; and

(ii) Delegated Authority to the Strategic Director Service Development and Improvement and Deputy Chief Executive, in consultation with the Director of Public Health, Corporate Director of Children's Services, Strategic Director Finance and Investment, and the Director of Law and Governance, to award the contract to the successful bidder in accordance with the strategy set out in the report.

83. 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 1 February 2015.

The Board noted the work that was ongoing in regards to the BHRUT Trust, RTT and Cancer Improvement Plans and the latest position on the Urgent and Emergency Care Vanguard.

84. Chair's Report

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

- New logo for the Health and Wellbeing Board.

- The CCG Great Staying Health Stakeholder Event
  The Chair thanked all the partners for the support they had provided for the event, which had been held on 16 February 2016.

- News from NHS England:

  - Mental Health Taskforce Report
    The report had been published in February 2016. The report had set out the three priorities for the NHS to deliver by 2020/21 and the associated funding expectations.

  - NHS had achieved its first target on climate change.
    The NHS had reduced its carbon emissions by 11% between 2007 and 2015, despite health and care activity increasing by 18% over the same period.

  - Urgent and Emergency Care Vanguard.
    An update on the business case and bid to carry out transformation work to the Urgent and Emergency system in 2016/17, including feedback from the Vanguard Quarterly Forum held on 25 February.

- Barking Riverside
  Barking Riverside had recently been awarded Healthy New Tow status, which would provide the opportunity to look at improving health through the built environment.

85. Forward Plan

The Board noted the draft April edition of the Forward Plan only had one item listed, which was for the June meeting.

The Chair reminded the Board that the Forward Plan enabled local people and partners to know what discussions and decisions would be taken at future Board meetings. The Chair asked all partners to provide details for future issues for the coming year as it was important to plan the business of the Board and to meet legislative requirements.

HEALTH AND WELLBEING BOARD

26 April 2016

Title:	**Draft primary care transformation strategy**
Report of the Accountable Officer, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Sarah See, Director, Primary Care Transformation	**Contact Details:** Tel: 020 8926 5411 E-mail: Sarah.See@onel.nhs.uk
Sponsor: Conor Burke, Accountable Officer, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups	

Summary:

The CCG has developed a strategy for the transformation of primary care over the next five years. The work is framed by national and London policy and the BHR system commissioning challenges and takes account of substantial input gathered from local GPs and wider local stakeholders.

The vision is of primary care leading the provision of joined-up health and social care in localities, with sustainable and productive practices at its foundation. This builds on the King's Funds concept of place-based care and wider evidence from places where this approach has been implemented.

In developing this strategy, we have engaged extensively with stakeholders with a role in the Barking & Dagenham health and care economy: patient representatives, patient groups, general practitioners, practice managers, the Local Pharmaceutical Committee, NELFT, Barking & Dagenham, Havering and Redbridge University Hospitals Trust (BHRUT), the Partnership of East London Co-operatives (PELC), the Local Medical Council, the Local Authority, NHS commissioners and Care City. We have also consulted with primary care and workforce leads at the NHS England London level. Extensive discussions have taken place with and between local clinical leaders about how this model will facilitate the development of local schemes which will deliver better care for local people and what the implications and opportunities will be for individual GP practices, their autonomy and sustainability.

The transformation programme for 2016/7 will be primarily about provider development – strengthening individual practices, progressing collaborative working amongst GP practices in localities and developing extended locality teams, bringing together GPs with all local health and social care professionals to provide the majority of care for patients. The plan is to draw on the CCG's strategies for planned, mental health and urgent and emergency care and identify specific local schemes, which can be used to inform development of collaborative governance and working arrangements in localities and as a proving ground n localities, ensuring they are wholly grounded in the business of local providers and the care needs of local people.

We are now aiming to complete the strategy in time for formal review by the governing body in

May 2016.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Review the contents of the Primary Care Transformation Strategy and comment on potential gaps in the strategy or improvements that could be made to it.

1 Introduction and Background

1.1 The CCG is developing a strategy for the transformation of primary care in Barking and Dagenham over the next five years. The work is framed by national and London policy and the BHR system commissioning challenges and takes account of substantial input gathered from local GPs and wider local stakeholders.

1.2 The Health & Wellbeing Board are requested to comment on the strategy attached to allow changes to be incorporated prior to the CCG Governing Body undertaking a formal review of the completed strategy, now scheduled for May 2016.

1.3 Further information on the proposals is provided in the attached primary care strategy communications slide pack, which is current as of **01/04/2016**.

2.0 Emerging Vision

2.1 The strategy proposes step-by-step migration to a place-based primary care-led delivery model for care out of hospital in each Barking and Dagenham locality. The model has at its foundation stronger GP practices and involves effective collaborative working across groups of practices and an extended team of mental health, community, social care, acute, pharmacy, dental and ophthalmology professionals and the voluntary sector.

2.2 Primary care, strengthened and extended, will have the collective capacity and funding to take on the majority of patient care, as well as prevention services.

2.3 Evidence advanced by the King's Fund, drawing on examples from New Zealand, Chen Med and elsewhere, is that place-based care works best with a population of 50-70,000 people, and clinical leaders in the borough are assessing the suitability of existing commissioning clusters as the starting point for deciding on the geographic footprints for localities.

2.4 Practice productivity and collaborative provision and administration will be enhanced through better exploitation of available information, IT and digital solutions.

2.5 A BHR-wide approach to the development of the primary care workforce will create the right staff mix for locality-based working, and localities will be empowered to co-design and deliver locally appropriate solutions for the recruitment and retention of staff.

3.0 Benefits for Patients and Implications for Practices

3.1 The benefits envisaged for patients from the primary care strategy are:

- personalised, responsive, timely and accessible primary care, provided in a way that is both patient-centred and coordinated
- an integrated service that supports and improves their health and wellbeing, enhances their ability to self-care, increases health literacy, and keeps them healthy
- more treatment closer to home where previously provided in secondary care
- involvement in the co-design of services with professionals in their locality.

3.2 The key implications for practices of the strategy are envisaged to be:

- Retention of practice autonomy, with GPs playing leading roles in locality-based care
- Improved financial sustainability through the pooling of resources to reduce costs and the creation of new opportunities to generate income
- Better practice productivity through improved teamworking and better use of IT, reducing administration and freeing up GP time for patient care
- The potential to develop more attractive career offers to recruit and retain primary care workers.

4.0 Implementation Approach

4.1 The King's Fund's framework for implementing place-based models of care will be used as the starting point from the implementation of primary care-led locality-based care in Barking and Dagenham.

4.2 It is proposed to work with a single locality within the borough as a pilot to design collaborative governance and working arrangements while working on selected prevention, planned care, mental health and/or urgent and emergency care schemes. This will enable initial lessons from locality-based working to be properly understood and the learning to be reflected in the designs and planning for the other localities.

4.3 A parallel programme of work will be put in place to help practices improve their productivity, make better use of information and IT systems and better understand their financial sustainability.

4.4 There is a 12-18 month target timescale for all localities to be operational and effective.

5.0 Resources/investment

5.1 Resources will be needed to help primary care leaders in localities establish organisational and governance arrangements for collaborative working and operate these effectively and to assist with specific initiatives to strengthen practice productivity and enable wider use of information, IT and digital solutions. Resource will also be needed to run the transformation programme at the BHR level. A review of CCG organisational arrangements may identify some individuals with the right skills and experience from programme roles.

5.2 An investment strategy for primary care is currently under development. This will enumerate the funding required for the transformation programme.

6.0 Equalities

6.1 No equalities impact assessment has been explicitly undertaken in relation to these proposals.

6.2 By delivering common standards of prevention, planned care, mental health and urgency and emergency care across the BHR system and organising delivery in localities, the CCG's overall approach aims to both reduce health inequalities and optimise services to meet the needs of local populations in Barking and Dagenham.

7.0 Risk

7.1 An iterative process of risk analysis will be part of the design and implementation phases of the new model of care. Current risks and assumptions identified include:

7.2 **Risks**

- Insufficient grass roots buy-in from GPs and other health and care professionals
- Insufficient capacity within General Practice to participate
- Dependencies on other projects – IT, workforce
- The pace of change demanded vs the time necessary to develop localities sustainably
- Compatibility of the strategy with main providers' strategies
- Insufficient investment in the resources to enable the programme to succeed

7.3 **Assumptions**

- Improving team working in localities will release significant quality and productivity benefits
- GP Practices are receptive to opportunities to improve their practices
- This strategy will have top-level support regardless of whether the Accountable Care Organisation proceeds
- Interoperable IT agenda sufficiently advanced to enable localities to provide continuity of care to patients

8.0 Public Background Papers Used in the Preparation of the Report:

- *Five Year Forward View*
- *Better Health for London*
- *Strategic Commissioning Framework for Primary care in London*
- *Place-based systems of care: a way forward for the NHS in England*

List of Appendices:

Appendix A Draft Primary Care Transformation Strategy – current at 01/04/2016

NHS
Barking and Dagenham
Clinical Commissioning Group

Transforming Primary Care in Barking and Dagenham

Our strategy 2015 – 2020

Contents

1 Executive summary

For patients, primary care and their relationship with their local GP form the foundation of the NHS service they expect and receive. If the NHS is to be clinically and financially sustainable in the years ahead, primary care and the rest of the system need to be transformed. If this can be done right, primary care can be a rewarding place to work for the professionals working in it, now and in future.

Nationally, the NHS faces significant future challenge in the form of the increasing health needs and expectations of the population; changes in treatments and technologies; and increasing pressures on finances, both from reduced spending growth in the NHS and cuts to social care budgets. Current projections from Monitor and NHS England estimate that the NHS will face a £30 billion funding gap by 2020/21. To tackle these challenges within Government funding limits, the *Five Year Forward View* sets out a transformational change agenda for the NHS that involves:

- Reducing variation in care quality and patient outcomes
- Increasing the emphasis on preventative care
- A shift towards more care being delivered in primary care
- Breaking down the barriers in how care is provided through the introduction of new models of care spanning current organisational boundaries
- Action on demand, efficiency and funding mechanisms to improve financial sustainability.

Barking and Dagenham, along with the wider Barking and Dagenham, Havering and Redbridge (BHR) system, has a greater commissioning challenge than the national average in the form of a system-wide budget gap of over £400m. The BHR system needs to be transformed to:

- Meet the health needs of the diverse, growing young population in one of the most deprived areas in England where an increasing number of people are living with one or more long-term condition in its local communities
- Improve health outcomes for these populations and reduce health inequalities overall
- Meet national and regional quality standards for care
- Close a £400m budget gap.

To achieve this, commissioners agree that acute hospital care should be reserved for acutely ill patients and the majority of care should be delivered nearer home. Key themes for the development of primary care are that it should be accessible, coordinated and proactive.

So what is the current state of primary care in Barking and Dagenham and how does it need to be transformed to meet commissioners' requirements and the needs of local people?

Significant progress has been made in improving access to general practice, with the establishment of hub-based urgent GP appointment evening and weekend services. However, local GPs and stakeholders have told us that the current model in primary care is unsustainable. The workforce is stretched, with recruitment and retention of staff challenging. Workload is increasing, and will do further with an ageing population, and practices cannot deliver the quality of care their patients need without becoming financially unsustainable. While national funds are available for clear, coherent transformation strategies, there is no additional ongoing funding available in the system beyond funding potentially released through a proportional reduction in acute hospital care. Primary care

needs to change to better meet demand and be a rewarding place to work and attractive to future potential recruits.

The CCG's vision is to combine primary care with other community-based health and social care into a place-based care model with productive general practice at its foundation and GPs overseeing care for their patients. Each of the three existing localities in Barking and Dagenham where neighbouring GP practices work together will be a 'place', and the vision is therefore to establish locality-based care across all health and social care services for the populations within those geographical localities.

Locality-based care will be proactive, with a focus on prevention, support for self-care, active management of long-term conditions and the avoidance of unnecessary hospital admissions. Patients will have a more joined-up care experience, be enabled to take more control of their care, and more of their treatment will be closer to home.

The locality-based care model has at its foundation highly productive GP practices working collaboratively to deliver care, free up GP time and reduce administrative costs, making best use of available IT solutions. General practice will lead a highly effective extended locality team of community, social care, pharmacy, dental and ophthalmology professionals and the voluntary sector providing local people with the majority of their care. With input from local patients, this team will decide local pathways, how the care workload is shared, and where care delivered from, in line with standards set and common assets managed at the BHR system level.

In configuration terms, locality teams will initially be virtual teams. General practice will have the opportunity to lead and shape the way locality provision develops, learning from the experience of joint working. In 2021, provision may continue in the form of an alliance of individual GP practices who operate autonomously. Alternatively, by then, general practices may consolidate into a larger scale provider, or join with community and other providers into a multi-speciality community provider.

A system-wide programme will be established to refresh the roles and mix of professionals needed for locality-based care and to develop the career packages needed to sustainably attract and retain the GPs, nurses and healthcare assistants needed.

With the balance of care delivery shifting away from hospital care, a commensurate share of the existing funding envelope will fall to general practice and fellow locality team providers. In time, it is likely that contractual arrangements will change to incentivise population-level outcomes rather than reward provider activity.

Locality-based care aims to be fully operation within two years. Key changes will be:

1. GP practices will work more productively and free up GP time to provide and oversee patient care.

2. Collaborative working between GP practices in localities and with the extended team of care professional will become established, raising quality and increasing capacity for locality care services and helping reduce the cost of administration.

3. Clear boundaries between primary care and acute hospitals, with good handovers between teams.

4. A programme will be put in place to recruit, develop and retain a primary care workforce suited to delivery in a place-based model in Barking and Dagenham.

5. Increasingly, reliable IT solutions will enable joined-up patient care and the automation of administrative tasks, and locality-based providers will adopt and use them with confidence .

2 Introduction

This strategy sets out a future vision for primary care in Barking and Dagenham in the context of wider change in Barking and Dagenham and the Barking and Dagenham Havering and Redbridge (BHR) health system, defines the overall scope and approach for the associated transformation programme and provides a detailed plan for 2016/17.

The strategy addresses the future roles, form and sustainability of general practice specifically, given the role of the CCG in commissioning primary medical services. It also considers the future role of other primary care services such as community pharmacy, dentistry and ophthalmology as participants – along with community health, social care and voluntary sector providers – in integrated local care services.

Section 3 describes the drivers for change, summarising the commissioning agenda at national, London and local levels and the presenting a thematic analysis of the issues and opportunities raised at grass roots level by local stakeholders.

Section 4 assesses the strategic options for a future primary care model, making the case for change, and Section 5 describes the future vision and how it addresses the drivers for change.

Section 6 describes what will change over the first two years of the programme and Section 7 presents the detailed 2016/17 plan.

In developing this strategy, we have engaged extensively with stakeholders with a role in the Barking and Dagenham health and care economy: patient representatives, patient groups, general practitioners, practice managers, pharmacists, nurses, community and mental health services provided by North East London NHS Foundation Trust (NELFT), acute services provided by Barking and Dagenham, Havering and Redbridge University Hospitals Trust (BHRUT), the Partnership of East London Co-operatives (PELC), the Local Medical Council (LMC), the London Borough of Barking and Dagenham, NHS commissioners and Care City. We have also consulted with primary care and workforce leads at NHS England London level. Thanks are due to individuals who have provided their time and perspectives.

In formulating the vision, programme and plan we have worked closely with the BHR primary care transformation programme board. Many of the issues that have been identified in the

development of this strategy are local and specific to Barking and Dagenham. Others we share with our neighbouring boroughs in Redbridge and Havering and where we believe that a collaborative approach can be taken to addressing them, we will.

We have also consulted BHR commissioning colleagues responsible for parallel strategic work on planned care, mental health and urgent and emergency care to ensure alignment of vision and clarity on programme scope where proposals overlap.

3 Drivers for change

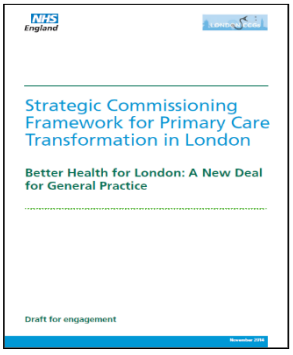
3.1 The commissioning context

3.1.1 National

Nationally, the NHS faces significant future challenge in the form of the increasing health needs and expectations of the population; changes in treatments and technologies; and increasing pressures on finances, both from reduced spending growth in the NHS and cuts to social care budgets. Current projections from Monitor and NHS England estimate that the NHS will face a £30 billion funding gap by 2020/21. To tackle these challenges within Government funding limits, the *Five Year Forward View* sets out transformational change for the NHS to be driven by commissioners and realised by providers. This involves:

- Reducing variation in care quality and patient outcomes
- Increasing the emphasis on preventative care
- A shift towards more care being delivered in primary care
- Breaking down the barriers in how care is provided through the introduction of new models of care spanning current organisational boundaries
- Action on demand, efficiency and funding mechanisms to improve financial sustainability.

3.1.2 Regional



At a London level, the *Better Health for London* report from the Mayor's Office contained a range of recommendations that related to primary care. In particular, it called for significant investment in premises, developing at scale models of general practice and the need for ambitious quality standards. This vision for primary care was further articulated by the publication of the Strategic Commissioning Framework for Primary care in London which outlines a key set of specifications (service offers) aligned to the areas that patients and clinicians feel to be most important:

- **Accessible care** – better access to primary care professionals, at a time and through a method that's convenient and based on choice
- **Coordinated care** – greater continuity of care between the NHS and other health services, including named clinicians and more time with patients as and when needed
- **Proactive care** – more health prevention by working in partnerships to improve health outcomes, reduce health inequalities, and move towards a model of health that treats causes and not just symptoms.

The 17 indicators under these themes will be used across London to ensure a consistent, high quality service offer is available across the city.

3.1.3 Local

Barking and Dagenham, along with the wider BHR health system, has a greater commissioning challenge than the national and London average - the system-wide budget gap for BHR is over £400m, as seen in Figure 1, below.

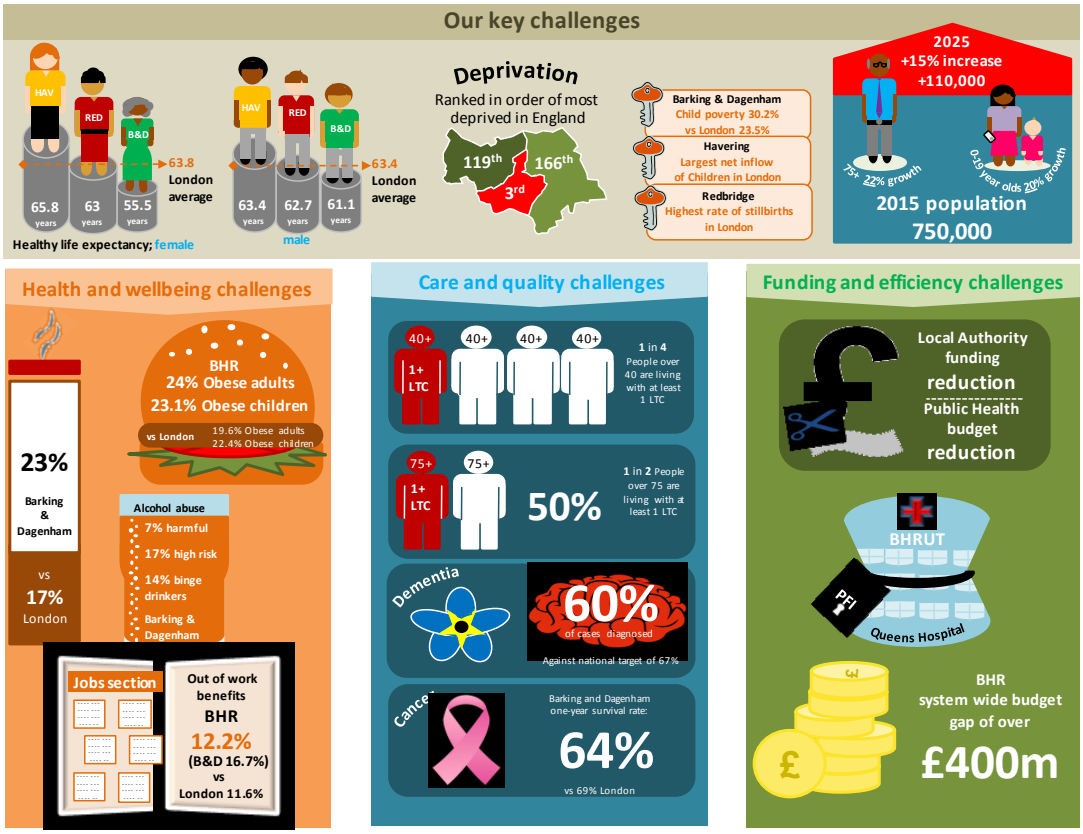


Figure 1 Key challenges for BHR CCGs

The BHR system needs to be transformed to:

- Meet the health needs of the diverse, growing and ageing populations in its various local communities
- Improve health outcomes for these populations and reduce health inequalities overall
- Meet national quality standards for care
- Close a £400m gap.

To achieve this, commissioners and local providers agree that acute hospital care should be reserved for acutely ill patients and deliver the majority of care nearer home, and that more emphasis is needed on prevention to improve outcomes and contain demand for care.

Local strategies

Within BHR, strategies are in development that will have a large impact on the transformation of primary care, both in terms of future service configuration and contracts, supporting infrastructure and work that must be coordinated to achieve maximum benefit across the local health system (e.g. workforce development). These include:

- A new model of urgent and emergency care, which will radically transform local urgent and emergency services, removing barriers between health and social care and between organisations. Urgent care will be simple for people to use and services will be consistent,

no matter where people use them (i.e. by phone, online or in person). This will be enabled by the use of the latest technology to make care records accessible to patients and clinicians.

- The mental health and planned care strategies, which are in early stages of development.
- The preventative care strategy, which aims to allow all Barking and Dagenham residents to have the support needed to improve their health and wellbeing and to reach their full potential. This involves primary, secondary and tertiary preventative interventions and services to help people get the right care, in the right place, at the right time, enabling them to live independently and at home for as long as possible.
- The BHR partnership is currently drawing up a business case to develop an Accountable Care Organisation (ACO) pilot. If implemented, it would deliver structural changes in the local health economy that align incentives and payment mechanisms to enable common goals and integrated working. The creation of an ACO locally would be a further demonstration of local ambition and see a large part of the budget currently controlled by NHS England and Health Education England devolved to the new body to spend on local needs. No decision to form an ACO has yet been taken by BHR partners.

Services within the scope of primary care include:

Preventative care	Health and wellbeing advice: healthy eating, physical activity, mental health, kicking bad habits
	Screening
	Immunisations
Planned care	Self-care, self-management with coaching, education and support from primary care to manage their condition and to have a plan for escalation/emergency
	Planned and preventative case management
	Pharmacy services: Dispensing, medicine reviews, prescribing
	Enhanced services
	Specialist input
	Transitions between secondary care/reablement
Urgent and emergency care	Urgent care - holistic assessment, streaming, booking
	Minor ailments advice and treatment
	Planned GP appointment

3.2 Performance and future sustainability of the current primary care model

Our analysis shows that current performance is mixed and the current model will not be able to cope with higher demand and meet care quality expectation. The headlines are:

- Our primary care workforce is already stretched
- Demand is growing due to a growing and younger population, with high levels of migration in and out of the borough, and more patients having more than one long-term condition
- A high proportion of GPs are nearing retirement, and recruitment and retention is challenging
- There is too much variation in primary care quality
- Substantial progress in improving the accessibility of general practice, but more to do
- There is too much variation in patient satisfaction, particularly around access
- Some of our premises are poor quality

- Patients are being seen in a hospital setting for conditions that could be better managed in primary care.

More detail is provided below.

3.2.1 Workforce

Our workforce is stretched and recruitment & retention is challenging

Barking and Dagenham has some of the lowest rates of GPs per 1,000 population in London, with 0.44 GPs for every 1,000 registered patients compared to a London average of 0.55. The number of Practice Nurses only just meets the London average (0.22 Nurses per 1,000 population compared to a London average of 0.2). See Figure 2, below.

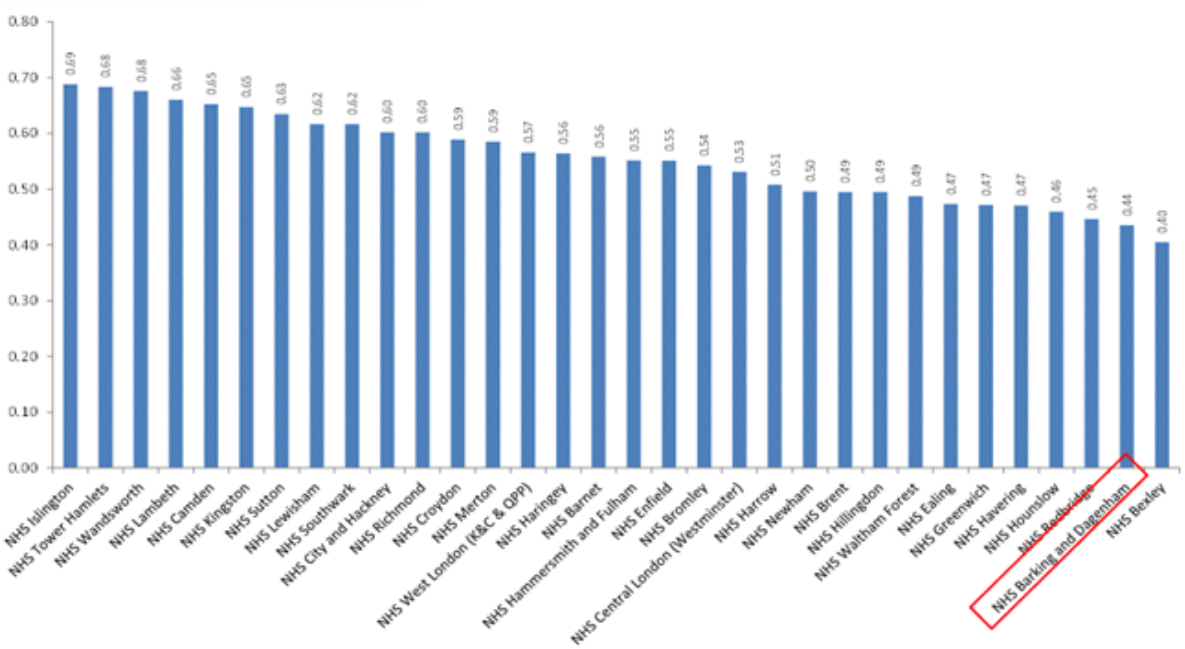


Figure 2. London CCGs rate of full time equivalent (FTE) GPs (exc. Registrars and Retainers) per 1,000 patients.

Traditionally, outer London has found it harder to attract newly qualified GPs than inner London. It is difficult both to recruit and retain salaried GPs and to attract GP partners in Barking and Dagenham, as well as other members of the primary care workforce. Stakeholders identified the following reasons:

Isolated GPs	Salaried GPs and long-term locums feel disenfranchised and isolated. High numbers of single handed GPs.
Older GPs	High proportion GPs reaching retirement age
Older nurses	High proportion nurses reaching retirement age
Overworked GPs	Lowest quartile of GPs per head of population in the country
Nationwide shortage of GPs	Shortage of medical students going into general practice despite Health Education England mandate. Training posts remain unfilled

Cost of living in London	Inner London posts attract Inner London Weighting pay whereas Outer London posts attract lower band Outer London weighting
Brand and reputation	Other parts of London are further ahead in marketing themselves and adjacent opportunities e.g. career development, research opportunities, honorary positions

High proportion of GPs nearing retirement

In addition to the current challenges faced by the shortage of GPs working in Barking and Dagenham, the age profile of the GP workforce signals that this challenge will be greater in future years. Barking and Dagenham has more than twice as many GPs over the age of 60 than the national average: 30% of GPs are over 60, compared to 15% in London and 9% nationally (Figure 3). With potential retirements in this already stretched workforce, this is clearly a local priority.

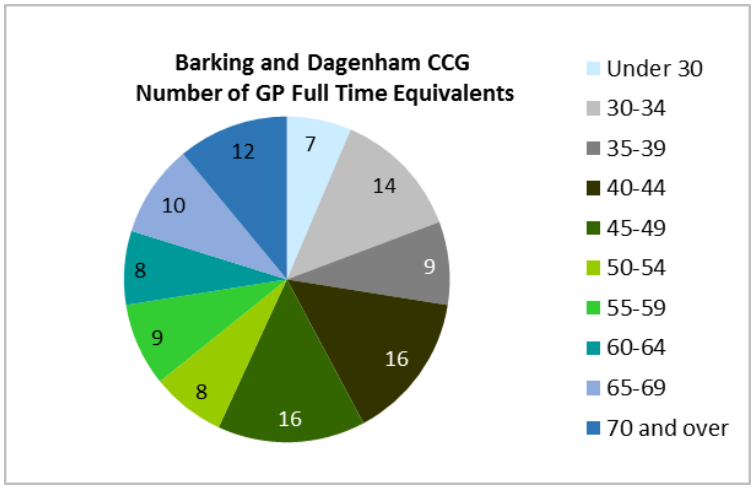


Figure 3. GP age profile, (Practice Reported): HSCIC General and Personal Medical

3.2.2 Workload

Local stakeholder interviews provided us with a consistent narrative of increased demand, increased workload and, especially, increased time spent on bureaucracy and administrative tasks. Barking and Dagenham's GPs find their current workload unsustainable. Many are overworked, and feel they are spending too much time on administrative tasks and chasing information, with not enough time for patient care. This work can be from external sources (e.g. patients who are discharged from secondary care with increased demands from primary care) as well as work generated within their practices (e.g. time spent on repeat prescriptions). Delegating care to other healthcare professionals/services can be difficult, with uncertainty over resources and capacity elsewhere in the system. Lack of information sharing between services makes it difficult for all members of the primary care team to know what other professionals are doing. This means work may be duplicated and confidence in the whole system working in an integrated way is reduced.

Patient behaviour also contributes to GP workload. Many patients find the primary care offer around urgent care confusing and will seek an appointment with their own GP, on top of contact with GPs/other professionals in urgent care, to 'check' their treatment is correct. Others still feel

they need to see their GP for minor illnesses such as coughs and colds when another professional such as a community pharmacist could provide that care.

Population growth and demographic change - growing population and a rise in the number of patients suffering from one or more long-term condition

The population of Barking and Dagenham is growing and the local healthcare needs are changing.

- Barking and Dagenham has seen a significant overall population increase of 13.4% to 185,911 (2011 Census). This is 22,000 more people since 2001, including a 50% increase in 0-4 year-olds. Within Greater London, Barking and Dagenham had the fourth biggest percentage population increase (2%) of all London boroughs between 2012 and 2013.
- 30% of the population are children, placing a huge pressure on school places, housing and social care including on workloads across key agencies working with the borough's families.

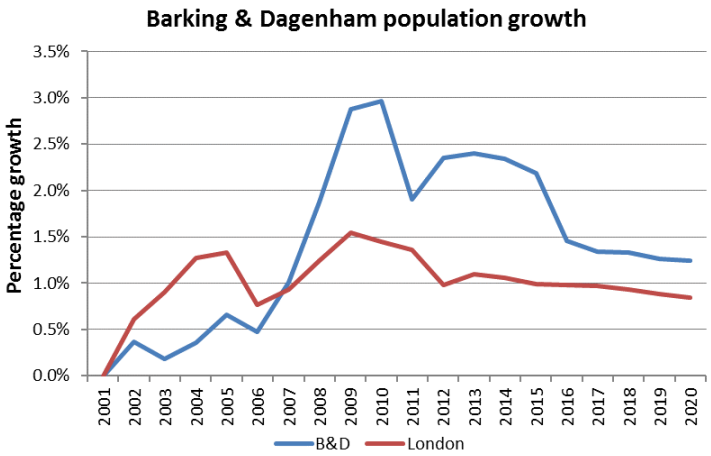


Figure 2. Projected population growth in Barking and Dagenham, GLA 2014

- The population is projected to rise from 190,600 in 2012 to 229,300 in 2022. This is a 20.3% increase and is the second largest in England after Tower Hamlets.
- Barking and Dagenham has a population churn of 189 per 1000 or 19% which is significantly higher than the London rate of 9%.

The Barking and Dagenham Independent Growth Commission report [1] sets out a 20-year vision for the London Borough of Barking and Dagenham to deliver Barking and Dagenham's growth opportunity. The Commission proposes at least 35,000 new homes and 10,000 new jobs will be created over the next 20 years, the most high profile development being at Barking Riverside. The council will publish its detailed response to the Commission's report and strategy for transforming the borough and transforming the way in which the council is organised in April 2016.

Barking and Dagenham has also seen a rapid shift in the proportions of various ethnic groups across the borough, with a large decrease in the white British ethnic group and a large increase in the black African ethnic group. The most recent ethnic breakdown is shown in Figure 5. By 2020, the expectation is that black and minority ethnic community will make up approximately 50% of the population.

The borough is the 7th most deprived in London and 22nd most deprived nationally which is also reflected

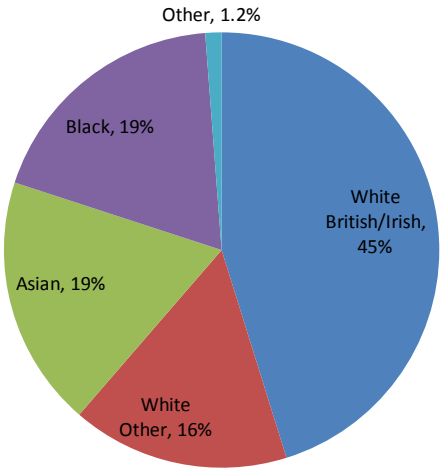


Figure 3: Barking and Dagenham ethnicity profile, community mapping 2015

[1] No-one left behind: in pursuit of growth for the benefit Dagenham Independent Growth Commission www.lbbd.gov.

in the relatively poor standard of health - life expectancy for both men and women is lower than the England average. Over half of the borough's population live in the 20% most deprived areas in England and around one third of children in the borough are living in poverty.

Long-term conditions

In addition to the growth in our population, we are seeing a growth in the number of people living with one or more long-term condition.

- Diabetes prevalence is higher in Barking and Dagenham than the London and England average and the burden of disease from long-term conditions is likely to increase in primary care. The number of people recorded with diabetes in Barking and Dagenham increased from 10,625 in 2013 (6.4%) to 11,418 (6.8%) 2014 and is projected to increase further.
- About 10% of the population has caring responsibilities for someone who is ill, frail or disabled.
- Of the over 75 year olds living alone in the borough, almost 4,100 (41%) are living with a long-term condition and 1,317 have dementia.
- A population such as Barking and Dagenham is likely to have particularly high mental health needs and it is known that the rate of mental health disorders in children and adolescents in Barking and Dagenham is significantly higher than the national averages.

General Practice has a key role in the identification, treatment and management of long-term conditions and mental health. These trends impact on the demand on GPs and the primary care team.

Improved care coordination is central to the model of care provided to patients with long-term conditions. It has been shown to deliver better health outcomes, improve patient experience and is vital for people living with multiple conditions. Better care coordination is key to delivering an integrated health service. However, care coordination is complex and requires a shared approach across the healthcare system.

3.2.3 Quality

There is variation in the patient outcomes across Barking and Dagenham. General practice makes a significant contribution to improving the health of the population and influencing patient health outcomes. Across Barking and Dagenham there are examples of excellence in practice. We need to learn from these examples of excellence to reduce the variation that currently exists.

Quality outcome framework (QOF) achievement in Barking and Dagenham is an indicator GP practices will be familiar with that highlights the needs for reducing variation in the quality of care between Practices in the borough. The variance in QOF achievement in 2014/15 ranged from 458 to 559 (maximum). Lower QOF scores affect both the care of patients with long-term conditions and practice income.

Table 1. BHR CCGs QOF achievement, 2014/15

CCG	Average achievement (559 maximum)	Lowest score	Highest score
Barking & Dagenham	530	458	559
Havering	516	282	559
Redbridge	522	443	559
London	521	139	559
England	530	139	559

Achievement against the general practice outcome standards (GPOS) allow us to see how GP practices perform against a set of 26 indicators for quality improvement agreed with GP leaders, clinicians, the London-wide LMCs, commissioners and other health care professionals, think tanks and patient groups. Barking and Dagenham CCG has a slightly lower proportion of GP practices rated as 'achieving' or 'higher achieving' against GPOS as London. The proportion of practices in the lowest performing category of 'review identified' is 45% (18 practices), similar to average of 46% in London. Practices in this category have nine or more triggers in total, or three or more level two triggers (where they are well below target/England average). For more detail on individual indicators where comparison to the England average is possible see Figure 7, below.

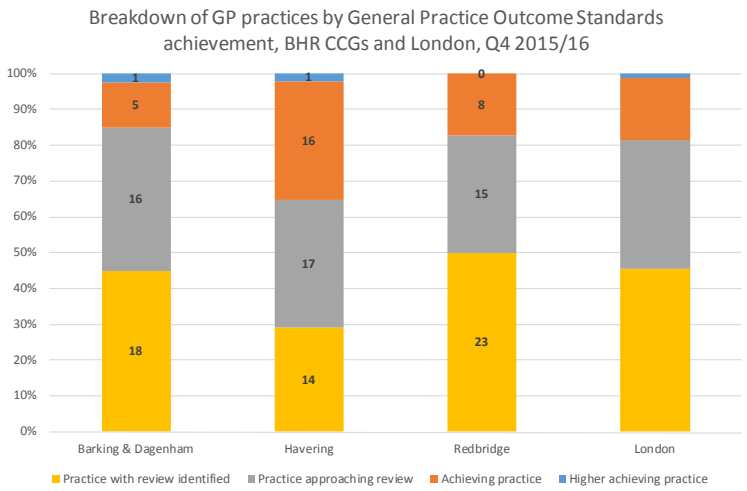


Figure 4: Breakdown of GPOS performance by BHR CCG

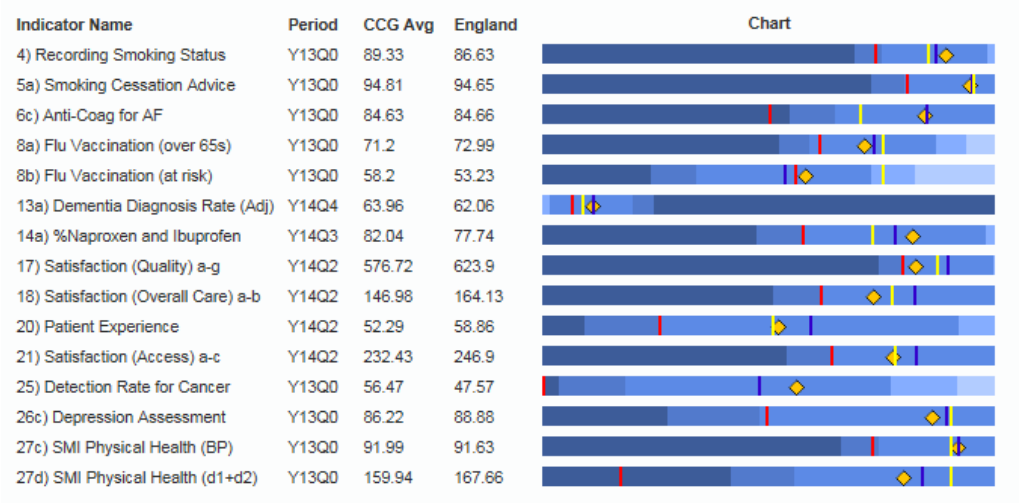


Figure 5: Barking and Dagenham CCG compared with national performance in general practice outcome standards

Key: Yellow diamond represents the CCG value; blue line the national average for the standard; yellow line the level one trigger value; red line the level two trigger value.

Some of our premises are of poor quality and need further investment

To ensure that patients receive high quality, accessible and safe care it is fundamental that general practice is able to deliver care from buildings that are fit for purpose and have the relevant facilities. Investment in primary care estates and IT has lagged behind investment in secondary care. Some general practices are working from inadequate buildings with limited facilities. This creates a poor environment for patients and staff. Much of the primary care estate is out-of-date, under-developed and cannot provide the facilities needed to deliver high quality care.

In Barking and Dagenham there has recently been significant investment in the health estate over the last decade, with one new community hospital and seven large LIFT centres but there is still a very mixed picture across primary care. Much of the primary care estate is in poor condition, with a large number of single-handed practices operating out of old houses.

Barking and Dagenham have invested in a DDA and infection control compliance programme for a portion of their primary care estate in 2010 and continuing this improvement in primary care premises must continue to remain a focus. This improvement needs to be coupled with opportunities presented through the new modern estate, which now needs to be fully utilised with extended opening hours. Most is generic space that would benefit from sessional booking and use. This will allow for rationalisation of the remaining NHS Property Services sites, a lot of which is in poor condition and not fit for purpose.

An additional consideration for the primary care estates picture in Barking and Dagenham is the number of regeneration schemes planned in the borough. The council's local housing strategy for Barking and Dagenham identified dense areas of regeneration such as Barking town centre and Barking Riverside. The borough is situated in the Thames Gateway growth area and has the potential to develop 15,000 new homes over the next ten years. Barking Riverside will be the most significant of these developments, leading to the creation of a major new community in the borough, with approximately 10,800 new homes. There is an opportunity to improve our primary care estate through the funding available through London Borough of Barking and Dagenham and housing developers to support public infrastructure as a result of these developments.

There are variable levels of patient satisfaction, particularly in terms of access

Improving access to primary care professionals, at a time and through a method that's convenient and based on choice is outlined as a key priority for the delivery of primary care services in London. General practice core hours of operation are 8.30am to 6.30pm, Monday to Friday. The direct enhanced service for access incentivises practices to open additional hours outside of this core offer. Across Barking and Dagenham there are eight practices, one in five, that are not open during core hours impacting on the amount of access available to their patients

As part of the engagement on the development of this strategy a survey was circulated to patients, carers and their representative groups to seek

More receptionists to answer the phones when the telephones are busy in the morning

It needs to be easier to get an appointment on the day

their views on local primary care services. Access to services was highlighted as an issue for some respondents and highlighted as an area where things could be improved. These are a selection of comments captured that relate to patient satisfaction in relation to access.

Access has been a key priority for primary care development over recent years and work has begun to develop the strong foundations for opening up access to patients across Barking and Dagenham. In collaboration with Redbridge and Havering CCGs integrated primary care services through access hubs during evenings and weekends are being offered across the network. Provided by the local GP Federations, this new model of extending access has so far achieved a 90% patient satisfaction rate and has opened up an additional 5,000 urgent care slots a month.

GP services are getting worse, unable to make an appointment by phone, nearly always engaged. Shorter hours than previously

Patients are being seen in a hospital setting for conditions that could be better managed in primary care

As the usual first point of contact for patients when accessing the healthcare system, primary care plays a crucial role in preventing unnecessary hospital attendances and admissions.

Across Barking and Dagenham a high proportion of patients attend A&E. It may have been appropriate to treat some of these patients in primary care. Figure 8 reflects the attendance rate per thousand registered patient at each practice in Barking and Dagenham in 2013-14:

- In Barking and Dagenham the average attendance rate is 426 per 1,000 registered patients, one of the highest rates in London;
- The London average in in 2012-13 was 312 per 1,000 population which itself was the highest in the country;
- Variation locally in A&E attendance rate by Practice range from approximately 320 to 680 per 1,000 and is unlikely to be as a result of population factors alone.

This suggests that more can be done to treat patients in primary care, ensuring they have access to the care closer to home.

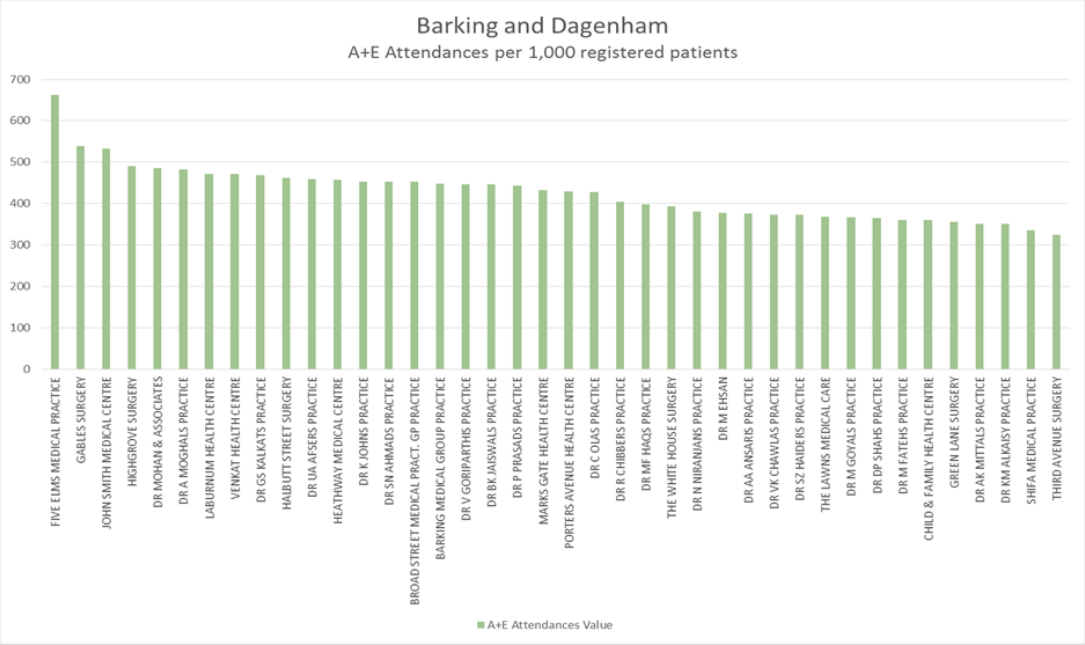


Figure 6: A&E attendance by practice per 1,000 population

Out-patient referrals show a similar trend with variation in referral rates varying across practices, see Figure 9.

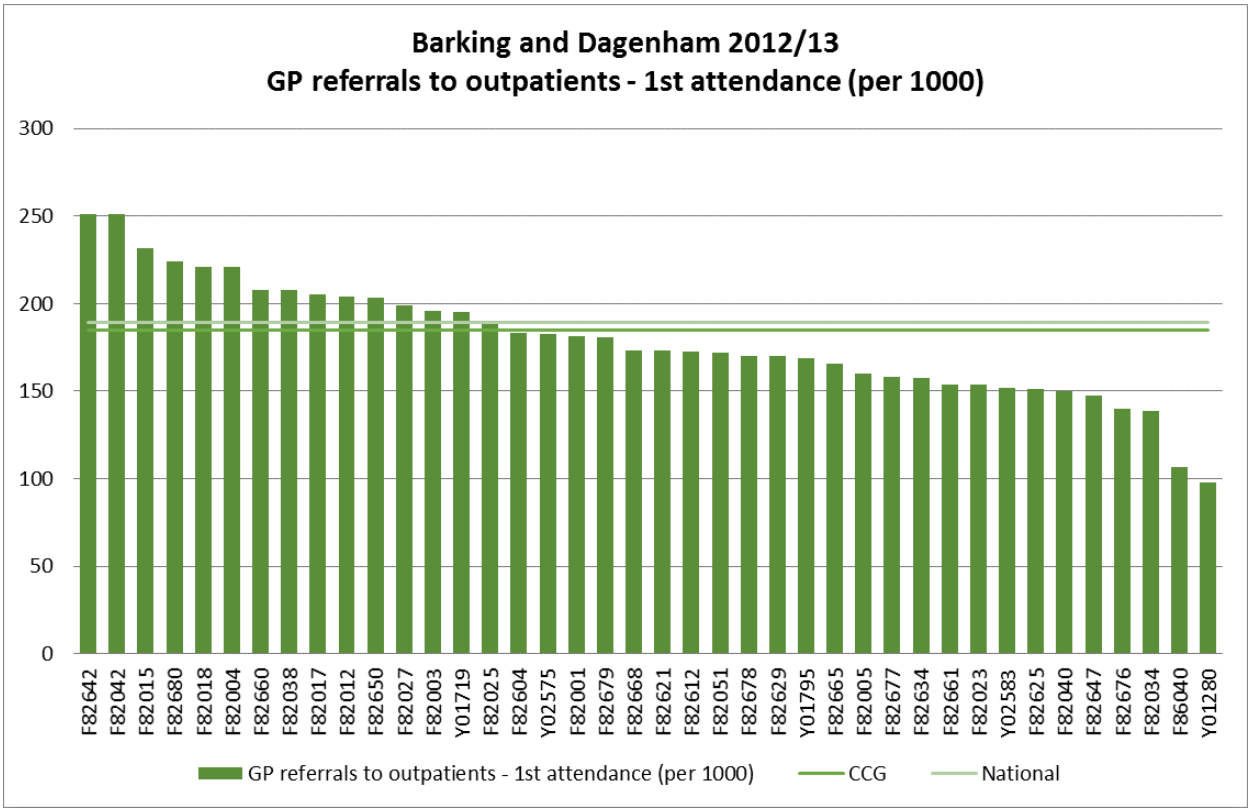


Figure 7. GP referrals to outpatients, first attendance by practice per 1,000 population

[Drafting note: Information request in progress. GP practice codes to be replaced with practice names prior to strategy finalisation]

3.3 GP and stakeholder perspectives

We have consulted with patient representatives, general practitioners, practice managers, pharmacists, nurses, community and mental health services (NELFT), acute services (BHRUT), the London Borough of Barking and Dagenham, NHS commissioners and Care City. We have also had conversations with primary care and workforce leads at NHS England London level. Local stakeholders have identified issues with primary care as it is now, and potential solutions. There is wide recognition that transformation in primary care is both necessary and desirable.

A full thematic analysis of feedback is available from the primary care transformation team. The key themes are shown below.

Challenge	Aspiration	Solutions offered
The system is fractured – we work in silos and there is a lot of inefficiency and duplication	We want integrated health and wellbeing services that meet our populations' physical, mental and social care needs	• We want more focus on prevention • We need to help patients to self-care • Care should be close to home • Links and handovers between primary, community, secondary and social care should be seamless • To improve quality and reduce costs we should align incentives across providers.
Demands and expectations of GPs are too high	We need to re-define the role of the GP in relation to the rest of the primary care team	• GPs want to retain overall responsibility for their patients but not feel like they have to do everything • We want GPs to be able to delegate work/decisions to other members of the primary care team where appropriate • We want GPs to have more time for complex, planned and preventative work • We want the benefits of collective working but also need to balance that against the desire for GP autonomy.
Our workforce is stretched and the workload is getting bigger	There are ways we could tackle our workload and workforce challenges	• We could share staff • We could pilot new care pathways and ways of working • By enhancing peoples' skills we could enable more sharing of the workload • Shared education and training would help team working and build relationships between professionals • We could train hybrid health and social care workers • Building communities of practice and support across professions would reduce feelings of isolation and allow us to share knowledge • Sharing back office functions would cut down on work.
We are	We want to build on	• We want to roll out the successful pilots we

committed to our patients and do some things really well	what already works	already have • We want to keep what works well.
Poor use of technology and low quality facilities makes our work harder	To do our jobs well we need fit for purpose buildings and good IT	• We need good IT and digital platforms to improve self-care and access for patients • We need integrated IT to improve quality and reduce workload.

4 Primary care strategic options

4.1 Requirements

In summary, the drivers for change described in the previous section give us a set of requirements a new primary care model must aim to meet. These are:

Delivery

- Meet the health needs of the diverse, growing and ageing populations in its various local communities
- Contribute substantially to the improvement of health outcomes for these populations and the reduction of health inequalities overall
- Meet national and regional quality standards for primary care, ensuring care is accessible, coordinated and proactive
- Increase capability/capacity to deliver the majority of patient care – planned, mental health and urgent – out of hospital with a focus on prevention, reducing demand for acute care and enabling savings of £400m across BHR.

Patient Experience

- Patients can continue to benefit from a relationship with their local GP
- Patients receive a joined-up, cost-effective care service with unnecessary duplicate assessment and treatment avoided.

General Practice

- Productive GP practices can retain their autonomy and have a financially sustainable future
- GPs have the time they need to provide quality patient care
- The time and effort spent by GPs and practice colleagues on administrative tasks is minimised
- The respective roles and responsibilities of GP practices and all local care providers in delivering care are clearly defined and consistently applied day-to-day by all parties

Workforce

- The career offer and working environment for GPs in Barking and Dagenham are sufficiently compelling to retain existing GPs and attract new enough recruits.

Infrastructure

- GPs and their fellow professionals can rely on IT to present the information about their patients that they need at the point of care to make the best decisions for patients
- Care is delivered in premises that are fit for purpose in a way that makes the best use of existing assets.

4.2 Strategic options

We have identified five possible options for the transformation of primary care in Barking and Dagenham over the coming five years:

1. "Do nothing" – retain the existing model at current levels of funding
2. Retain the existing model and increase funding
3. Invest in improving the quality and productivity of general practice and make it sustainable
4. Extend primary care incrementally to become a place-based model of care, whereby general practice and other primary and community-based providers collaborate to deliver proactive, joined-up care out-of-hospital for a local population
5. Building on the Five Year Forward View, move directly to merging the provision of general practice and community-based care and create a new form of provider, such as a multi-speciality community provider.

Our analysis in Section 3 demonstrates that option one is not sustainable.

Option two is neither clinically sustainable nor financially viable. BHR has a system wide budget gap of over £400m, and there is no additional funding available in the system beyond funding potentially released through a proportional reduction in acute hospital care.

The current primary care model therefore needs to change. A focus on improving general practice (option three) meets a number of the requirements above, but is not sufficient to create the capability and capacity needed to deliver the majority of patient care, or to transform care so it is joined-up and cost-effective with unnecessary duplicate assessment and treatment avoided. This would require closer integration of general practice with other primary and community-based care (option four).

Our recommendation is a vision which combines the strengthening of general practice (option three), maintenance of the patient-GP relationship and the continued autonomy of practices, with the extension of primary care to become place-based care (option four).

Experience of collaborative working in a virtual team may, in time, build a case to move to new forms of provider configuration (option five), but change should be made incrementally by local care professionals with a focus on what will improve services for patients.

5 The vision for primary care in Barking and Dagenham

5.1 Vision for primary care

The CCG's vision is to combine primary care with other community-based health and social care into a place-based care model with productive general practice at its foundation and GPs overseeing care for their patients. Each of the three existing localities in Barking and Dagenham where neighbouring GP practices work together will be a 'place', and the vision is therefore to establish locality-based care across all health and social care services for the populations within those geographical localities.

Locality-based care will be proactive, with a focus on prevention, support for self-care, active management of long-term conditions and the avoidance of unnecessary hospital admissions. Patients will have a more joined-up care experience, be enabled to take more control of their care, and more of their treatment will be closer to home.

The locality-based care model has at its foundation highly productive GP practices working collaboratively to deliver care, free up GP time and reduce administrative costs, making best use of available IT solutions. General practice will lead a highly effective extended locality team of community, social care, pharmacy, dental and ophthalmology professionals and the voluntary sector providing local people with the majority of their care. With input from local patients, this team will decide local pathways, how the care workload is shared, and where care is delivered from, in line with standards set and common assets managed at the BHR health system level.

Collaborative working will include GPs deciding how GP practices will work collectively across localities to offer services to patients, both within routine and extended opening hours, as defined by the strategic commissioning framework standards, and how collective working to manage workload will create more time for extended appointments. Localities will also decide what blend of services best meet local need and standards, for example the number of appointments available with GPs and other health professionals, and where those appointments will be offered (e.g. GP practices, hubs). To see how locality-based care will meet each strategic commissioning framework standard, see Appendix A: Transforming primary care live SPG delivery plan.

In configuration terms, locality teams will initially be virtual teams. General practice will have the opportunity to lead and shape the way locality provision develops, learning from the experience of joint working. In 2021, provision may continue in the form of an alliance of individual GP practices who operate autonomously. Alternatively, by then, general practices may consolidate into a larger scale provider, or join with community and other providers into a multi-speciality community provider.

A system-wide programme will be established to refresh the roles and mix of professionals needed for locality-based care and to develop the career packages needed to sustainably attract and retain the GPs, nurses and healthcare assistants needed.

With the balance of care delivery shifting away from hospital care, a greater share of the existing funding envelope will fall to general practice and fellow locality team providers. In time, it is likely that contractual arrangements will change to incentivise population-level outcomes rather than reward provider activity.

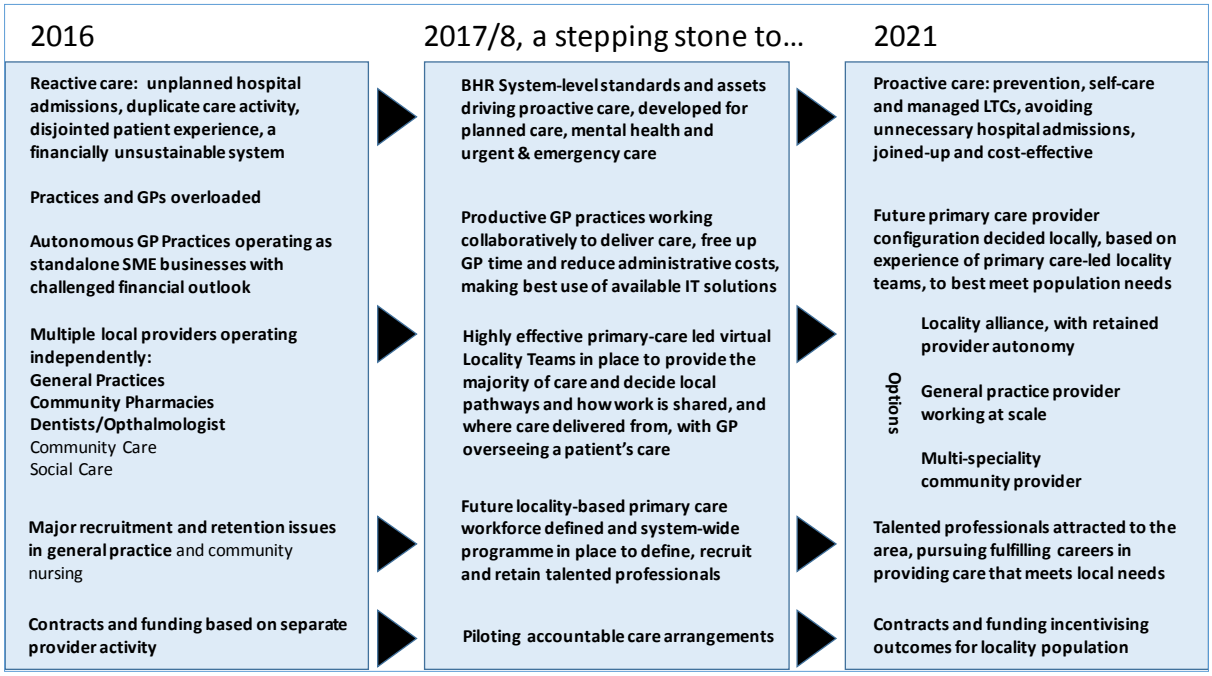


Figure 10. Milestones in journey towards achieving the vision

5.2 What is place-based care?

The King's Fund proposes place-based care as a way to create an environment where health care organisations can effectively work together towards improving health outcomes for the populations they serve. By pooling their resources, providers are freed from the pressure to focus on their own services and organisational survival to the potential detriment of other organisations within the health economy. In place-based care, providers collaborate to manage pooled resources, enabling them to consider the whole health economy when making decisions and to better use resources to meet their local populations' needs. Place-based care is not about top-down change, it's about enabling local systems of care to develop ways of working that effectively meet population need. The King's Fund's framework for developing place-based models of care will be used to develop the model in Barking and Dagenham. More details on this framework are in Section 0.

Evidence advanced by the King's Fund, drawing on examples from New Zealand, Chenn Med, is that place-based care works best with a population of 50-70,000 people. As Barking and Dagenham has a history of working in localities which contain populations of this size (see Appendix B: Current localities), it is proposed that place-based care be established within these boundaries.

5.3 How will place-based care in a Barking and Dagenham locality work?

The vision for general practice-led, locality-based care is summarised in the Figure 11, below. As now, it is founded on GP practices.

Providers and professionals working collaboratively

The locality-based care model comprises multiple layers, operating in parallel:

- Individual GPs, supporting, treating and referring patients on their list, taking, where appropriate, oversight of their care across the system, equipped with the information they need to do so
- Productive GP practices, effective at managing and prioritising their workload, using the full resources of the practice and making best use of IT solutions to free up GP time for patient care
- GP practices working within collaborative arrangements to deliver primary medical and additional services and to manage administrative activity more cost-effectively; existing federation arrangements may offer a starting point for this
- General practice leading an extended extended multi-professional team of community, social care, pharmacy, dental, ophthalmology and voluntary sector services.

The team in a locality will be sufficiently small (averaging circa 100 team members) to allow the formation of trusted working relationships between clinicians and care workers from different organisations and professional backgrounds, which will be important in improving care quality, patient experience and productivity. The inclusion of patients in that team of 100 will be key for the co-design of services with the population they serve.

It is assumed, initially, that general practice and fellow providers will come together in a virtual team, with the option to evolve into more formal organisational structures for collaborative working based on experience from delivering care collaboratively.

General practice-led locality-based care

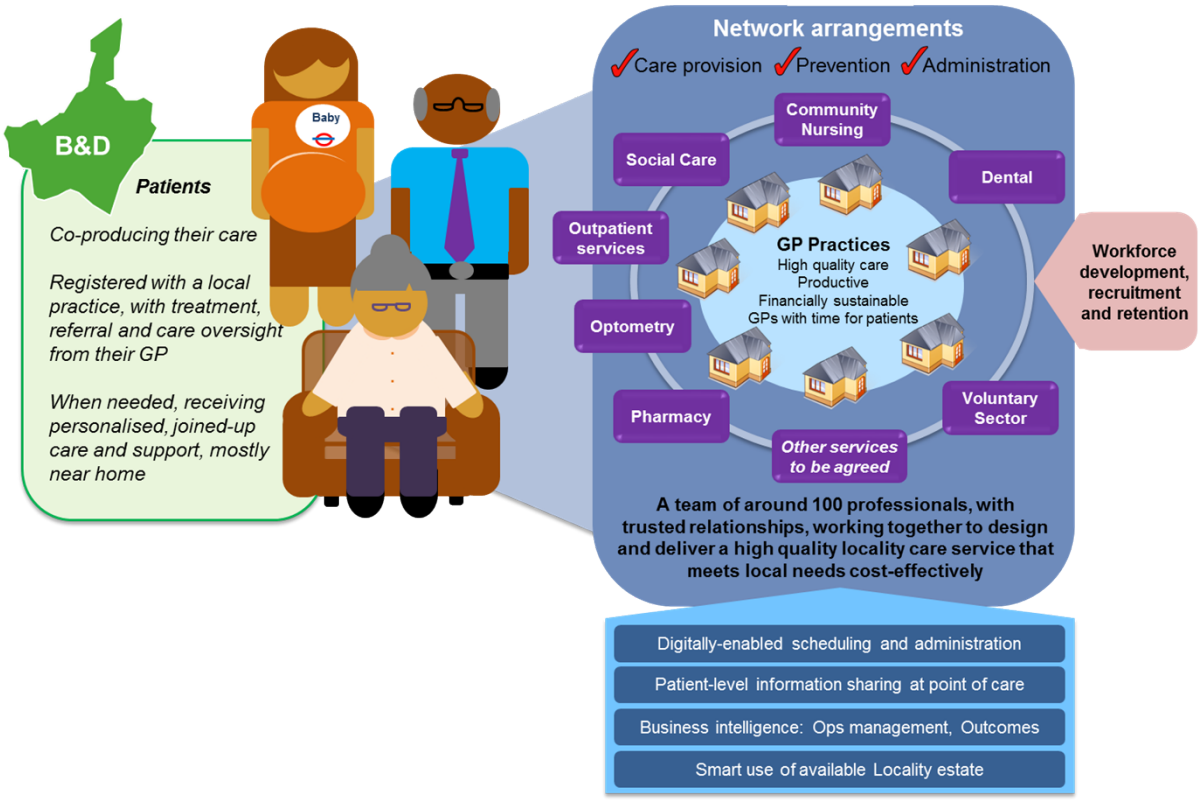


Figure 11. General practice-led locality-based care

Building a locality strategy and plan

To ensure equity and quality of care, localities will need to provide services which meet NHS England's strategic commissioning framework quality standards, and with BHR ambitions set

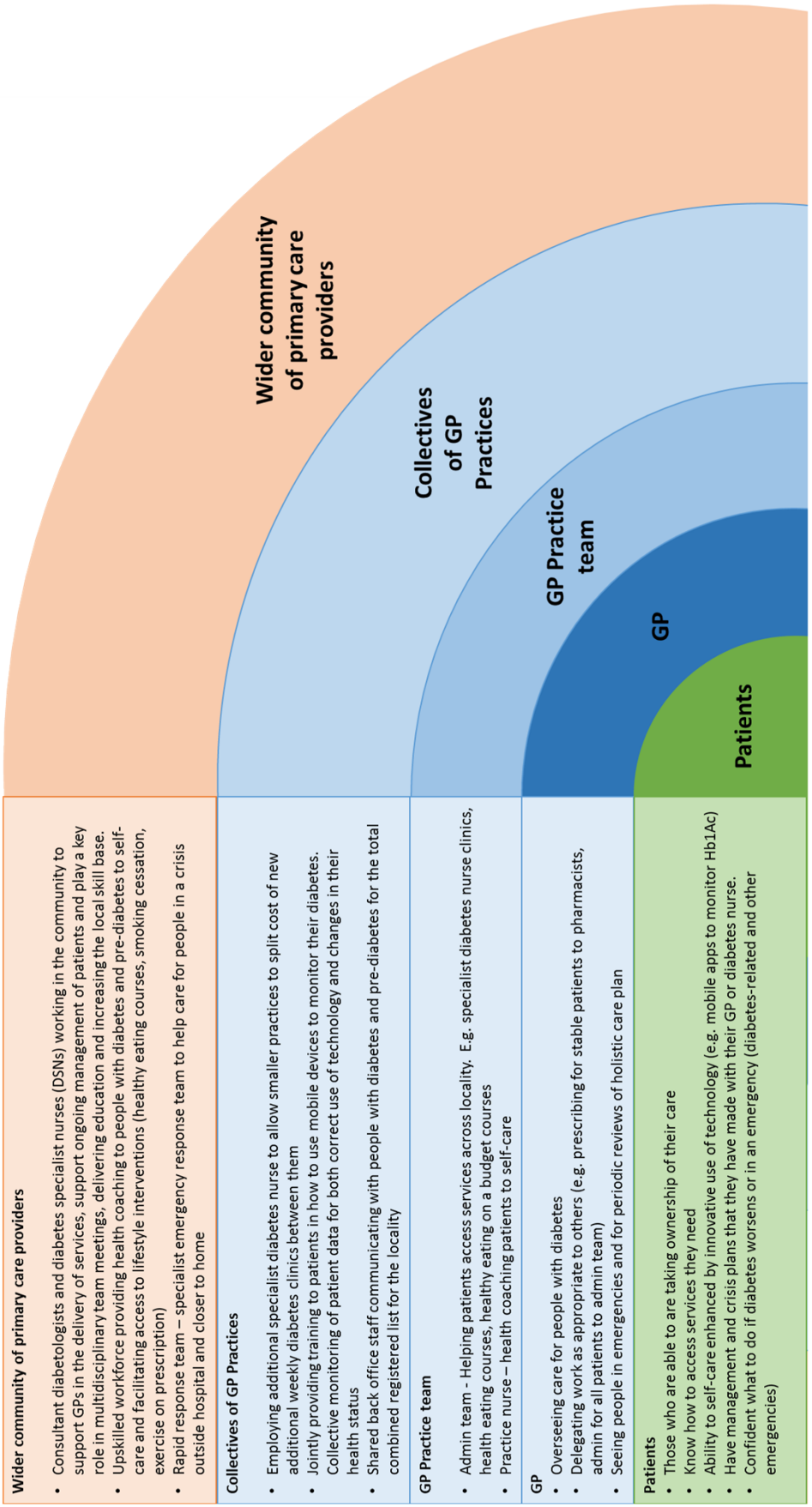
within a formal quality improvement framework with evaluation via the system's agreed primary care transformation dashboard (Appendix C – Primary care transformation dashboard). Within this framework, locality teams will develop a shared strategy and plan to meet the needs, priorities and preferences of the population they serve. They will decide what resources will best meet local health needs, and the specific health outcomes they want to target and track.

Localised pathway design

Pathway design within each locality will be informed by BHR standards for pathways for preventative, planned, urgent and mental health care. Within these standards, localities will be supported to design the pathways that work best for their population. Pathway design at locality level will include:

- Deciding the division of responsibility for delivery of primary care services across GP practices individually, GP practices collectively and the extended team
- Thresholds and protocols for referral to, and discharge from local hospital services
- The relative proportion of GP practice appointment time to be made available for prevention, planned and unplanned care.
- How the locality will utilise the planned urgent and emergency care 'click, call, come in' capacity as part of their urgent care offer
- How care across providers is joined up around the patient
- How providers all play to their strengths
- How quality is assured.

Figure 12. Example of how the mix of services might be distributed across the locality team



Enablers and support

The CCG will provide investment and support in the enablers of this vision for primary care-led locality working. BHR will:

- Provide each locality with dedicated resources to support the development of locality working.
- Identify solutions for the recruitment, retention and development of the GP workforce, as well as nursing, pharmacists and practice management. Other roles, including primary care healthcare assistants, may need to be developed (details below).
- Develop funding and contractual arrangements for primary care and the wider system to incentivise joined-up care, prevention and avoidance of avoidable hospital admissions.
- Enable GPs and the extended primary care team to operate from fit-for-purpose premises, making best collective use of local public service estates.
- Support both patients and their care providers to be confident users of information and IT solutions that enable self-care, care scheduling, joined-up care planning and management, and safe clinical decision-making.

At the same time, the financial sustainability of the system will be enhanced through the de-duplication and appropriate automation of administrative functions, releasing more patient-facing time.

Local authority contribution

- Social care services will make up a core part of locality-based primary care teams
- Public health will contribute in a number of ways:
    - input into needs assessments for each locality
    - map the current social capital available within each locality
    - commission services that focus on prevention of ill health
    - evaluate the impact of prevention on care capacity.

Evolution of the way providers are organised and work together

In configuration terms, locality teams will initially be virtual teams. General practice will have the opportunity to lead and shape the way locality provision develops, learning from the experience of joint working. Provision may continue in the form of an alliance of autonomous health and social care providers. Alternatively, by 2021, general practices may consolidate into a larger scale provider, or join with community and other providers into a multi-speciality community provider.

5.4 What is the vision for workforce in general practice and the locality?

Throughout our stakeholder interviews, there was a shared vision of integrated primary, community and social care working at a locality level with the patient and GP in the centre.

This strategy, therefore, makes recommendations for the primary care workforce for the first two years whilst the landscape becomes clearer with other strategies and initiatives. These recommendations will create the framework for a more engaged, mature and agile locality-based primary care team empowered to 'sense and respond' in a fast-changing world.[2] This will allow benefits from working as part of the CCG but also be locally driven.

[2] Frederic Laloux: Reinventing Organizations: A Guide to Creating Organizations Inspired by the Next Stage of Human Consciousness (Nelson Parker,2014). www.reinventingorganizations.com

As the vision is very much about empowering localities to co-design and deliver locally appropriate solutions, we have set out a range of potential options proposed by stakeholders for workforce development within locality settings. Localities can choose to adopt solutions that suit their population's and workforce's needs. These are set out in Appendix D – Workforce development in primary care.

5.5 What would locality-based care mean for a GP practice in 2018?

Different ways of working will develop within each locality, but GPs will see key changes in their day to day working across Barking and Dagenham take place over the next two years.

1. GP practices will work more productively and free up GP time to provide and oversee patient care

I'm a Practice Manger for quite a big practice (9 FTE GPs). I did a bit of work with one of our partners looking at the activity in our practice using a tool developed by the RCGP, which we found out about at one of the locality support sessions. I found the tool really helpful, not least because while everyone at our practice feels stretched and that things could be more efficient, they all have different opinions about what the problem is! Having the information about how we were spending our time in black and white made it a lot easier to agree what we should focus on, and ways we could change it.

We realised that a lot of GP time was spent on patients that could be seen by someone else in the practice. For example, GPs were doing routine blood pressure checks that could have been done by the nurse; hospital referral chasing that could have been done by reception; repeat prescriptions could have been done by our admin team. We talked through a couple of options that we'd gone through at a locality workshop and decided we would try 'process triage' at our practice. That means getting reception to ask what appointments were for and directing the routine checks, repeat prescriptions, coughs etc to alternative members of staff or the pharmacy. Of course, if a patient doesn't want to say why they want a GP appointment, we don't push them to say, it's just where they are happy to give that information. It's also not infallible, sometimes patients do reveal they have another problem which needs GP attention during their nurse appointment. Even taking all that into account, we managed to move about 10-15% of our GPs' workload onto other members of the practice team. That frees up about a day a week of GP time that can be spent on more valuable work.

2. Collaborative working between GP practices in localities and with the extended team of care professional will become established, raising quality and increasing capacity for locality care services and helping reduce the cost of administration

I'm a partner in a small practice and, like many practices, we have a lot of patients with diabetes. A specialist nurse helping to care for these patients would really improve these peoples' care, but we don't have the resources to employ a full-time specialist nurse, and have never been able to recruit one on a part-time basis. Because the practices in our locality have all outsourced our payroll and HR through the same company, it's been easy to join up with two other small practices to create a full-time role for a specialist diabetes nurse that we share between us. We share the cost of her salary, and all our patients get the benefit of specialist nursing. Our nurse likes the variety and was attracted by the full time job close to home. Our practices are close together so it's similar for her in terms of travel, and she's never working too far away from her son's nursery either.

We don't just outsource as a locality though; we also share work between our existing staff. We realised there are a lot of tasks that we didn't want to outsource, but that didn't make sense for every practice to do its own. Our practice managers have divided up this work we all do between them and now focus each team on doing one thing (e.g. call-recall) really well for the whole locality.

3. Clear boundaries between primary care and acute hospitals, with good handovers between teams

I used to spend hours chasing up information about my patients that had been discharged from hospital, making sure I knew what care needed to be in place and that it was happening. It was very often reactive, non-medical work, that was draining and frustrating. Having better information flows with our local hospital has improved things a lot. Joined-up IT means I have much more of the information I need to manage patients post-discharge. Reducing the administrative burden associated with discharged patients means I have more time to focus on planned care. For example, working on emergency plans with those patients who are likely to require acute care when their condition deteriorates. By having those plans in place with patients, and other services they will need, we can make the transition between primary and secondary care much better for those patients.

4. A programme will be put in place to recruit, develop and retain a primary care workforce suited to delivery in a place-based model in Barking and Dagenham

After years of trying, six months ago I finally recruited a new salaried GP to my practice and it's made a huge difference. Before she started I'd been reliant on locums and working myself into the ground. I used to regularly think to myself 'I'm a GP in my prime, I'm highly skilled, do I really want to do this for another 20 years when I could have a much, much nicer life in Australia?!'. Having another full time GP that's committed to the practice and the patients has really helped take some of that pressure off.

I think the recent changes have helped make our borough an attractive option for newly qualified GPs, when they wouldn't have considered it a few years ago. Now we're getting a reputation as the top place in London for innovation, what with the Vanguard and work on integration. She wanted to work somewhere where she would definitely be developed, on top of getting experience in all the multiprofessional working. It also helps that the CCG have got a bit slicker at marketing the area - good house prices compared to the rest of London and so on – as well as the work we do.

5. Increasingly, reliable IT solutions will enable joined-up patient care and the automation of administrative tasks, and locality-based providers will adopt and use them with confidence

I knew that joined-up IT would release a significant amount of time that my receptionists

used to spend printing and scanning paper documents. What I hadn't really expected was the difference it's made in terms of building trust in my colleagues outside my practice, and the benefits that has brought me in my job as a GP. It's not just that I started to build relationships with them in joint IT training sessions, or during Skype MDT meetings. Having shared records where we can access the information we need means I can easily see what community nursing, pharmacies, social care etc are doing to care for my patients. For example, if a patient needs a home visit after coming out of hospital, I can see when it's happened, what the outcome was and who is doing what. I don't have to hunt for that information, or call to double-check. It's just there. It means that I can really focus on what I need to do as a doctor for my patients, keep an overview of their care, but not feel like I have to do everything myself to be sure it will get done.

5.6 What would be the benefits of locality-based care for patients?

Across primary care there will be an overall improvement in quality of primary care in Barking and Dagenham, and a reduction in the variation of quality between GP practices. Patients will benefit from care that is more proactive, accessible and coordinated, as out outlined in the patient offer of the strategic commissioning framework. Their experience will be of an integrated service that supports and improves their health and wellbeing, enhances their ability to self-care, increases health literacy, and keeps people healthy. Primary care will be personalised, responsive, timely and accessible, and provided in a way that is both patient-centred and coordinated.

Practices across Barking and Dagenham will show improvement in the quality of treatment for key cancer, COPD, diabetes, mental health and patient satisfaction indicators (including four patient access indicators), as measured by progress against baseline in the primary care transformation dashboard (Appendix C – Primary care transformation dashboard

Issues around patient access will be addressed by providing seven-day primary care, with integrated IT allowing appropriate sharing of their records between services so that they receive high quality care no matter where they are. Joined-up services and shared records will enhance patients' confidence in primary care, reduce their reliance on their GP where other professionals could help them, and reduce their frustrations around having to repeat their story to different professionals.

The locality model will also allow patients that would previously have been treated in secondary care to be treated closer to home, for example by bringing consultants out of hospitals and into community clinics hosted in hubs.

Localities will actively engage with the population they serve, with the priorities and preferences of patients feeding into the locality vision and patients involved in the co-design of services with professionals.

6 The transformation needed in primary care

6.1 What is the transformation needed?

Within the next five years, care for Barking and Dagenham residents will move from reactive to proactive, with a focus on prevention, support for self-care, active management of long-term conditions and the avoidance of unnecessary hospital admissions. Patients will have a more joined-up care experience, be enabled to take more control of their care, and more of their treatment will be closer to home.

As illustrated in Figure 13 below, this will be achieved by

- Improving the productivity and financial sustainability of GP practices through better management of workload and use of IT, freeing up GP time for patient care
- Introducing/extending collaborative working between GP practices on care delivery and administration
- Transforming further how care is provided and organised in each locality, combining professionals in general practice with those in other primary and community-based health and social care providers into an extended team which provide a joined-up service for the majority of patients' care, with GPs overseeing care for their patients
- Developing BHR system strategies for planned care, mental health, urgent and emergency care and prevention, which establishes common standards and services for the BHR population, including defining standards regarding increasing access for those who are not currently accessing primary care.
- Locality teams working within this framework to decide local pathways, how work is shared and where care is delivered from, to best meet the needs of their population
- Locality teams having the governance, resources and business intelligence to monitor delivery, learn from experience and continuously improve their care quality and cost-effectiveness
- Locality teams are competent at capacity planning, enabling them to effectively design new ways of working taking into account how time spent on secondary prevention can free-up time currently spent on patients who have been discharged after an emergency admission.
- Developing a sustainable workforce for general practice and locality working
- Aligning contractual and funding arrangements with the achievement of population outcomes.

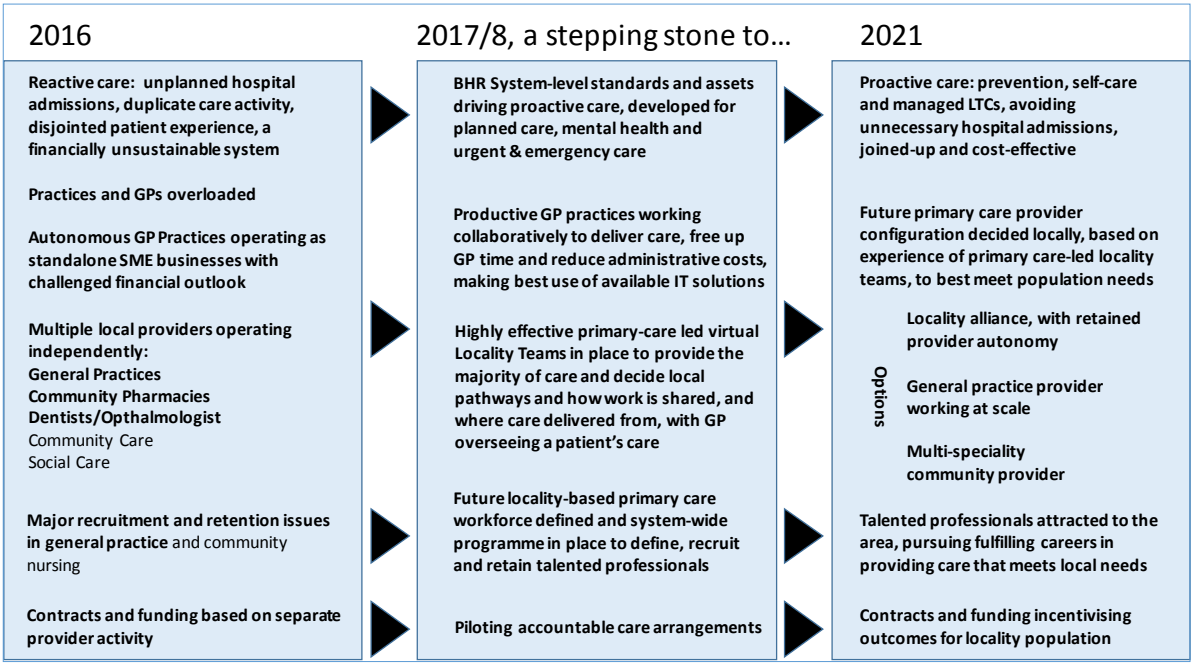


Figure 13: Milestones in journey towards achieving the vision

This agenda draws on the Kings Fund's guidance for establishing place-based care, shown below.

6.2 What will be the outcomes of the transformation?

Operating effectively, locality teams delivering the majority of care, working within the BHR standards framework, should achieve a range of outcomes:

- Reduction in unnecessary duplicate assessments and diagnostic tests
- Enhanced outcomes at individual patient and locality population levels
- Better targeting of local resource to locality health needs
- Increased support for individuals' self-management
- Enhanced life expectancy
- Better access to the right urgent care services
- Reduced unplanned A&E attendances and emergency admissions
- Reduced re-admissions to hospital.

In addition, there are outcomes specifically related to general practice:

- Enhanced patient satisfaction with the general practice service
- Continued high levels of access to GP practice services
- Proportional increase in GPs' patient-facing time
- Improved productivity and financial sustainability of GP practices
- Improved morale, teamworking and patient focus amongst locality-based staff
- Quality and financial benefits realised from investment in digital, IT and business intelligence solutions

These will all contribute to improved outcomes for patients, which will be monitored via the primary care transformation dashboard (see Appendix C – Primary care transformation dashboard.

6.3 How will implementation of the transformation agenda be organised?

The transformation agenda is multi-dimensional and, as shown in the table below, will be led from locality teams with support from a primary care transformation programme (PCTP) and adjacent planned care, mental health and urgent and emergency care transformation programmes, all at BHR system level.

Transformation theme	Vehicle
Improving the productivity and financial sustainability of GP practices through better management of workload and use of IT, freeing up GP time for patient care	PCTP
Introducing/extending collaborative working between GP practices on care delivery and administration	PCTP
Transforming further how care is provided and organised in each locality, combining professionals in general practice with those in other primary and community-based health and social care providers into an extended team which provide a joined-up service for the majority of patients' care, with GPs overseeing care for their patients	PCTP
Developing BHR system strategies for planned care, mental health, urgent and emergency care and prevention, which establishes common standards and services for the BHR population	Adjacent BHR transformation programmes
Extending access to urgent care services	Urgent and emergency care programme
Locality teams working within this framework to decide local pathways, how work is shared and where care is delivered from, to best meet the needs of their population	Localities, with BHR adjacent programme input and PCTP OD support for first cycle
Locality teams having the governance, resources and business intelligence to monitor delivery, learn from experience and continuously improve their care quality and cost-effectiveness	PCTP
Developing a sustainable workforce for general practice and locality working	BHR System/ CEPN/ Care City
Aligning contractual and funding arrangements with the achievement of population outcomes.	ACO Programme

The primary care transformation programme itself will be primarily about provider development – strengthening individual practices, progressing collaborative working amongst GP practices in localities and developing extended locality teams, bringing together GPs with all local health and social care professionals to provide the majority of care for patients. To bring this to life and establish a learning culture, the approach is to draw on the CCG's strategies for planned, mental health and urgent and emergency care and identify specific local schemes, which can be used to inform development of collaborative governance and working arrangements in localities and as a proving ground in localities, ensuring they are wholly grounded in the business of local providers and the care needs of local people.

The PCTP will be directed by the BHR Director of Primary Care Transformation and governed by the Primary Care Transformation Programme Board who:

- Provide system wide leadership and accountability for the transformation of primary care in BHR

- Recommend the priorities for primary care strategy to the governing bodies of BHR CCGs and the respective health and wellbeing boards
- Oversee implementation of the strategic commissioning framework for primary care transformation in London.

A programme management office will operate at BHR system level to ensure the four BHR transformation Programmes are co-ordinated and aligned so that localities are enabled to deliver the outcomes set out above.

6.4 Transformation Plan

6.4.1 Five-year programme

Phase 1	Establish effective localities, founded on productive general practice, to provide the majority of patient care	April 2016 to September 2017
Phase 2	Localities deliver care to meet local needs, line with BHR standards, and continue to evolve through learning and trial new contractual and funding arrangements	April 2017 to April 2021
Phase 3	General practice and locality provider configuration and evolves where appropriate from virtual team to alternative provider form	April 2018 to April 2021

6.4.2 Phase one: objectives and plan

The provider development work associated with improved productivity and the design and mobilisation of collaborative general practice and locality working needs to be undertaken with strong drive but at a measured pace to ensure the work is clinically led, that participating clinicians and care workers buy in, that professional relationships form sustainably and there is the opportunity to learn from experience and adapt the model accordingly.

The implementation will need to involve a collaborative partnership between the centralised BHR/CCG team and teams in each locality. A key requirement of the new model is that the ways of working and approach within each local area should be designed by the teams working within that area. There are however some key attributes that will need to be present in all models and additionally there are synergies and benefits that can be delivered through an understanding of the models under development in all localities, which would not be identified and exploited through a purely devolved implementation approach.

The objective is that locality teams should be working at full capacity and across the full scope of primary, community and social care by September 2018, in time for the 2019 contracting found.

Second-level objectives to achieve this are set out in the table below.

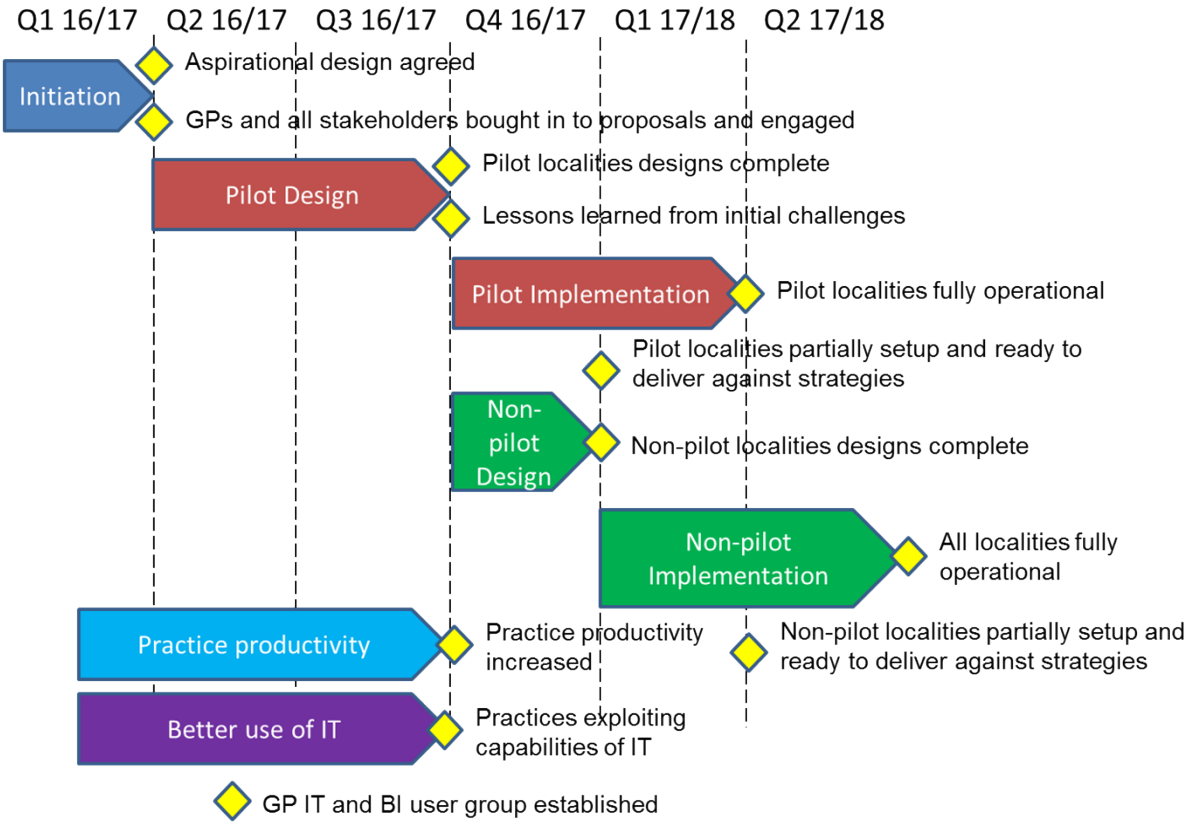
Objectives for primary care transformation phase one	
Provider development: **Practice productivity, collaborative working and**	• GPs are able to, and effective in, providing appropriate oversight for all of a patient's care • Individual GP practices are effective in managing their workload and focusing GP time where it adds most value • GP practices are clear what IT and digital solutions are available to improve productivity, have implemented them and realised the associated benefits • In each locality, each GP practice is clear on what primary care

locality team development	services it delivers and effective at delegating responsibility for other primary care services to other providers • Members of extended primary care teams in each locality have formed trusted working relationships with colleagues serving the same cohort of patients • Locality teams are clear what IT and digital solutions are available to enable interoperability, effective collaboration and a joined-up patient experience, have implemented them and realised the associated benefits
Quality	• Individual GP practices sustainably meet and exceed quality standards set out in NHS England Strategic Commissioning Framework for primary care and show progress against baseline in the primary care transformation dashboard
Locality pathways	• Arrangements are in place and used for locality pathways to be jointly designed by a cross-section of patients, GPs and other members of the locality team • Arrangements and protocol are in place whereby locality teams work with the BHR planned care, mental health and urgent and emergency care programme to agree mutual expectations for service design, capacity assumptions and outcomes and to communicate progress, issues and learning • Each locality has developed and implemented a holistic plan for prevention, including the upskilling of clinicians to coach for health and the organisation of screening and immunisation services • Each locality has pathways for frail elderly patients and for those with multiple co-morbidities • Each locality has determined how the CCG's planned 'click, call, come in' urgent care solution will be combined with urgent appointments in GP practices to provide an unplanned care service for the local population. They will have a clear plan for implementing this • Each locality has worked with Barts Health and/or BHRUT to develop and implement a full set of protocols for referral to hospital and discharge.
Governance, intelligence and learning	• Governance and management arrangements are established for collaborative working in general practice • Governance and management arrangements are established for locality working • Business intelligence arrangements are in place and used actively to monitor operational activity across each locality and to monitor the achievement of outcomes • Protected time is available and used by GPs and fellow locality team members to learn and develop together • Successes are identified, shared and celebrated.

While some work has been done in Barking and Dagenham to establish a GP federation, full implementation of the vision will require a significant change from current ways of working, and therefore it is proposed to start with a pilot. One locality will lead the way for Barking and Dagenham with the designs for the other localities not being started until that for the pilot locality has been completed. This will enable lessons learned from the pilot to be incorporated in the designs and planning for the other localities.

To minimise risk and allow greater chance of success robust project and programme management arrangements will be put in place, and localities will receive significant support from BHR and the CCG. This is not to take away from the responsibilities and ownership of teams in localities, but to provide a support to them in the design and implementation of change.

Key milestones for phase one are as follows:



6.4.3 Programme for 2016/17

6.4.3.1 Initiation phase

An initiation phase is required to undertake the following tasks:

- Creation of a set of design principles against which all Locality Models should be designed. These will be based on the King's Fund: 10 principles to guide the development of systems of care in the NHS
- Development of the framework of outcomes that all locality models will need to deliver as a minimum in addition to their locally identified outcomes
- Development of a business case for the implementation of the new model articulating the case (costs and benefits) at all levels - system and borough, locality, GP practice
- Agreement of resources needed for implementation and how these resources will be identified
- Definition of each locality area and agreement of these, including development of locality profiles to enable localities to prioritise and plan around the needs of their populations
- Identification of the pilot locality and working with them to mobilise the project to design their new model

- Communications and engagement to gain buy-in and support from all parties across Barking and Dagenham who need to be involved in the design and implementation of the new model.

6.4.3.2 Practice productivity

A workstream will be initiated to help GP practices increase their productivity. This will be delivered through a series of workshops teaching skills and using real-life data from GPs to drive improvement. These workshops will cover:

- Theory and methods of demand and capacity modelling to support analysis of their own practices. E.g. the RCGP's *3rd available appointment*
- Sharing modelling findings and selection of interventions to trial within their practices
- Sharing of impact and learning from changes made within practice

This additional independent workstream will involve working with all members of the extended primary care team to help everyone understand the capabilities and make use of their existing IT.

6.4.3.3 Design phase – collaborative working in general practice and across localities

Each locality designing its new operating model, with the pilot locality taking the lead and lessons learned from the pilot fed into the design of the other localities. This will include work on (but not limited to) the following areas:

- Processes and pathways - including business models of operation for all different areas of the operation and functions (both front and back office), the operational costs of these and the expected performance levels
- Organisation and people – the organisation structure, staffing levels, roles, skill requirements, culture etc
- Estates – how the different accommodation across the locality will be utilised to support the new operating model
- Governance – how the locality will be governed and managed
- Use of IT and information (N.B. the designs for IT and information governance will be completed at a system level to achieve economies of scale and consistency across localities).

To develop this new operating model, practitioners from different disciplines will need to come together and will follow a co-design approach. This approach will play a part in developing the organisation and creating trust and relationships between the different groups of professionals within a locality.

The implementation plan, to be followed through the next phase of the implementation, will also be developed. This will include in detail all of the activity that will need to be completed to move from a design on paper into live operations.

At a system level designs for IT and information governance will be completed incorporating the requirements of the emerging locality models. There will also need to be a re-design of the CCG and system level support and management arrangements so that they are aligned with and fit-for-purpose with the new locality ways of working. This level will also have responsibility for oversight of the designs that are in development to recognise synergies and opportunities for efficiency and collaboration between localities.

6.4.3.4 Implementation phase

This phase of activity will include all the activity needed to move from a design on paper into live operations. The detail of this cannot be known until the completion of the design phase; however it will touch on all areas of the new operating model.

7 Risks and assumptions

Risks

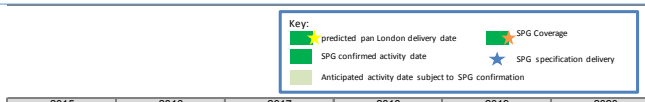
- Insufficient grass roots buy-in from GPs and other primary care professionals
- Insufficient capacity within general practice to participate
- Dependencies on other projects – IT, workforce
- The pace of change demanded vs the time necessary to develop localities sustainably
- Compatibility of the strategy with main providers' strategies
- Insufficient investment in the resources to enable the programme to succeed.

Assumptions

- Improving team working in localities will release significant quality and productivity benefits
- GP practices are receptive to opportunities to improve their practices
- This strategy will have top-level support regardless of whether the ACO proceeds
- Interoperable IT agenda sufficiently advanced to enable localities to provide continuity of care to patients.

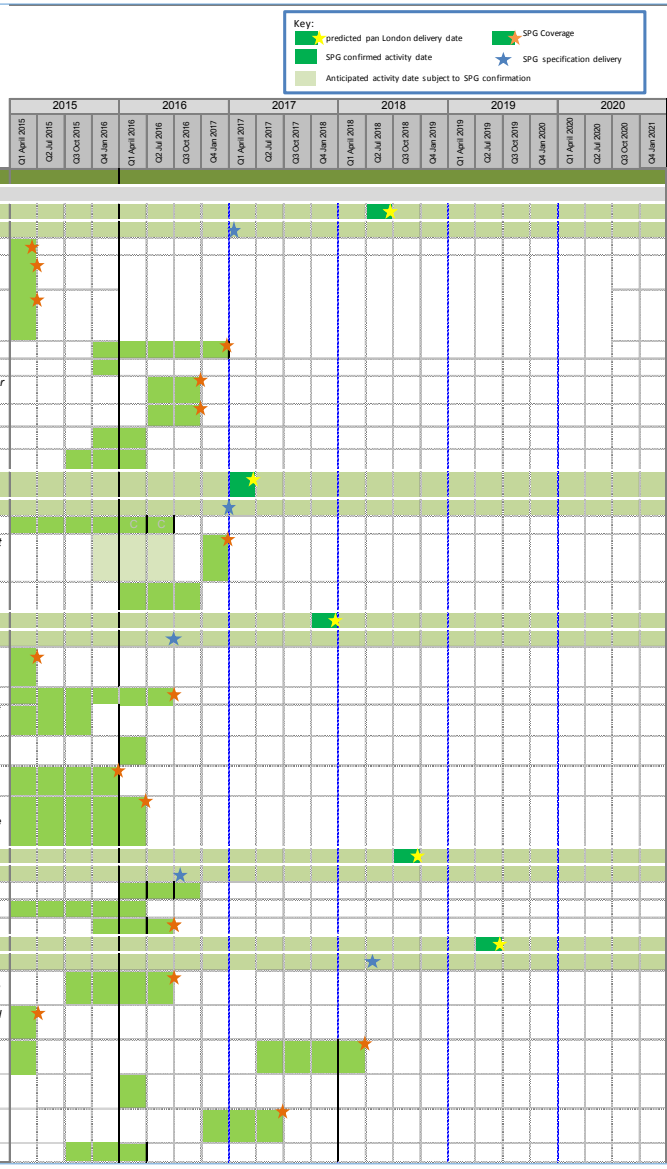
8 Appendix A: Transforming primary care live SPG delivery plan

Transforming Primary Care
Live SPG delivery plan



Spec	Examples of supporting activity	2015 Q1 April 2015	2015 Q2 Jul 2015	2015 Q3 Oct 2015	2015 Q4 Jan 2016	2016 Q1 April 2016	2016 Q2 Jul 2016	2016 Q3 Oct 2016	2016 Q4 Jan 2017	2017 Q1 April 2017	2017 Q2 Jul 2017	2017 Q3 Oct 2017	2017 Q4 Jan 2018	2018 Q1 April 2018	2018 Q2 Jul 2018	2018 Q3 Oct 2018	2018 Q4 Jan 2019	2019 Q1 April 2019	2019 Q2 Jul 2019	2019 Q3 Oct 2019	2019 Q4 Jan 2020	2020 Q1 April 2020	2020 Q2 Jul 2020	2020 Q3 Oct 2020	Q4 Jan 2021	How does the vision for locality-based primary care enable and accelerate cost-effective compliance with the standard?
		Year 1				Year 2				Year 3				Year 4				Year 5								
	Accessible Care																									
A	**Patient Choice**																									
	BHR																									
	Pilot access hubs as part of PMCF in place across BHR																									Patient choice built into the urgent care offer designed by localities which will work alongside the BHR-wide click, call, come-in urgent and emergency care offer Non-urgent care offering patient choice in all pathways as part of locality designs.
	Accessible care scheme to be fully defined																									
	Patient record sharing functionality in place																									
	Patient records are shared across the federations and are available at the access hubs																									
	Access hubs advertised via practice websites and A&E																									
	Roll out of additional access hub in B&D																									
	MiDoS available to patients with local asset database content loaded into the directory																									
	Nuffield trust evaluation of success of access hub following completion of pilot stage																									
A2	**Contacting the practice**																									
	BHR																									
	Practices have online functionality through a module within their clinical systems																									Productive GP practices will make best use of IT and Digital solutions to simplify access and actively promote online services
	Training of telephone triage/consultation to the federations pilot practices in BHR																									
	Practice 'patient on-line' functionality in place and training delivered to allow practices to offer online availability																									
	Pilot of telephone triage/consultation (12 practices)																									
	Development of BC to enhance telephone triage/consultation through a central (BHR wide) call centre																									
	Federations to apply for CEPN funding to rollout telephone triage/consultation training post pilot																									
	Further pilot of telephone consultations through central call centres subject to pilot success																									
	Rollout of telephone consultations through central call centres subject to BC and pilot success																									
A3	**Routine opening hours**																									
	BHR																									
	No current plans to change contracted routine opening hours, Saturday opening to be achieved via access hubs																									Localities will collaborate to deliver pre-bookable routine appointments with a primary health care professional within routine hours using all resources available within the locality including hubs
	Pilot access hubs as part of PMCF in place across BHR																									
	Patient record sharing functionality in place																									
	Patient records are shared across the federations and are available at the access hubs																									
	Access hubs advertised via practice websites and A&E																									
	CCG to review requirement to open in-hours as part of federation planned and unplanned care pathway redesign																									
A4	**Extended opening hours**																									
	BHR																									
	Pilot access hubs as part of PMCF in place across BHR, providing 6.30 - 10pm weekdays, and 12-6pm weekends																									Localities will collaborate to deliver pre-bookable and unscheduled appointments within extended hours using all resources available within the locality including hubs
	Walk in centres currently providing 8 - 8pm																									
	Additional services providing extended opening (FOPAL, CTT team, ICM, intensive rehab service, enhanced psychiatric liaison)																									
	Patient record sharing functionality in place																									
	Patient records are shared across the federations and are available at the access hubs																									
	Access hubs advertised via practice websites and A&E																									
	Roll out of additional access hub in B&D																									
	Evaluate success of access hub following completion of pilot stage																									
	Health1000 pilot in place providing care to patients with 5+ LTC who registered on the Health1000 list. Extended access is provided through on-call within the GP practice																									
	Improve alignment between access hub and services such as GP OOH and WIC through CCGs urgent care strategy workplan																									
A5	**Same day access**																									
	BHR																									
	Pilot access hubs as part of PMCF in place across BHR																									Effective use of the wider primary care team and utilising technology to improve access will create capacity that will allow patients who want to be seen the same day at their practice within routine hours.
	Additional services providing extended opening (FOPAL, enhanced psychiatric liaison). CTT/IRS in place on a pilot basis pending formal establishment																									
	Pilot of telephone triage/consultation (12 practices)																									
	Development of BC to enhance telephone triage/consultation through a central (BHR wide) call centre																									
	Federations to apply for CEPN funding to rollout telephone triage/consultation training post pilot																									
	Further pilot of telephone consultations through central call centres - subject to BC and pilot success																									
A6	**Urgent and Emergency Care**																									
	BHR																									
	CTT work across BHR and in Queens A&E																									Localities will collaborate to design local urgent and emergency care offers that work alongside the click, call, come-in urgent care pathway
	Urgent Care Centres in Queens & King George's run by GPs in place																									
	Streamline access to services within A&E (CTT, ambulatory care, enhanced psychiatric liaison and FOPAL)																									
	Urgent care pathway development to be launched at 1 July conference																									
	Urgent care strategy - workplan with milestones to be developed following conference)																									
	Federation to develop business case to review new ways of working with in-hours and out of hours																									
A7	**Continuity of Care**																									
	BHR																									
	Integrated case management (ICM) in place																									In locality-based care all patients will have a named GP for care continuity and coordination, who effectively oversees the appropriate delivery of the care plan by the wider primary care team
	Mainstream intermediate care pilot services (CTT-ICM/IRS)																									
	Record sharing is available for MDTs with the ICM																									
	Joint Assessment and Discharge team established in BHRUT to improve discharge and care planning for complex patients																									
	Unplanned admissions DES in place - optimising coordinated managed care for the most vulnerable patients in their homes																									
	Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list.																									
	Patient records are shared across the federations and are available at the access hubs																									

Transforming Primary Care
Live SPG delivery plan

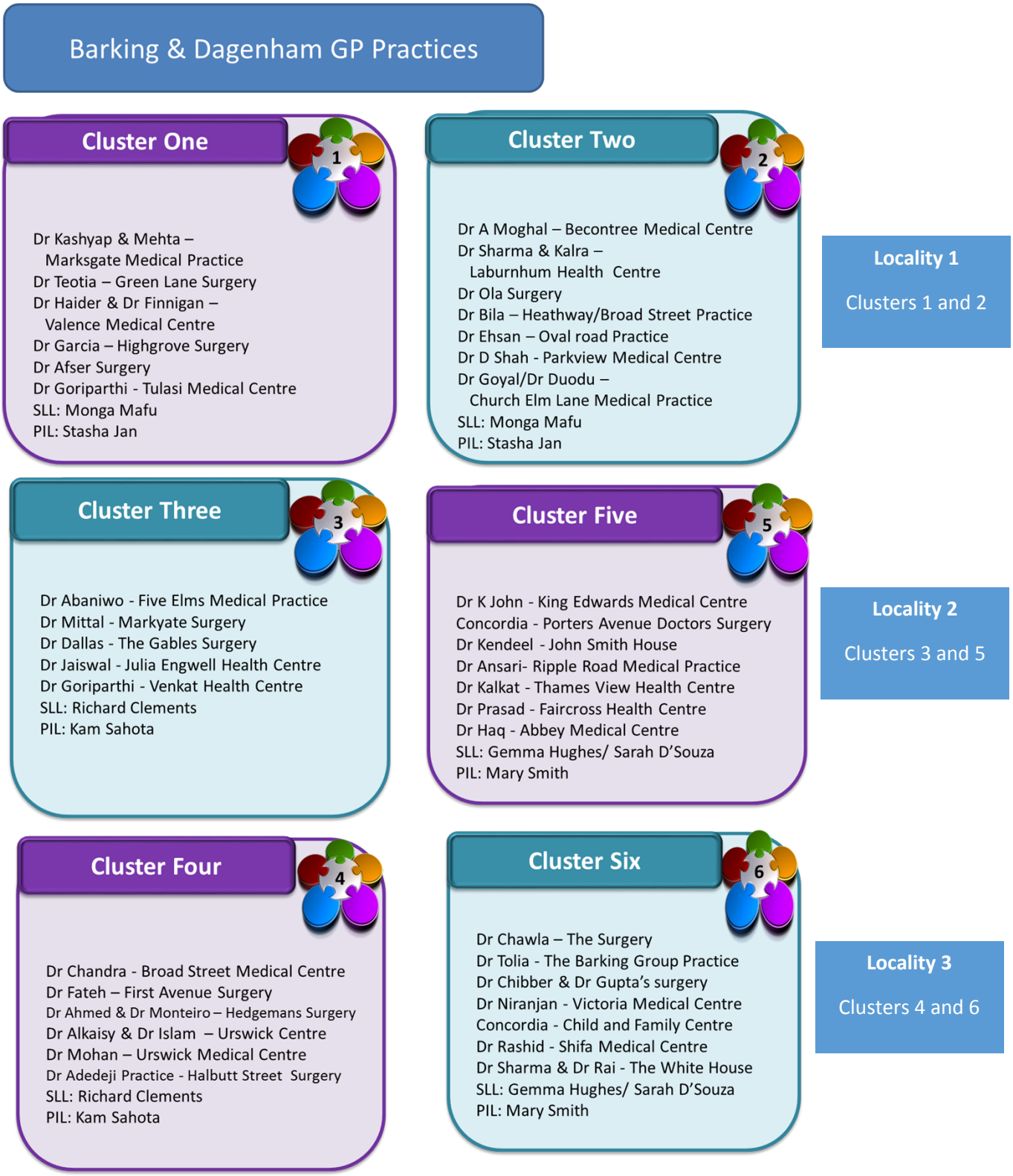


		How does the vision for locality-based primary care enable and accelerate cost-effective compliance with the standard?
	Proactive Care	
	Delivery of specifications	
P1	**Co-Design**	
	BHR	
	Focus groups led by the federations with Healthwatch representation	Patients and voluntary sector organisations will be part of the locality team and will help co-design services within localities
	H1000 model developed with UCLP and patient groups linked into the design process	
	Development of the new intermediate care model (ICM, CTT, IRS) followed extensive engagement with stakeholders to determine co-design the model	
	Focus group to review central call centre initiative across the federations	
	CEPN to review workforce planning and training needs	
	Map dementia services across health, social care and voluntary sector in Havering	
	Map health services for over 75s to review the pathway alignment	
	Test impact of new operational resilience schemes	
	Development of the primary care strategy	
P2	**Developing assets and resources for improving health and wellbeing**	
	BHR	
	MiDoS developed to include local asset database	Locality teams will include colleagues from the Local Authority, voluntary and community, health and third sector organisations and will work together to ensure best use of community resources (including social capital) to improve population health and wellbeing
	Work with the local council, community and voluntary services to input into MiDoS (this is dependant on LA sign-up which is being sought through ICC and ICSG)	
	MiDoS used by ICM to locate support and care services close to peoples' homes	
P3	**Personal conversations focussed on an individual's health goals**	
	BHR	
	Risk stratification is in place to support targetting the top 1-3% for conversations	Localities will design planned care pathways that include opportunities for patients to access coaching for health from a member of the primary care team who will be able to direct them to appropriate local services (e.g. leisure centres, citizen's advice) Training in coaching for health will be part of workforce development
	Integrated case management (ICM) in place to manage the top 1%	
	Care co-ordination and Frailty training being commissioned as part of the Locality Training Fund for 2014/15	
	Review whether to roll out intervention pharmacists pilot as a QIPP scheme	
	Health1000 pilot in place providing tailored care to patients with 5+ LTC who registered on the Health1000 list.	
	Everyone counts initiative - GP Practices have been allocated CCG funds based on their list sizes with which to devise new and innovative services to support the >75s within their practice population.	
P4	**Health and wellbeing liaison and information**	
	BHR	
	MiDoS developed to include local asset database	Locality teams will design ways to use local assets and IT/ Digital to prevent ill health by enabling patients to access information and advice
	Clinicians use MiDoS	
	Patients are able to use MiDoS	
P5	**Patients not currently accessing primary care services**	
	BHR	
	Patients encouraged at walk in centres & UCC to register at a practice	Localities will collaborate to design ways to reach people who do not routinely access primary care, including a joined-locality approach to working with the unregistered population. Productive GP practices making best use of IT and Digital solutions will have more time to focus on people on their registered list who do not attend, and processes in place to potentially consolidate that work.
	Homeless patients encouraged to register at walk in centre co-located practices	
	CCG and LA to develop and implement plans to work with local schools and business around healty life styles	
	Review London Commissioned services around homeless practice/provision	
	Primary care strategy developing additional plans to target vulnerable groups	
	Queens A&E to review patients with 10+ attendances in 12 months	

Transforming Primary Care
Live SPG delivery plan

		How does the vision for locality-based primary care enable and accelerate cost-effective compliance with the standard?
	Coordinated Care	
	Delivery of specifications	
C1	**Case finding and review**	
	BHR	
	Regular engagement with the Integrated Care Coalition (ICC)	Localities will collaborate to allow the efficient and effective stratification of their combined registered lists to allow identification of individuals who would benefit from coordinated care and a joint approach to working with those patients.
	Risk stratification is in place to support targetting the top 1-3% for conversations	
	Integrated case management (ICM) in place to manage the top 1%	
	Queens A&E to review patients with 10+ attendances in 12 months	
	Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list. Patients targeted through a tailored risk stratification tool focussed on patients with more than 5 LTC's.	
C2	**Named professional**	
	BHR	
	Integrated Case Management in place	Localities will design pathways for planned care that allow patient-focused, coordinated care, overseen effectively by their named GP and making effective use of the wider primary care team. This will be enabled through shared patient records using interoperable IT systems that enhance the ability for work to be shared across the team, remove duplication of work and free GP time for planned care.
	All patients included in the ICM model have a named professional	
	Risk stratification tools used to identify further patients at risk	
	Unplanned admissions DES in place - optimising coordinated managed care for the most vulnerable patients in their homes	
	Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list.	
C3	**Care Planning**	
	BHR	
	Integrated Case Management model in place	Interoperable IT systems will allow patients' care plans to be effectively shared across the primary care so that they can access the appropriate care in all settings.
	Care plans developed and managed with the MDTs in ICM	
	Patient records shared across MDTs within the ICM	
	Data governance for patient records to enable sharing within ICM agreed	
	Pilot Skype MDT with acute geriatrician in Havering	
	Joint Assessment and Discharge team in BHR University Hospital Trust to improve discharge and care planning for complex patients	
	Care co-ordination training commissioned as part of the Locality Training Fund for 2014/15	
	Patient records shared across access hubs & federations	
	Shared care summary being developed to pull key clinical information from sources to aid clinical decision making and improve patient experience	
	Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list.	
C4	**Patients supported to manage their health and wellbeing**	
	BHR	
	Integrated Case Management model in place	Localities will design planned care pathways that include opportunities for patients to access coaching for health from a member of the primary care team who will be able to direct them to appropriate local services (e.g. leisure centres, citizen's advice) Training in coaching for health will be part of workforce development Locality teams will design ways to use local assets and IT/ Digital to prevent ill health by enabling patients to access information and advice
	Care plans developed and managed with the MDTs in ICM	
	Patient records shared across MDTs within the ICM	
	Care co-ordination training commissioned as part of the Locality Training Fund for 2014/15 (training includes cognitive behavioural techniques to support patients to self-care).	
	Patient records are shared across the federations and are available at the access hubs	
	Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list.	
	System wide training / specific workshops through the CEPN e.g. EOL - difficult conversations for secondary care clinicians	
C5	**Multi-disciplinary working**	
	BHR	
	Integrated Case Management model in place	Localities will design pathways for planned care that allow patient-focused, coordinated care, overseen effectively by their named GP and making effective use of the wider primary care team. This will be enabled through shared patient records using interoperable IT systems that enhance the ability for work to be shared across the team, remove duplication of work and free GP time for planned care.
	Care plans developed and managed with the MDTs in ICM	
	Patient records shared across MDTs within the ICM	
	Patient records are shared across the federations and are available at the access hubs	
	Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list. Team consists of dedicated: Geriatrician, social workder, physiotherapist, occupational therapist, nurses, GP and key workers	
	System wide training / specific workshops through the CEPN e.g. EOL - difficult conversations for secondary care clinicians	

9 Appendix B: Current localities



10 Appendix C – Primary care transformation dashboard

Placeholder – dashboard has not been populated but was finalised mid-March

11 Appendix D – Workforce development in primary care

Solutions offered include using a greater skill mix of practitioners in primary care, offering a seamless integrated service with clear opportunities for career development for all members of the primary health care team.

Specific ideas for different members of the primary health care team are summarised below.

GPs

Attract young GPs	Fourth year fellowships in Barking and Dagenham for GP trainees. Provide "home" (perhaps a BHR-wide employment agency) with identity, peers and support for ongoing learning, personal and professional development, parental leave, study leave, management opportunities to lead small projects and research opportunities, whether a partner, salaried or long-term locum Plurality of provider models to include independent contractors, federations, chambers, super practices, and increased salaried working, to achieve economies of scale in management, infrastructure, and clinical resources, and to provide wider ranges of patient services. Become exemplars of multiprofessional working
Attract returning GPs	By marketing package for returning GPs: ongoing support for personal and professional development, family friendly approach, parental leave and carers leave offer, easy to access Ofsted reports, RIghtmove and Zoopla. Clarity on career path and ongoing development.
Attract international GPs	From Eastern Europe (via the IMG scheme) GP profile to match changing population profile. Offer IMGs a registrar-level salary while training (as they do in East Midlands) to enable senior experienced GPs to afford to come to London.
Promote sustainable model of General Practice	To promote fulfilling, rewarding and sustainable career. Become known as *the* place in London for excellent integrated care with primary, community and social care building on innovation of the Vanguard and ACO. Time to see patients and deal with issues properly Interesting variety of patients Integrated locality model of working with joint learning and co-development of services with other providers and patients. Identify, prioritise, implement and evaluate local models of QI initiatives Social prescribing Pharmacist prescribing Support older GPs with retirement planning
Market Barking and Dagenham as a place to live and work	Effective HASS in Barking and Dagenham with S75 agreements in place between LA and community provider Affordable housing (for London) Good schools

	Range of career development pathways identified
Opportunities in Barking and Dagenham as a GP	To develop as clinical leader - locality lead, clinical lead, committee chair, CCG board member To develop as educator and trainer To develop as a researcher (with Care City, BHRUT, UCL Partners)
Ongoing learning and development	Protected time for learning with peers both in general practice and with rest of the primary health care team Training in coaching for health Training in solution focused conversations Continue to develop skills e.g. joint injections, update on dermatology
Use workforce modelling data	Available from April 2016 from NHS England (London) to identify existing workforce. Match to current and future models of care, identify gaps and plan to address
Identify areas to prioritise and work on collaboratively	Form localities/communities of practice All GPs part of geographical network (including salaried and long-term locums) Find ways to innovate/incentivise joint working e.g. • top slice secondary care services and provide network enhanced services • One HV for network of GP practices • Share services across network of practices e.g. phlebotomy, direct access physio, counsellor • Develop care pathways across the locality • Share back office functions e.g one book keeper, IT support, HR support • Autonomy to use delegated budget at locality level to meet the needs of the local population

Pharmacists

Upskill community pharmacists	In behaviour change Train as health coaches
Develop role of practice pharmacists	Medicines reconciliation Medication review Prescription management Prescription safety/concordance Acute common conditions Chronic disease management Practice performance Primary care practice research
Develop role of pharmacists to work in urgent care settings	Training in coaching for health Training in common clinical conditions Independent prescriber
Upskill to become independent prescribers	For urgent prescriptions as well as LTCs Career path to develop expertise in diabetes, asthma etc
recruit clinical pharmacists	Have “off the shelf” Barking and Dagenham offer, ready to

	advertise for new clinical pharmacists (London-wide initiative)
Recruit local pharmacists	Through local pharmacy apprentice scheme
Ongoing joint learning	With GPs and other members of the primary health care team Career paths identified
Family friendly	
Introduce Pharmacy First scheme	Free OTC medicines for patients on benefits

Nurses

Attract young nurses	Multi-agency training: acute, primary and community Key worker housing
Retain nurses	Career development pathways identified Ability to work in primary care and community care Supported by AHPs Part of a learning community of practice Key worker housing
Recruit international nurses	
Train nurse prescribers	To work with patients with LTC
Train nurse practitioners	To work with patients with LTC Career path e.g. community matron, specialist practice nurse
Family friendly	
Life long learning	Ongoing joint learning with GPs, pharmacists and other members of the primary and community health team
Optimise use of pool of nursing resource across a locality	Using practice nurses and community nurses, with links to midwives, health visitors and school nurses.
Develop specialist nurses for non registered population	e.g HV for the homeless develop working relationship with third sector e.g. AA, narcotics anonymous

AHPs

Recruit physician's assistants Physician associates support doctors in the diagnosis and management of patients. They are trained to	London-wide scheme to train physicians assistants Have a Barking and Dagenham offer "on the shelf" ready to advertise when PAs graduate See patients for same-day appointments Review test results Booked appointments with patients with LTC Home visits Cryotherapy

perform a number of roles including: • taking medical histories • performing examinations • diagnosing illnesses • analysing test results • developing management plans. They work under the direct supervision of a doctor	Teaching Clinical audit Maintaining practice registers Supervision of HCAs Make Barking and Dagenham primary care an attractive place to work by offering apprenticeships (PAs have to find £9,000 tuition fees and loans and grants are not available) NB PAs cannot gain prescribing rights as do not have registration. This is being addressed nationally.
Train generic staff to work across health and social care	Care City to provide mechanism to train generic health and social care workers to work across health and social care. Care City to host peer networks, provide mentorship and facilitate apprenticeships CEPN are developing care navigators
Family friendly	To recruit and retain
Life long learning	Framework for ongoing personal and professional development Career paths identified

Admin and Clerical

Practice Managers Board	Could be developed to • help PMs share work between them (QOF, call-recall) • develop areas of personal expertise/sub specialisation • develop career path
Receptionists	Develop reception staff skills in signposting Career path as care navigators
Family friendly	
Life long learning	Opportunities to continue to learn and develop Career paths mapped out and supported

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HEALTH AND WELLBEING BOARD

26 April 2016

Title:	Better Care Fund 2016/17 Plans
Report of the Strategic Director for Service Development & Integration	
Open Report	**For Decision** Yes
Wards Affected: ALL	**Key Decision:** Yes
Report Author: Mark Tyson, Group Manager, Integration & Commissioning, London Borough Barking Dagenham Sharon Morrow, Chief Operating Officer, Barking and Dagenham CCG	**Contact Details:** Tel: 020 8227 2749 E-mail: mark.tyson@lbbd.gov.uk
Sponsor: Anne Bristow, Strategic Director for Service Development & Integration, London Borough Barking Dagenham Conor Burke, Accountable Officer, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups	

Summary:

This report provides the Health and Wellbeing Board (HWBB) with the detailed plans for the local Better Care Fund (BCF) for 2016/17 and asks the HWBB to endorse the BCF plan and budget for 2016-17 prior to submission to NHS England, conditional on adjustments following input and comment from the Health and Wellbeing Board. The Board is also asked to delegate authority to the appropriate officers to extend the Section 75 agreement for the BCF.

This reports follows on from the March 2016 meeting report to the HWBB, where the Board was provided with an end of year 2015 assessment of performance and an outline of the plans for developing the 2016/17 BCF Plans, including the national timetable for submission of the BCF and the Board's role in approving the plan.

The report sets out the national conditions for the BCF as well as setting out a high level narrative of how we are meeting these national conditions. These are the same conditions in 2015/16 BCF with two new additional requirements: on investment in NHS commissioned out-of-hospital services, and agreement on a local action plan to reduce delayed transfers of care.

Our BCF metrics for 2016/17 are largely a continuation of the priorities set in 2015/16, informed by a detailed analysis of the past year's performance. The report outlined how a realistic assessment has been undertaken on the proposed impact of BCF initiatives on performance in 2016-17.

The BCF Pool in 2016/17 will be comprised of the CCG minimum required contribution to

the fund, the Local Authority minimum contribution, plus additional contributions from the Local authority over and above the required minimum. The BCF Pool for 2016/17 will total £20.705m.

Guidance from NHS England indicates that risk sharing agreements, as part of contingency planning, should be considered to manage potential excess emergency hospital activity (admissions). Whilst the CCG has proposed that a risk sharing agreement should be in place for this risk in 2016/17, the local authority has also raised the significant financial pressures on its services, including the costs and activity levels within its commissioning of residential placements and crisis intervention services, clearly identifying that any risk share ought to take these costs into account, alongside those of unplanned admissions. In recognition of the fact that both partners have significant financial pressures in 2016/17 and the complexity of identifying proportionate arrangements for mitigating these multiple risks within the timescales available, it is being proposed that there will be no risk share agreement in 2016/17. From its own resources, the CCG has identified a contingency sum which is being included as part of the BCF pool.

The Joint Executive Management Committee has provided approval at each stage of the submission of information to NHS England as well as strategic direction and guidance throughout the process. The timelines for developing the BCF 2016/17 have been imposed on us by NHS England and there has been flexibility in our own governance processes in order to accommodate this. The 2015/16 governance arrangements for the BCF will be maintained for 2016/17. These arrangements and the processes have been robust as the BCF received full assurance from a recent internal audit carried out by the Council's auditors, as has been previously reported to the Board.

The finances of the BCF will be governed by a Section 75 agreement made between the CCG and London Borough of Barking & Dagenham. The existing Section 75 agreement will be extended to cover the BCF 2016/17 with minor amendments to reflect changes to levels of funding and risk sharing.

Recommendation(s)

It is recommended that the Health and Wellbeing Board:

1. Endorses the Better Care Fund plan, budget for 2016-17 and activity as well as delegate authority on behalf of the Council to the Deputy Chief Executive and Strategic Director, Service Development and Integration, for submission to NHS England as set out in Appendix A, conditional on adjustments following input and comment from the Health and Wellbeing Board.
2. Delegates authority on behalf of the Council to the Deputy Chief Executive and Strategic Director, Service Development and Integration, to extend the Section 75 agreement for the Better Care Fund, with amendments in line with this report, and in consultation with the Director of Law and Governance and the Strategic Director Finance and Investment.

Reason(s)

The Better Care Fund is a major plank of the Board's strategy for promoting integration of services, which forms part of the statutory remit of the Board. This report sets out the priorities and activities for the BCF for 2016/17 and provides the Board with an

opportunity to approve plans for a further year's work to integrate and improve services via the Better Care Fund. This contributes to the priorities of the Clinical Commissioning Group and the Council, as well as other partner agencies.

1 Purpose of the Report

1.1 The purpose of this report is to provide the Health and Wellbeing Board (HWBB) with the detailed plans for the local Better Care Fund (BCF) for 2016/17 prior to submission to NHS England. There is a requirement in the BCF technical guidance for plans to be jointly developed and approved by the Board.

1.2 The report provides the Board with an overview of what is contained in the planned submission, including the national conditions set out for this year's BCF, the timeline for the process, and the 2016/17 plans and targets that the BCF will deliver in 2016/17. The report also sets out the programme management and governance process that will underpin the BCF in 2016/17.

1.3 The Board is being asked to delegate authority for approval of the final submission on behalf of the Council, since NHS England is still releasing parts of the submission template it is not possible to include all final documents with the reports pack for the 26 April meeting. The substantive content is, however, all present in this report.

2 Better Care Fund reports to HWBB

2.1 In December 2015 a report to the HWBB provided the Board with details of the progress the BCF had made in 2015, including information on performance against the agreed metrics, delivery of the agreed schemes within the BCF and actions that were being taken to address underperformance.

2.2 This report was then followed up at the March 2016 meeting of the HWBB, where the Board was provided with an end of year 2015 assessment of performance and an outline of the plans for developing the 2016/17 BCF Plans, including the national timetable for submission of the BCF and the Board's role in approving the plan. The report also highlighted that national technical guidance and templates had not yet been received.

3 Better Care Fund Plans for 2016/17

3.1 The 2016/17 BCF Plans are set for one year. As Board members will be aware work is underway on the development of the Sustainability and Transformation Plan for North East London, of which the Barking & Dagenham, Havering and Redbridge components will be worked up alongside the development of the Accountable Care Organisation Business Case. This will set the vision, model and approaches which will lead to greater integration in the delivery of health and social care by 2020 and, if successfully developed, the guidance suggests the there would not be a requirement for BCF plans beyond the current year.

3.2 The BCF technical guidance issued by NHS England sets out the national conditions that all BCF plans are required to meet. The following conditions are the same in 2016/17 as for 2015/16:

- Plans to be jointly agreed;
- Demonstrate how areas will maintain provision of social care services in 2016/17;
- Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate;
- Better data sharing between health and social care, based on the NHS number;
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;

3.3 In addition, for 2016/17 there are two further conditions that have been added, which are:

- Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;
- Agreement on local action plan to reduce delayed transfers of care.

3.4 Appendix A provides the high level narratives that detail how we are meeting each of the national conditions. These were submitted in draft to NHS England on 21 March 2016 and have since been revised following feedback received on 13 April 2016. Appendix A also includes the targets against the required metrics for the Better Care Fund, with the plan included at Appendix B setting out how we proposed to deliver against those ambitions for 2016/17.

3.5 We will meet the new condition of investing in NHS commissioned out-of-hospital services by maintaining the investment in the Joint Assessment and Discharge Service (JAD) which has successfully brought together teams from partner organisations into a single service, and has removed structural barriers to effective collaborative working. The BCF to commission a handyperson scheme in the Borough to complement a range of interventions. In addition, there continues to be investment in intermediate care services and social care crisis intervention support to facilitate safe and timely discharge.

3.6 In response to the level of delayed transfers of care in mental health inpatient settings, we have also identified particular opportunities to improve the provision of mental health supported living and to increase investment in social care support for this client group. This also relates to the second national condition, around the need to develop a clear, focused action plan for managing delayed transfers of care (DTOC).

3.7 Our DTOC plan is set out in Appendix C and is designed to tackle delays occurring in acute and inpatient settings across the health and care system. It reflects the

actions included under the 'Improved Discharge from Hospital' Theme in the overall BCF plan that is set out in Appendix B.

3.8 Barking and Dagenham has worked hard to deliver its aspirations against the original trajectories for the BCF metrics but with limited success. Understanding the reason for this underperformance and using that information to inform planning, monitoring and aspiration setting for 2016/17 has been a significant aspect of preparing to refresh the plan.

3.9 In terms of the targets we propose to achieve, the details are included below:

Metric 1: non-elective admissions

3.10 A non-elective admission is an admission to hospital for overnight stay where the patient's admission is not planned; it includes emergency admissions, and admissions for maternity, births, and non-emergency patient transfers. In 2015/16 we failed to meet the target reduction, with a consequential loss of the performance reward payment to the local system.

3.11 The target for 2016/17 will be 228 admissions avoided. This will be against an expected total admission of 2,405 in 2016/17.The target for BCF has been reduced in line with actual performance in 15/16 but still represents a challenging target and is based on impacting avoidable admissions. The BCF plan represents one element of the overall CCG operating plan for admission reduction. The BCF plan is focused on local joint actions most likely to impact admissions and is supported by wider system work through Systems Resilience Group. In setting the target we have made sure that the schemes overview milestones details how the schemes will impact on this metric.

Metric 2: Permanent admissions into residential/nursing placements

3.12 A further key aim of the Better Care Fund is the promotion of care closer to home, and for social care this concerns avoidance of admission to residential care as far as possible. Last year, we set a target based on the 2013/14 outturn, which was low compared to a longer-term trend. It proved to be a target that it was not possible to meet. This year, we have reviewed a longer trajectory and set a reduction target which better reflects achievable performance.

3.13 There has been a fluctuating pattern of admissions over the last few years, within which there are signs of a reduction in admissions. Over the past four years, admissions have been:

- 2011/12: 200;
- 2012/13: 170;
- 2013/14: 135;
- 2014/15: 179.

3.14 This has averaged at 171 admissions. In 2015/16 the outturn is around 180 admissions, subject to data validation.

3.15 We therefore feel confident that a target of 170 admissions is realistic, given the variability in this data, as well reflective of the expected continued pressure on admissions.

Metric 3: Re-ablement effectiveness

3.16 The Better Care Fund also seeks to ensure that hospital discharge is effectively setting people up for continued independent living, and that care plans put in place are sustainable.

3.17 The measure has a crude element of calculation and is understood to be subject to national review. Its collection involves contacting people that were admitted in hospital within a 3 month period to ask if they were re-admitted into hospital within 90days after that 3month period. Concerns about the viability of this measure are shared across other London authorities, including the variability in how it can be affected by various service interventions, the identification of the cohort of individual service users it takes in, and the challenge of the manual data collection involved. Changes to the way the data collection was approached for 2014/15 are a significant contributor to performance dropping so markedly to 67.2%. The Council's approach to crisis intervention over a conventional re-ablement service also adds confusion about definitions of those service users to include in the measure.

3.18 Taking into account greater clarity about who is included in the cohort of service users to be assessed for this measure, it is proposed that our target for 2016/17 is set at 75%.

Metric 4: Delayed Transfers of Care from Hospital

3.19 Ensuring people are supported in an integrated way to enable them to be safely discharged from hospital was a key BCF priority in 2015/16 and it is expected to remain a critical metric again in 2016/17.

3.20 The Joint Assessment and Discharge team have made a significant and positive contribution to our DTOC target in 2015/16. We are clear on the areas that are causing us significant issues, which include Mental Health delays, and we have reflected this in the DTOC plan which will be submitted as part of the overall BCF plan.

3.21 A 2% reduction in delayed transfers of care against 2015/16 outturn will be our target of 2016/17. This is both reflective of the significant pressures we are expecting as well taking into account the actions proposed in our plan.

Metric 5: GP user survey – people feeling supported by services to manage their long term conditions

3.22 This periodic survey uses a small cohort of respondents to assess a range of measures, one of which is the judgment about feeling supported to manage long-term conditions. Even within the usual variability of perception surveys, the methodology and small sample mean it is difficult to have robust confidence in this measure. Nonetheless, patient perceptions of feeling supported remains an important aspect of our joint service delivery.

3.23 Our current performance is 54% which is lower than the London average of 58%. Our performance target therefore is to match or improve on the London average figure.

Metric 6: Injuries due to falls in people aged 65

3.24 This indicator measures the number of emergency admissions due to falls-related injuries.

3.25 This is one of our local indicators on which we have performed well against its set target. In the calendar year 2015, there were 17 fewer falls-related admissions compared to a baseline of 410 in the previous year. We intend to improve on this in 2016/17, and are proposing a target of a further reduction.

4 Finances for the BCF

4.1 The BCF Pool in 2016/17 will be comprised of the CCG minimum required contribution to the fund, the Local Authority minimum contribution, and additional contributions from the Local authority over and above the required minimum. The BCF Pool for 2016/17 will total £20.705m and full financial details are included in Appendix D. The table below summarises the funding streams:

BCF 2016-17	**£'000**
Local Authority funding	
LA Minimum contribution: Disabled Facilities grant (DFG):	1,265
LA Other contributions:	
Base Budgets:	5,070
Public Health grant:	1,191
Total LA funding:	7,526
CCG funding	
CCG Minimum contribution:	13,179
Total BCF 2016-17 pool:	20,705

4.2 In 2015/16 the key performance target associated with the BCF was a reduction in non-elective admissions to hospital, which was subject to a payment for performance regime. As detailed in previous reports, due to the failure to achieve the target set the performance penalty was invoked resulting in a penalty of £710k, split equally between the CCG and Local Authority. In 2016/17 non-elective admissions to hospital will continue to be a key performance indicator, however without an attached performance penalty.

4.3 The Board will be aware that in the 2015/16 Section 75 Agreement, the CCG and Local Authority entered into a risk share agreement whereby if non-elective admissions did not fall below a 2014 calendar year baseline, both partners contributed to a risk share that was to be used by the CCG to pay for unplanned non-elective activity in acute hospitals.

4.4 Guidance from NHS England indicates that risk sharing agreements, as part of contingency planning, should be considered in the event of excess emergency hospital activity (admissions). Whilst the CCG has proposed that a risk sharing agreement should be in place for this risk in 2016/17, the local authority has also raised the significant financial pressures on its services, including the costs and activity levels within its commissioning and delivery of residential placements and crisis response services, and that any risk share ought to take these costs into account, alongside those of unplanned admissions. In recognition of these multiple sources of system cost pressure, and the complexity of arriving at a proportionate risk share arrangement within the available guidance and timeframe, it has been agreed that there will be no risk share agreement in 2016/17

4.5 In discussions we have noted that both partners have a positive history of working together, and are developing transformative approaches to addressing on-going sustainability. It also remains our view that any risk share for 2016/17 is likely to be counterproductive to these developments. Rather, working across the whole health and social care sector (with all partners such as BHRUT and community services), including the potential development of an Accountable Care Organisation or similar partnership arrangements, would represent the main mechanism through which rising activity/acuity risks will be mitigated.

5 Process of developing the BCF Plans 2016/17

5.1 The BCF Delivery Group has worked to develop all aspects of the BCF Plans for 2016/17, ensuring that the plans meet the national conditions, that targets for metrics are set that are challenging but achievable and based on robust data, and that the revised schemes have an improved focus on specific projects that help support achievement against the set metrics. The Joint Executive Management Committee has provided approval at each stage of the submission of information to NHS England as well as strategic direction and guidance throughout the process.

5.2 The timelines for developing the BCF 2016/17 have been imposed on us by NHS England and we have flexed our own governance processes where possible in order to accommodate this. An outline of the timelines for the development and submission of the BCF Plans are set out below:

	Date	**Milestones**
Final submission timeline and sign off process	22 March – 13 April 2016	Amend and draft plans based on the feedback received from NHSE
	5 April 2016	Delivery group to develop the details schemes milestone and amend plans based on feedback received.
	12 April 2016	JEMC to agree and sign off the Plans
	13 April 2016	BHR CCGs JMT sign off
	21 April 2016	Final submission template released by NHSE
	26 April 2016	HWBB to agree overview of plans and delegate authority to conclude the planning process and submit the plan
	3 May 2016	Submit to NHSE
	24 May 2016	Update the CCG Governing Body of the final Plans that were submitted.

6 Programme governance of Better Care Fund in 2016/17

6.1 The current governance arrangements for the BCF will be maintained for 2016/17. We are confident that these arrangements and the processes around them are robust as the BCF received full assurance from a recent internal audit carried out by the Council's auditors. The finances of the BCF will be governed by a Section 75 agreement made between the CCG and the Council. The existing Section 75 agreement will be extended to cover the BCF 2016/17 with minor amendments to reflect changes to levels of funding and the new approach to risk share. The Section 75 was previously approved by the Board for 2015/16 at its meeting on 17 March 2015.

Mandatory Implications

Joint Strategic Needs Assessment

6.2 The Better Care Fund is specifically mentioned in Recommendation 11 of the 2015 JSNA as a key programme to ensure services promote residents' independence. The Better Care Fund also contributes to Recommendation 12, reducing hospital admissions and re-admissions as well as Recommendation 14, allowing terminally ill adults to die with dignity in a supported and planned way with real choice about where they die.

Health and Wellbeing Strategy

6.3 The Better Care Fund reinforces the aims of the Health and Wellbeing Strategy and aligns to three of the four priorities set out in the Health and Wellbeing Strategy: Care and Support, Improvement and Integration of Services; and Prevention. In particular, it is a significant vehicle for the delivery of integration of services, principally for frail older people.

Integration

6.4 Integrated commissioning and provision is at the heart of the Better Care Fund and the report sets out a number of ways in which the management of the Fund has furthered integrated service delivery.

Financial Implications

Completed by
Olufunke Adediran, Group Accountant, Corporate Finance

6.5 The Better Care Fund is an important aspect of ensuring the longer term financial sustainability of social care by aiming to reduce and better manage demand for both health and social are services.

6.6 The total BCF pooled fund for 2016/17 is 20.705m and is set out in more detail in Section 4 and Appendix D of this report.

Legal Implications

Completed by
Daniel Toohey, Principal Corporate Solicitor and Deputy Monitoring Officer

6.7 The Section 75 of the National Health Service Act 2006 gives powers to local authorities and clinical commission groups to make certain joint arrangements, including the establishing of pooled funds out of which payment can be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions. Such arrangements are often referred to in short hand as "s75 agreements". Council and CCG must agree and implement a Better Care Fund Programme for 2016-17.

6.8 It is a requirement of the Better Care Fund grant programme, as set down in national directions, that an agreement in the form of a Section 75 agreement be entered into between the Council and the Clinical Commissioning Group for Barking and Dagenham, and an agreement for the year 2015/16 was accordingly entered into. There is accordingly now a requirement for an extension for the coming financial year. The agreement also formalises the management of the pooled funds and the role of the Joint Executive Management Committee in monitoring and improving performance across the Better Care Fund plan.

6.9 Under the s75 agreement, the Council has undertaken to host the fund, and in particular to manage and maintain the pooled funds, which entails ensuring that expenditure out of the pool occurs within strict parameters, and that specified actions regarding potential overspends are taken, including timely reporting back to the Joint Executive Management Committee. The procurement of services or supplies will need to comply with the requirements of the Public Contracts Regulations 2015 and any future proposed procurement exercises by the Council will require a return report to the Committee; Legal Services are available to advise and assist the Council and its officers in that regard.

Risk Management

6.10 Risk management arrangements are being put in place by the Joint Executive Management Committee as part of planning for the BCF. The JEMC will then be considering these risks on an on-going basis, with officers identified with responsibility for mitigating actions.

Patient / Service User Impact

6.11 The purpose of the Better Care Fund is as a vehicle to improve services to patients and service users through greater integration. Across a number of areas, including hospital discharge, falls prevention and end of life care, improvements are being made through BCF schemes. It also provides an opportunity to engage with frontline staff and patients/service users themselves about potential improvements that could be made to their services.

7 Non-mandatory Implications

Contractual Issues

7.1 Across the Better Care Fund there are investments which are delivered through contracts held by either the Clinical Commissioning Group or the Council. Where procurement activity is taking place (such as proposals that have been before the Health & Wellbeing Board already around carers' services) they are planned jointly, even where one partner is taking the procurement lead. This report proposes no specific changes in itself, and no decisions are required on contractual matters as a result of this update.

8 List of Appendices

Appendix A	**BCF High level Narratives for NHSE submission**
Appendix B	**BCF 2016/17 Schemes and milestones**
Appendix C	**DTOC Plan 2016/17 for NHSE submission**
Appendix D	**BCF Financial Expenditure Plan 2016/17**

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Better Care Fund Plans 2016-17
High Level Plans Narrative and update

1.0 Introduction

Barking and Dagenham developed and agreed their Better Care Fund plan in 2014. The final submission of the plan was made in December 2014 having been signed off by the CCG and LBBD and following engagement with local communities, providers and other stakeholders. The following narrative should be read in conjunction with the 2014 submission.

The following narrative sets out:

- Updated BCF plans– in particular in the local vision, lessons learnt from 15/16 and refreshed metric trajectories.
- Details as to how the national conditions are met
- Confirmation of funding contributions – detail of this is included in the BCF planning return submission
- Scheme level spending plan – detail of this is included in the BCF planning return submission

2.0 Updated BCF plans

2.1 local vision

Since the BCF was agreed and submitted in December 2014, a number of developments have taken place, which will support and enable the aspirations set out in the original plan.

These include:

- Urgent and Emergency Care Vanguard – see Urgent and Emergency Care Value Proposition
- Accountable Care Organisation – see ACO bid
- Operating Plan and Sustainability and Transformation Plan
- Ambition 2020 – with increased focus on targeting services and integrating approaches
- Mental Health needs assessment and strategy development

The development of revised locality delivery networks based on the needs of populations of 50-70,000 residents is at the heart of transformation programmes described above and the BCF.

The content of the BCF revised plans for 2016/17 has been developed to take into account and align with the transformation work described above.

Stakeholder engagement and co-design in our emerging transformation programmes is at different stages but very much an integral part of each strand of work. Recent work has included an informal café style engagement afternoon, focusing on staying healthy and very much reflecting the prevention elements of the BCF plan.

2.2 Lessons learnt

We have achieved limited headway on our delivery of the non-elective admissions target for 15/16 which has led to significant further work to understand what is, locally, driving non-elective admissions and as a result how those might best be impacted upon. This has included a detailed review of admissions to understand in particular those areas that are more difficult to impact upon (examples being maternity and patient transfers) and where local work needs to align with wider system work taken forward through the Systems Resilience Group and the Integrated Care Coalition across BHR.

Testing hypotheses around admissions was explored with front line staff from a range of provider organisations at a stakeholder event in October 2015. This work was followed up with a specific piece on rising admissions in the 40-64 age group – not traditionally part of the elderly frail patients who are referred to Integrated Case Management.

This learning underpins the development of our refreshed scheme plans.

2.3 Revised Plans

One of the areas of learning from the previous year has been the management of the 11 BCF schemes described in the original plan. The number and variety of schemes proved unwieldy and introduced unhelpful barriers between related areas – for example equipment and Joint Assessment and Discharge. A number of projects have been, or are in, the final stages of completion. Based on this learning the schemes have been streamlined, refreshed and clustered under to demonstrate how each supports the key metrics – enabling an easier description of overall plans and better links between each scheme. There are now 3 themes, which provide a strategic focus for our work, and which are:

- Theme 1. Avoiding Admission to Hospital
- Theme 2. Integrated Support in the Community
- Theme 3. Discharge from Hospital

These provide a structure to the schemes of work which remain broadly consistent with those in the original plan:

- Scheme 1. Models of care
- Scheme 2. Dementia
- Scheme 3. EOLC
- Scheme 4. Carers
- Scheme 5. Mental Health
- Scheme 6. Prevention
- Scheme 7. Equipment and Assistive Technologies

Each Theme enables improvements across each scheme and is anchored to the key BCF outcomes. The following table sets out this approach in more detail and includes high level milestones for each element of the overall plan. Please see **Appendix 1** for details.

2.4 Revised metrics

Barking and Dagenham has worked hard to deliver its aspirations against its original trajectories for the BCF metrics but with limited success. Understanding the reason for this and using that information to inform planning, monitoring and setting aspirations for 16/17 has been a significant aspect of preparing to refresh the plan. A summary of metrics and rationale for setting them is set out in **Appendix 2.**

3.0 National conditions

3.1 Plans jointly agreed

Our existing plan delivers against a number of performance outcomes that will continue to be delivered against in the coming year, alongside areas of renewed focus. Previous work as part of the Better Care Fund has successfully delivered an integrated Joint Assessment and Discharge Service across health and social care partners, which is now at full operational capability and has robust governance in place. Integrated services such as these have supported our shared development of the workforce through joint training and development.

In the next year of the Better Care Fund we intend to extend the reach of the fund to encompass housing and the preventative role housing services play. There will also be a focus on early intervention, promoting self-care and delaying for as long as possible the need for high cost bed based services. We have identified the need to develop a shared approach to areas that can positively impact upon identified performance metrics (such as around DToC) and address emerging local priorities which include End of Life Care and Dementia Care. These priorities reflect those identified and endorsed by the Health and Wellbeing Board and reflect the views of partners, commissioners and providers.

Further detailed scoping will identify the investments that will be required to deliver the Better Care Fund for 2016/17. The current governance arrangements will provide an opportunity to share these further detailed steps, as well as the broader strategic context, alongside the impacts that these will have upon current arrangements and services which sit outside of the Better Care Fund pool.

In developing the Better Care Fund for 2016/17, partners have been aware of the need for longer term strategic integration between health and social care. As part of the London Health and Care Collaboration Agreement announced in December 2015, Barking and Dagenham, Havering and Redbridge were awarded a pilot to test the concept of 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.

This pilot work will identify whether delivery of an Accountable Care Organisation (ACO) will accelerate the delivery against the ambitions being set out by the partnership, which will be reflected as Barking & Dagenham, Havering and Redbridge's contribution to the Sustainability and Transformation Plan for north east London. If the business case suggests this is a viable model, then the eight statutory organisations that form BHR's Integrated Care

Coalition will take the decision on whether to proceed with an ACO from 2016/17. The emphasis of the business case development process is on a coherent strategic direction for the health and social care system across BHR, so that if an Accountable Care organisation is not deliverable, there will still be strong strategic direction articulated for the long term integration of services, including how to deliver the best outcomes for local people, future capacity and workforce requirements and implications for both local providers and the regulation of services as part of a potential set of devolution 'asks'. In 2016/17 Better Care Fund will continue in its role integrating services and contributing to the work around developing an Accountable Care Organisation and a system-wide vision.

3.2 Maintain provision of social care services

The review of our BCF seeks to protect identified services that have a health and or whole system benefit across the coming year. Key priorities are ensuring people are safe, healthy and well and that those needs under the Care Act are met.

The BCF will ensure that funding is in place for the Council to meet its duties under the Care Act. Particular emphasis is applied to interventions that improve outcomes for individuals, specifically actions to prevent, reduce or delay needs, improved information and advice and the delivery of appropriate and proportionate assessment. Without such steps there would be a marked and growing challenge to the ability of the Council to effectively manage demand pressures within a markedly reduced core budget. We will support a holistic approach, encourage and support self-assessment and self-care, improving and fully embedding integrated assessment and the consequent commissioning and delivery of services. We will further support the shift towards proactive, preventative early interventions.

As the result of a robust piece of market analysis, in 2015/16 the Council has taken the decision to radically reset its 'usual price' for residential and nursing care. This was explicitly to ensure compliance with the duty to ensure market sustainability, and will have the effect of increasing the cost of these services by over £1.8m per annum. It will also, however, enable the Council to foster stronger partnerships with the residential care sector to drive up quality and to bring them more fully into the work of the Better Care Fund around admissions avoidance and supporting rapid discharge. An investment from the Better Care Fund into mental health placements, allied to work to reprofile the available supported living services, will also contribute to the reduction in delayed transfers of care, and ensure improvements in timely care planning for people with eligible severe and enduring mental health needs.

Supporting carers through the delivery of assessment and services will ensure that we both better understand carers needs and that they are better supported in their caring role. Carers play a key contribution in helping people to remain in their own homes / place of their choice and delay for as long as possible, and reducing avoidable admissions to costly bed based care. Our investment in integrated health and social care teams is well established, providing early identification for those who are most likely to need future support. Social care services are recognised as being critical to keeping people with complex needs and frailty safe and in promoting independence, self-care and in improving wellbeing. Social care provides a key contribution to 7 day working arrangements, providing improved access to timely assessment and support where this is required. We maintain a focus upon regular review of both the impact of our BCF and opportunities for further development and improvement, including the development of improved services for people with dementia and for End of Life

Care which we have identified as a key local priority for integrated service development. through our utilisation of the fund and the flexibilities this provides, protecting social care services will positively impact upon avoidable admissions to bed based care and once there, ensuring that people can be discharged in a safe and timely way and don't remain in acute care for longer than necessary. The BCF partners will maintain the current level of investment into the fund for the coming year.

3.3 Agreement for the 7 day delivery of services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate

Seven day services are embedded with acute hospital services through the full operationalisation of the Joint Assessment and Discharge Services. We are undertaking further work to extend the reach of community based services to better, and more comprehensively, provide improved access across the week. Of equal importance is our work to provide, through services such as those of Integrated Case Management a pro-active approach with individuals at risk of admission, with specific targeting at those with long term conditions to build improved levels of self care and resilience so that crises can both be avoided and levels of health and well being improved.

The Barking and Dagenham, Havering and Redbridge System Resilience Group (a partnership of CCGs, providers, local authorities, GP Federations, out-of-hours provider PELC, London Ambulance Service, Healthwatch and Local Pharmaceutical Committee) has been granted national urgent and emergency care (UEC) Vanguard status, giving a platform from which to streamline and simplify the urgent care system and access for patients.

The UEC Vanguard has identified 7 day delivery of services as an important component in reshaping a UEC system that is simple for people to use and provides consistent services that are integrated and seamless. As part of this, the UEC Vanguard has identified where the BHR system is meeting the Keogh report's aspiration around providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments. Current 7 day provision accessible by Barking and Dagenham residents includes:

- Walk-in centres and UCCs
- Primary care access hubs HTT and CTT
- IRS
- EMHL services at Queen's

The UEC Vanguard will be based around a 'click, call, come in' approach, where a digital platform is accessible 24/7 either online or over the phone, providing a tool for assessing the patient's needs, clear advice, access by professional staff to appropriate clinical records and navigation and access to the most appropriate care, including a booked appointment.

The Vanguard will undertake work to create UCCs in the community which users see as a genuine alternative to the ED. This will be a single integrated front door so patients will be

met by a 24/7 streaming function ensuring a rapid accurate clinical assessment as well as support around other care needs.

The UEC Vanguard Value Proposition (additional documents submitted with this narrative) at the time of constructing the BCF plan it is not possible to assess the impact of recent announcements on the reduction in national funding to be provided to support the transformation ambitions of Vanguards, particularly the pace at which transformation may be achieved in order to deliver BCF ambitions.

In addition, work is being done to enhance our mental health crisis response offer by extending the clinical input within our 24/7 telephone help line Mental Health Direct and creating a link to this from 111 as well as increasing street triage where mental health clinical support is provided to police officers and now paramedics.

Last years BCF plan saw the full operationalisation of the Joint Assessment and Discharge Service across health and social care, within our acute hospital, bringing together formerly desperate teams into one integrated service. The service comprises differing staffing disciplines, single line management, accountability through monthly performance reporting to the partners against a single performance framework and full delivery across 7 days. Discharge planning begins close to the point of admission and support within MDTs. The model has been flexed at points of whole system demand to provide interventions and alternative pathway support, at the front end of the hospital, diversion where appropriate avoidable admissions.

3.4 Better data sharing between health and social care based on NHS number

As part of the December 2014 submission we confirmed that all essential agreements and systems were in place to enable shared care records to be maintained for those patients for whom it was relevant and who provided their consent.

In addition, as part of the Vanguard programme the CCG has committed to developing a digital platform to enable data sharing across care settings. The Vanguard is aligned to our existing strategic plan for technology development and builds on substantial existing developments including:

- The development of a full, real time shared care plan that is visible to patients and a wide variety of health system and care providers.
- Commissioning solutions to allow automated payment of Continuing Health Care and Nursing Care payments
- The London NHS 111 Patient Relationship Manager pilot which uses the NHS number to retrieve crisis information, care plans (including end of life plans) and Special Patient Notes and enables sharing of this key information with LAS

Over the next two years it is expected the following elements of the digital platform will be delivered, utilising the NHS number as the consistent identifier:

- Central architecture to support interoperability of systems – this is a core element to enable data to flow. It will manage real time data flows and integration to other systems' Application Programming Interfaces (APIs).
- Further integration with 111, scaling up provision of care plans and end of life plans

- Further integration with GP systems, rolling out read/write access of care plans and end of life plans as well as read/write access to the entire GP record
- Integration with acute systems, read/write access to the entire GP record
- Real time data transfer between health care providers and social care providers

IG and security specialists will be in place during the scoping and implementation phase, and will be part of development and testing ensuring confidential data is stored and shared securely; all elements of the platform will conform to the need for security through testing and audit.

From the user perspective, Data Sharing Agreements will be in place between care providers sharing and accessing data. This includes social care, individual GP practices and community services. The Data Sharing Agreements set out the common rules to be adopted by the various organisations and ensures patient information is handled responsibly and securely.

3.5 Joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care there will be an accountable professional

Integrated Case Management (ICM) is in place in Barking and Dagenham. The population is risk stratified using the Combined Predictive Model. The top 1% of the population identified as being at highest risk of admission to hospital care are targeted for integrated case management and provided with a joint care plan across health and social care. General practices also use their clinical judgement to identify patients at risk of hospital admission to the top 2% as they implement the unplanned admissions enhanced services.

The ICM approach provides a single point of access to a wider range of services including mental health, district nurses and long term conditions specialist nurses. The Integrated Care Teams are supported by a co-ordinator to direct the care planning and an MDT approach to providing holistic patient care. The patient's registered GP is the 'lead primary care provider'. The patient's care co-ordinator is the first point of contact in the ICM model, but each patient has a named GP lead in their care plan who is the accountable lead professional in line with their normal responsibilities for patients. This system also supports the 'accountable' GP for over 75's initiative. The MDTs take place every two weeks for most practices (with some with very small registered list sizes operating on a monthly basis). At this meeting the care management plan is developed and this is available to all members of the MDT and to the hospital.

Targeting individuals at risk of acute admission and providing preventative interventions are important in reducing current usage of acute services and delivering savings in whole system costs. Multi-disciplinary care plans are also available on Health Analytics enabling all care providers' real time access to care plans, which have the details of the accountable professional and opportunities for improved co-ordination.

As well as using the risk stratification tool to identify patients who could benefit from joint care planning to reduce risk of admission, ICM has also been developed further with input from secondary care consultants into MDT as part of the BHRUT CQUIN.

We are also promoting opportunities for improved levels of 'self-care' through providing access through 'active ageing', advice and information that may encourage lifestyle changes which promote improved health and well-being. We also commissioned a Whole Body therapy service in to reduce the incidents of falls, and long term effects from a fall therefore reducing admissions to hospital and reducing the need for extra care. It was a falls prevention exercise intervention aimed to improve people's independence through improving functional fitness, postural stability and reducing the fear of falling.

3.6 Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

Our 16/17 plans are a refinement and refocusing of current schemes. Engagement with stakeholders including providers impacted by the plans has taken place through a range of mechanisms as follows:

- HWB and Integrated Care Sub-Group of HWB – which includes providers and commissioners – were involved in developing the plan and in receiving regular updates on progress.
- Engagement with providers in developing 5 year strategic plans through the BHR Integrated Care Coalition and associated sub-groups.
- System management discussions with providers focusing on for example acute activity and DTOC rates through the BHR System Resilience Group.
- Engagement with health providers in respect of impact on activity through annual operating plan finance and activity returns/contracting process. This year that will be a joint process designed to set trajectories.
- Engagement with community and other providers is through contracting mechanisms, including review and performance assessment.
- More broadly a stakeholder workshop focusing on admissions activity and testing out 3 hypotheses as to drivers of activity was widely attended by frontline staff, senior provider leaders and service users and has been used to shape aspirations for 16/17 and associated actions.
- The BCF plans are also being considered in the context of wider system transformation programmes – Urgent and Emergency Care (Vanguard) programme, primary care transformation and Prime Ministers Challenge Fund access programme and the Accountable Care Organisation/Place based commissioning programme. These programmes are made up of provider and commissioner representatives across BHR and will be the fundamental mechanisms through which activity reduction activities will be developed.
- Engagement with Social Care providers impacted through the development of the Councils Market Position Statement (MPS) through which engagement with service providers was facilitated to conclude the MPS. The MPS itself, sets out the Councils priorities going forward, key information about the local market and the types of services and service models required for the future. Key messages are providing clarity about the role that service providers play in promoting improved health and wellbeing, promoting independence and self-care, alongside a greater focus upon information and advice and how the market as a whole better responds to individuals making their own individual purchasing decisions as an alternative to traditionally

commissioned care and support. The MPS is an iterative process of further development and deepening across the coming year.

- Re-commissioning steps - including the re-commissioning of support at home (Home Care) has provided a further example of both provider engagement and in re-setting expectations, performance and desired outcomes for local people. We are now taking forward further and specific re-commissioning steps with Mental Health supported living services.
- Strategy development- the development of our joint carers strategy was facilitated by engagement by Carers UK with local stakeholders, including service providers.

The BCF includes mental health outside of hospital. This is being considered in the wider context of a local mental health and wellbeing strategy which will inform joint commissioning and development of integrated mental and physical health models. Engagement on the strategy has taken place in summer/autumn 2015 – again involving providers and commissioners as well as service users and carers. The CCG is also engaging the public on its overall commissioning priorities for 16/17 at a commissioning café event on 16 February – with a focus this year of staying healthy.

3.7 Agreement to invest in NHS commissioned out of hospital services which may include a wide range of services including social care

Our 15/16 plan placed an emphasis within its out of hospital arrangements upon improving discharges and accompanying processes in acute services which resulted in the full operationalisation of our Joint Assessment and Discharge Service (JAD) successfully bringing together disparate teams from partner organisations, removing structural barriers to effective collaborative working into a single service and management. Investment in this service will be maintained by the partners in the coming year. However, in consideration of situational analysis completed we have identified particular opportunities to improve current arrangements- notably in non-acute settings such as Mental Health services which were impacting upon overall system flow and people remaining in bed based services longer than was necessary. We are therefore developing steps to:

- Deliver improved support through the provision of a 6 bedded housing support offer
- Re-tendering for services provided to support people into employment and education, building resilience and wellbeing
- Agreeing additional investment in Mental Health out of hospital services and the identification of an additional £250,000 comprising a contribution of £70,000 (utilising the increase provided from the former S256), diversion of areas of anticipated under spend within the BCF and resources currently falling outside of the pool, to enhance individual provision for out of hospital support.

Steps will be confirmed in our final submission.

Our commitment to intermediate Care and specifically Intensive Rehabilitation Services will be maintained in 2016/17. Our evaluation of IRS has demonstrated a number of very positive outcomes which include:

- Consultation completed (this was 2014/15 suggest remove) Challenges to the consultation and new model (IRP initial assessment, Monitor complaint) not upheld
- First phase of bed moves (H&G to KGH) are complete. Second phase (Grays court beds) planned to move to KGH March 16. Ongoing discussion re: co-location of the wards within the KGH site (phase 3)
- IRS service mainstreamed April 15 continues to see referrals above target and the in-reach element of the service has reduced total length of stay for patients admitted by 9587 days in 2015 equivalent to a saving of 46 hospital beds
- CTT mainstreamed April 15 continues to see referrals above target. The acute part of the service has had no admissions to acute YTD. The community part of the service has seen 9% YTD admissions (673 of 7573 referrals)
- Model continues to be recognised as an example of best practice- national webinar 25.1.16, CTT shortlisted for Advancing Healthcare Award 2016
- New model has delivered 10 fold increase in intermediate care capacity and 35% increase in capacity in the rehabilitation specifically. Waiting times for rehabilitation continue to be less than 2 days on average and patient experience remains consistently high at 9 out of 10

We have used the BCF to commission a handyperson scheme in the Borough to complement a range of interventions which focus upon the individual, but are less able to address environmental and domestic risks that exacerbate the risk of falls (and the consequential impact of these) and living conditions that may contribute to reducing risk and improved wellbeing. The service is free to access – broadening its reach and ensuring that people not currently engaged in contact with Health and Social Care can benefit, remaining healthy and well for as long as possible.

We are utilising the BCF to continue our focus upon the prevention of falls within a target cohort who don't current engage in programmes such as Active Aging, but for whom risks are more immediate. We will in 2016/17 further focus the work to the provision of 1-1 interventions, exercise programmes and stamina building into peoples own homes. This service will also provide further continuity for interventions people may have received as a part of their acute hospital stay who are leaving hospital returning to their own homes.

We are reviewing our approach to low level interventions which encompass people with low level needs, but for whom a timely intervention can reduce both the risks of admission and where admission takes place, a timely return home. The earlier ' Take home and Settle' pilot with a voluntary sector partner yielded some positive individual outcomes (and a business case) and we will be taking further proposals through our BCF governance for an extension of this service ensuring that where appropriate, we ensure the lowest intervention, at the right time, for the right cost to an extend cohort of people.

3.8 Agreement on local action plan to reduce DTOCs

We have undertaken further work to better understand what is driving levels of DToC across all in patient settings. This plan therefore reflects both our situational analysis based upon local conditions and strategic steps undertaken which saw within the previous BCF plan delivery of integrated services such as the Joint Assessment and Discharge Service, designed to markedly change the way in which acute discharges were undertaken between

the partners. In 15/16 the majority of delays were drawn from acute hospital services, with a significant minority drawn from non acute beds at 45%.

Our situational analysis has shaped the key actions which include areas such as, specific steps to improve delays for people with mental health needs, with the use of both additional funding and housing related solutions and more broadly, testing opportunities for 'step down' / interim service provision and delivering innovation in respect to 'trusted assessor' roles and the delivery of low level preventative interventions to reduce the incidences and likelihood, of admissions in areas such as falls alongside further targeting of care homes where levels of acute admissions are comparatively high. The plan also reflects positive steps to improve areas such as the Councils ability to secure, where required, bed based placements through an improved fee which mitigates previous issues with inward price competition by other commissioners into the Borough. Accessing care home placements represents, for example, 18% of current delays (417 bed days). Analysis has also identified where there is a need for further development of processes and protocols alongside areas for further work by the partners and where some more intractable issues such as those of Continuing Health Care and neuro-rehabilitation, which require escalation within our broader BHR system and for which milestone plans are to be developed.

We have developed this plan in order to both provide a specific focus for local actions and to align with System wide strategic discharge planning which is currently in the process of final development across BHR.

The plan and its actions are broadly reflected within the BCF milestone plan but also includes broader steps beyond our BCF, and provides, 'at a glance', the range of actions we are taking forward to improve current performance for the system as a whole and deliver better outcomes for individuals

3.9 Confirmation of funding contributions

The BCF Pool in 2016/17 will be comprised of the CCG minimum required contribution to the fund, the Local Authority minimum contribution i.e. the Disabled Facilities Grant, and also the Local authority is making additional contributions over and above their required minimum. These are shown in the Finance template.

4.0 Overview of funding contributions

The scheme spending plan has been submitted as part of this return. As mentioned above the BCF Pool is made up of contributions from the CCG and Local Authority, meeting all of the financial requirements. This includes continuing to passport the ex - section 256 funding to the local authority, and the amount suggested in the Care Act "ready reckoner" supplied by NHSE. We have also exceeded the amount that is required to be spent on NHS Commissioned Out of Hospital services.

5.0 Scheme level spending plan

The scheme level spending is submitted in the BCF Planning Return Template. It details the full use of the spending of the pooled budget with details of the value commissioner and scheme type. There is a confirmation on the summary tab of the amount identified for the

protection of social care and explanation of a variance, please refer to the BCF Planning Return Template. The table below sets out the scheme level spending plan.

	Expenditure				
Scheme Name	Scheme Type	Commissioner	Provider	2016/17 Expenditure (£)	Total 15-16 Expenditure (£) (if existing scheme)
1- Model of Care - Community Health & Social Care Services	Integrated care teams	CCG	NHS Community Provider	£4,494,000	£4,486,000
1- Model of Care - Community Health & Social Care Services	Integrated care teams	Local Authority	Local Authority	£2,147,000	£2,147,000
1- Model of Care - Community Health & Social Care Services	Integrated care teams	Local Authority	Local Authority	£2,570,500	£2,525,100
1- Model of Care - Improved Hospital Discharge	Intermediate care services	Local Authority	Local Authority	£1,028,000	£993,000
1- Model of Care - Improved Hospital Discharge	Intermediate care services	Local Authority	Local Authority	£991,100	£991,100
1- Model of Care - New Model of Intermediate care	Intermediate care services	CCG	NHS Community Provider	£2,483,057	£2,443,000
1- Model of Care - New Model of Intermediate care	Intermediate care services	Local Authority	Local Authority	£700,000	£700,000
1- Model of Care - Integrated Commissioning	Other	Joint	Local Authority	£145,000	£170,000
1- Model of Care - Care Act	Other	Local Authority	Local Authority	£100,000	£100,000
2- Dementia Support	Personalised support/ care at home	Local Authority	Local Authority	£347,300	£347,300
3- End of Life	Personalised support/ care at home	Local Authority	Local Authority	£105,000	£0
4- Carers - Support for Family carers	Support for carers	CCG	Local Authority	£495,000	£495,000
4- Carers - Support for Family carers	Personalised support/ care at home	Local Authority	Local Authority	£430,000	£430,000
4- Carers - Care Act	Personalised support/ care at home	Local Authority	Local Authority	£517,000	£513,000
4- Carers - Care Act	Personalised support/ care at home	Local Authority	Local Authority	£200,000	£200,000
5- Mental Health - Mental Health Support outside hospital	Personalised support/ care at home	CCG	Charity/Voluntary Sector	£256,000	£256,000
5- Mental Health - Mental Health Support outside hospital	Personalised support/ care at home	Local Authority	Local Authority	£340,000	£357,877
5- Mental Health - Mental Health Support outside hospital	Personalised support/ care at home	Local Authority	Local Authority	£572,000	£537,245
6- Prevention	Personalised support/ care at home	Local Authority	Local Authority	£1,191,000	£1,499,000
6- Prevention	Personalised support/ care at home	Local Authority	Local Authority	£30,000	£12,500

7- Equipment and Adaptation	Personalised support/ care at home	Local Authority	Local Authority	£1,456,009	£1,251,000
7- Equipment and Adaptation	Personalised support/ care at home	Local Authority	Local Authority	£107,000	£107,000

6.0 Financial risk sharing and contingency

In 2015/16 the key performance target associated with the BCF was a reduction in non-elective admissions to hospital, which was subject to a payment for performance regime. As detailed in previous reports, due to the failure to achieve the target set the performance penalty was invoked resulting in a penalty of £710k, split equally between the CCG and Local Authority. In 2016/17 non-elective admissions to hospital will continue to be a key performance indicator, however without an attached performance penalty.

In the 2015/16 Section 75 Agreement, the CCG and Local Authority entered into a risk share agreement whereby if non-elective admissions did not fall below a 2014 calendar year baseline, both partners contributed to a risk share that was to be used by the CCG to pay for unplanned non-elective activity in acute hospitals.

The BCF guidance for 2016/17 set out that the CCG and Local Authority should consider risk share and contingency arrangements. Following discussions in developing the BCF Plans it was decided that a local risk-share would not be part of this year's BCF.

The CCG faces the same financial risks in 2016/17 associated with non-elective activity as in 2015/16. The overall financial risks for the CCG are heightened by the continuing growth in demand for services. As such and on the basis of performance in 15/16, discussions have taken place between partners around putting in place CCG a similar risk share in 2016/17.

In these discussions it is noted that both partners are facing great financial pressures in 2016/17 and are developing transformative approaches to addressing on-going sustainability. It is also noted that any risk share for 16/17 is likely to be counterproductive to these developments and that the development of the Accountable Care Organisation may represents the main mechanism through which rising activity/acuity risks may ultimately be mitigated.

Appendix 1 BCF Schemes

Narrative

One of the areas of learning from the previous year has been the management of the 11 BCF schemes described in the original plan. The number and variety of schemes proved unwieldy and introduced unhelpful barriers between related areas – for example equipment and Joint Assessment and Discharge. A number of projects have been, or are in, the final stages of completion. Based on this learning the schemes have been streamlined, refreshed and clustered under to demonstrate how each supports the key metrics – enabling an easier description of overall plans and better links between each scheme. There are now 3 themes, which provide a strategic focus for our work, and which are:

- Theme 1. Avoiding Admission to Hospital
- Theme 2. Integrated Support in the Community
- Theme 3. Discharge from Hospital

These provide a structure to the schemes of work which remain broadly consistent with those in the original plan:

- Scheme 1. Models of care
- Scheme 2. Dementia
- Scheme 3. EOLC
- Scheme 4. Carers
- Scheme 5. Mental Health
- Scheme 6. Prevention
- Scheme 7. Equipment and Assistive Technologies

Each Theme enables improvements across each scheme and is anchored to the key BCF outcomes. The following table sets out this approach in more detail and includes high level milestones for each element of the overall plan.

	THEME 1 (T1) Avoiding Admission to Hospital	THEME 2 (T2) Integrated Support in the Community	THEME 3 (T3) Improved Discharge from Hospital
Outcomes	**Delivery the non-elective admissions target of 228 admissions in 2016/17.**	**Improve our reablement packages of care as well reduce admissions to residential and care home.**	**Deliver the 2% reduction of Delayed Transfers Of Care from the 2015/16 outurn.**
General scheme			
SCHEME 1 (S1) Model of Care	Work with key stakeholders to develop the locality based model to tackle admissions by working with cohort most likely to be admitted. **(S1,T1,1)** **Lead: Monga Mafu** Strengthening referral routes into the Community Treatment Team(CTT) in order to avoid hospital admissions and conveyance to A&E. **(S1,T1,2)** **Lead: Stasha Jan**	Improve the referral targeting of people to benefit from active aging programmes as well consider future commissioning of these services. **(S1,T2,1)** **Lead: Lewis Sheldrake** Clarify the locality model based vision of mental health strategy and utilisation. **(S1,T2,2)** **Lead: Lewis Sheldrake**	Review the BHR wide 'discharge to assess' pilot once completed and explore whether this can be extended and more widely implemented. **(S1,T3,2)** **Lead: David Millen/Andrew Hagger** Extend the trusted assessor model to reduce handoffs and delays in on-ward referrals. **(S1,T3,3)** **Lead: David Millen** Review the targeting of key cohort of people who have high bed days and assessment delays / multiple assessment episodes. **(S1,T3,4)** **Lead: Monga Mafu**

	THEME 1 (T1) Avoiding Admission to Hospital	THEME 2 (T2) Integrated Support in the Community	THEME 3 (T3) Improved Discharge from Hospital
Specific schemes			
SCHEME 2 (S2) Dementia	Identification and review of admissions data for those with possible dementia diagnosis to provide support and avoid possible future admissions. **(S2,T1,1)** **Lead: Gayathri / Carla Lubin**	Hold dementia awareness raising training sessions. **(S2,T2,1)** **Lead: Arabjan Iqbal** Identify, support and involve carers to build their awareness and confidence in support of people with dementia. **(S2,T2,2)** **Lead: Arabjan Iqbal** Enabling people with dementia to live well in the community by accessing services that help maintain their physical and mental health and wellbeing and promote independence. **(S2, T2,3)** **Lead: Stasha Jan**	Review hospital discharge support for dementia patients, and post diagnosis support in the community. **(S2, T3,1)** **Lead: Stasha Jan**
SCHEME 3 (S3) End of Life Care	Raise awareness and provide training for carers and nursing home staff to build confidence in managing EOLC patients without resorting to Acute settings. **(S3,T1,1)** **Lead: Michael Fenn**	Adopt a common DNR form across the borough to ensure patients are not unnecessarily moved to hospital when they are at home or in care homes. **(S3,T2,1)** **Lead: Stasha Jan**	Utilise Marie Curie staff and District Nurses to support patients within their own home, and share good practice with health and social care services. **(S3,T3,1)** **Lead: Stasha Jan**

	THEME 1 (T1) **Avoiding Admission to Hospital**	**THEME 2 (T2)** **Integrated Support in the Community**	**THEME 3 (T3)** **Improved Discharge from Hospital**
SCHEME 4 (S4) Carers **Leads as per Carers Strategy**	Promote and highlight the role of carers in supporting and helping patients avoid unnecessary hospital attendances and admissions to GPs. **(S4,T1,1)** **Lead: Arabjan Iqbal** Improve involvement and inclusion of carers in care planning and decision making. **(S4,T1,2)** **Lead: Arabjan Iqbal**	Utilise GPs and Pharmacies to identify, support and signpost carers. **(S4,T2,1)** **Lead: Arabjan Iqbal** Further develop the online resource Carers Hub in the development of care pathway to support assessment and referral of carers. **(S4,T2,2)** **Lead: Arabjan Iqbal**	Utilise the community treatment teams to support carers so they are better able to support people when they are discharged from hospital. **(S4,T3,1)** **Lead: Arabjan Iqbal**
SCHEME 5 (S5) Mental Health	Improve flow of resources in bed based Mental Health services. **(S5,T1,1)** **Lead: Michael Fenn/Cathie Kelly**	Review the current contract that supports people with mental ill health to remain well, free of crisis and on the way to gaining employment. **(S5,T2,1)** **Lead: Adrian Marshal**	Improve Independent Living beds and floating support service (supporting a 'step down' model) for people with mental health to reduce delays of transfers of care. **(S5,T3,1)** **Lead: Michael Fenn / Cathie Kelly**

	THEME 1 (T1) Avoiding Admission to Hospital	THEME 2 (T2) Integrated Support in the Community	THEME 3 (T3) Improved Discharge from Hospital
SCHEME 6 (S6) Prevention	Consider future commissioning of falls prevention of injuries and admissions due to falls for those at high risk. **(S6,T1,1)** **Lead: Lewis Sheldrake** Review local care packages and crisis interventions to prevent the early use of high cost care packages such as care homes. **(S6,T1,2)** **Lead: Michael Fenn** Strengthen links between the Care and Support hub and other signposting resources to better support patients and carers access to health information on what are the right services to access. **(S6,T1,3)** **Lead: Jolene Davis/Stasha Jan**	Improve early identification of people likely to need care home admission as part of assessment and discharge process. **(S6,T2,1)** **Lead: David Millen/Michael Fenn**	

	THEME 1 (T1) Avoiding Admission to Hospital	THEME 2 (T2) Integrated Support in the Community	THEME 3 (T3) Improved Discharge from Hospital
SCHEME 7 (S7) Equipment/Assistive Technology		Commission a review of the current utilisation of telecare and telehealth in Borough as well as options for improved use of telecare, telehealth, assistive technologies and other equipment. **(S7,T2,1)** **Lead: David Millen** Improve access to community equipment and daily living aids so service delays are minimised and the best procurement / store options are captured. This links with the 'trusted assessor' approach where access is less predicated upon 'professional assessment'. **(S7,T2,2)** **Lead: David Millen**	Review the current offer of rapid response equipment so that it supports reduced LOS and improved discharge planning. **(S7,T3,1)** **Lead: David Millen**

Appendix 2 National metrics

Metric	Comments
Non-elective admissions (General & Acute)	Target proposed is reduction of 228 admissions against an expected total admission of 2,405 in 2016/17. The target for BCF has been reduced in line with actual performance in 15/16 but still represents a challenging target and is based on impacting avoidable admissions. The BCF plan represents one element of the overall CCG operating plan for admission reduction. The BCF plan is focused on local joint actions most likely to impact admissions and is supported by wider system work through Systems Resilience Group.
Admissions to residential & care homes	Target proposed is 170. Previous target was 125 for 2015/16 and current forecast performance to be in the region of @180 admissions. Reviewing the last performance over the last 4 years (11/12 – 200, 12/13 – 170, 13/14 – 135, 14/15 – 179) has been on average has been 171 admissions. Local leads have suggested that the set target was an underestimation based on unusually low 2013/14 figure.
Effectiveness of reablement	Target proposed is 75%. The manual data collection presents distinct challenges and variability in collection of the data and its interpretation. Changes to the way this was approached for 2014/15 are a significant contributor to performance dropping so markedly to 67.2%, target had been set for 75%. Given the pressures that was experienced in 2015/16 is not changing it is more realistic to keep the target the same in 2016/17.
Delayed transfers of care	Target proposed is 2% reduction of our 2015/16 Outurn. The target in acute setting is being met at local hospital which suggests the Joint Assessment & Discharge team is having an impact. Areas which are negatively impacting the metric are in local acute Mental Health setting with patients awaiting discharge and specialist rehab. As there is clarity as to where changes need to be made, the target proposed is at same level as in 2015/16. A detailed DTOC plan is appears at appendix 2

Appendix 2 DTOC plan

Barking and Dagenham Better Care Fund 2016/17
Delayed Transfers of Care improvement plan

Target improvement 2% reduction (from 2015/16 288)

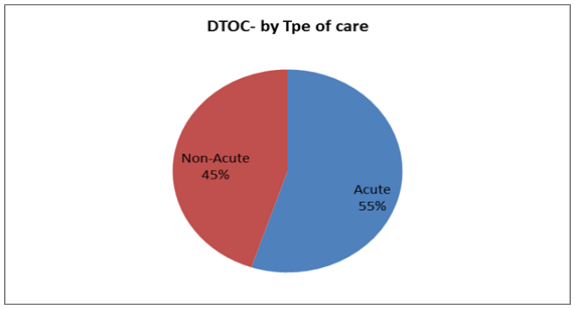
This plan reflects both our situational analysis based upon local conditions and strategic steps undertaken which saw within the previous BCF plan delivery of integrated services such as the Joint Assessment and Discharge Service, designed to markedly change the way in which acute discharges were undertaken between the partners. In 15/16 the majority of delays were drawn from acute hospital services, with a significant minority drawn from non acute beds at 45%.

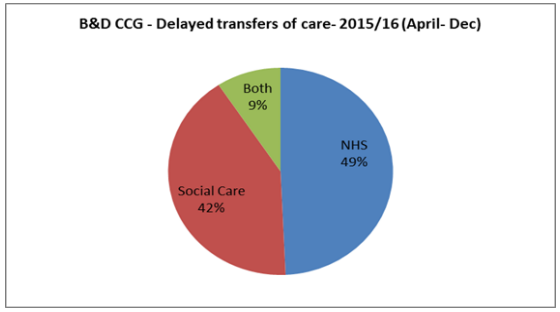
Our situational analysis has shaped the key actions which include areas such as, specific steps to improve delays for people with mental health needs, with the use of both additional funding and housing related solutions and more broadly, testing opportunities for 'step down' / interim service provision and delivering innovation in respect to trusted assessor roles and the delivery of low level preventative interventions to reduce the incidences and likelihood, of admissions in areas such as falls alongside further targeting of care homes where levels of acute admissions are comparatively high. The plan also reflects positive steps to improve areas such as the Councils ability to secure, where required, bed based placements through an improved fee which mitigates previous issues with inward price competition by other commissioners into the Borough. This represents, for example, 18% of current delays (417 bed days).. Analysis has also identified where there is a need for further development of processes and protocols alongside areas for further work by the partners and where some more intractable issues such as those of Continuing Health Care and neuro-rehabilitation, which require escalation within our broader BHR system and for which milestone plans are to be developed.

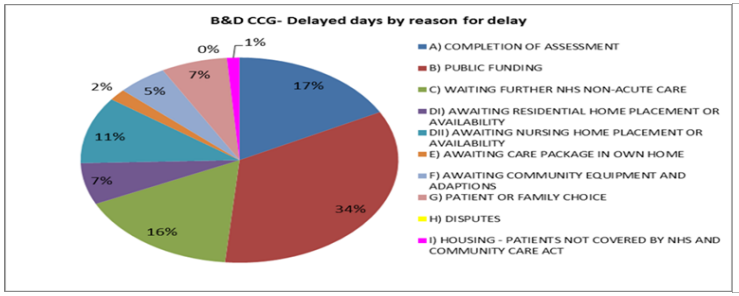
We have developed this plan in order to both provide a specific focus for local actions and to align with System wide strategic discharge planning which is currently in the process of final development across BHR.

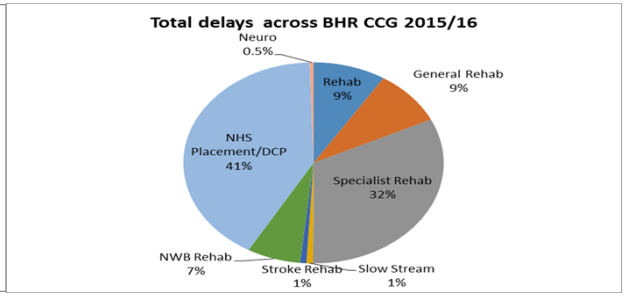
The plan and its actions are broadly reflected within the BCF milestone plan but also includes broader steps beyond our BCF, and provides, 'at a glance', the range of actions we are taking forward to improve current performance for the system as a whole and deliver better outcomes for individuals.

DTOC 15/16









	Rehab	General Rehab	Specialist Rehab	Slow Stream	Stroke Rehab	NWB Rehab	NHS Placement/DCP	Neuro
Total delays in 2015/16	57	56	203	5	5	42	260	3

Situational analysis	Actions	Impact % /numbers	Resources	Lead and milestone plan ref.
There is a need to shift reliance upon 'professional' assessment and allocation. This free up both resources and accelerate pace. Evidence of some individuals having multiple assessments and delays between referrals.	We will extend 'discharge to assess' and trusted assessor arrangements thereby reducing 'handoffs' and delays in onward referrals	The average time taken from referral to completion of assessment reduced	Staff time- 'discharge to assess' Protocols and process revisions. 3 month pilot to commence from 1st April 16.	BCF Delivery Group- DM/ AH (S1,T3,2) (S1,T3,3)
Insufficient focus upon throughput on Length of Stay (LOS) in secondary bed based services. Significant actions have been put in place to improve acute discharges and therefore non acute is an area of new priority.	Principles established within the JAD being considered within non-acute services- this would include our moving to establishing an indicative discharge date at (or closer to) the point of admission. Discharge protocols established. We will promote shared learning across trusts (incl. NELFT)	Bed day delays attributable to acute hospitals in 15/16- 1342 days (**55%**)	Development of revised protocols and working practices. This will include an agreed sign off process which will ensure that DToCs are accurately recorded and owned.in line with recently released revised guidance.	TW / DM

Delays are significant from other hospitals such as BARTS and WHIPs Cross	We will implement a new 'sign off' processes for hospital outside our health economy	Delays attributable to BARTs and WHIPs Cross. Bed days social care 75, NHS 321		
Due to significant financial pressures and the need to improve secondary provider performance blockages have occurred in secondary bed based MH services which have impacted upon our overall DToC position.	We will Improve flow of resources in bed based Mental Health services We will complete the delivery of housing based solutions to complement the existing offer		Improve resources available through both specific BCF allocation as an investment priority for the BCF partners drawing in specific 'ring fenced' 'out of hospital' funding agreed through BCF. (£70k allocation through BCF, deployment of under spends). Increased fund of £250k. Provision of 6 bedded house to provide a supported living/ interim housing based solution	MF/ DM BCF delivery Group (ST, T3,1)
Improvement needed in response times, alongside need for improved focus upon short term (time limited interventions). Too many people with both dementia and EoLC going into and dying within hospital based care.	We will undertake further deep dive analysis to confirm impact of EoLC and people falling outside of 'eligibility' criteria We will review hospital discharge support for people with dementia Consider and scope the provision of a community based rapid response service that would	Deep dive analysis to confirm: - delayed bed days attributable to people with dementia and EoLC -delayed bed days for people falling outside of Social Care / CHC etc..	Review existing provision such as the new support at home services and provision for rapid response and identify requirements for further capacity building *To be costed and commissioned as part of Out of Hospital Services*	BCF Delivery Group – DM (ST, T3,1)

Investment is heavily weighted in high end / high cost services	respond quickly to DToC and provide provisional support whilst on-going solutions were sought. This would support key target groups such as people with dementia and EoLC and those currently falling outside of eligibility criteria (already BCF schemes and priorities) leave hospital and thus remove such issues as access to services/ capacity as a cause of delay. We will increase our ability to divert people through lowest intervention at least cost necessary		<u>Out of hospital commissioned</u> 'take home and settle service'*£50 k 'take home and settle' service* Additional cost implications to be considered by the BCF partners through the Joint Executive Management Committee.	
We have identified a cohort of individuals who need to leave acute and non-acute bed based care but are not yet ready to return home	We will develop a business case for Independent Living beds and floating support service (supporting 'step down' model).	Costs to be confirmed with recommendations for the JEMC	Commissioning resources to scope and develop business case for a pilot number of 'step down' beds commissioned as a pilot	BCF delivery Group - DM
Delays in DToC due to care home availability. Migration into Borough absorbing capacity and reducing choice for local residents. Delays due to family	We will deliver improved capacity in care homes We will improve the early	Delayed days attributable to awaiting Residential home placement are currently 160 days (**7%)** Delayed days attributable to awaiting Nursing home placement are currently 257 days (**11%)**	New fee uplifts applied Assessment capacity	BCF delivery Group MF / DM (S6,T2,1)

choice	identification of people likely to need care home admission as part of assessment and discharge process	Delayed days attributable to Patient/ family choice 164 days (**7%**)		
An opportunity to improve access to both equipment and AT solutions, as part of universal offer	We will build upon the work to improve access to community equipment (including rapied response) and daily living aids so that as a jointly commissioned service delays are minimised and best procurement / store options are captured. Again this would link with 'trusted assessor' where access would become less predicated upon 'professional assessment'.		To be held within Equipment BCF scheme under development by the BCF commissioning partners.	BCF Delivery Group – DM (S7,T3,1) S7,T2,1) (S7, T2, 2)
A small number of individuals within our system disproportionately impact upon delayed days. Identified through our risk stratification Target cohort- delays due to 'neck braces'.. Therapy staff believe that on-going support post discharge is	We will undertake Deep dive analysis to support the 'targeting' of a key cohort of people who have high bed days and assessment delays / multiple assessment episodes. Analysis to better understand the characteristics of high intensity users We will agree processes and shared responsibility to improve discharge flow.	Deep Dive analysis to confirm the number of delayed days currently attributable to people receiving integrated cluster support	Cluster teams….. Improved requirement for in reach to provide **'pull through' discharge** and admission avoidance through proactive case management. In centivisation of primary care to improve support independent sector providers of bed based care To be developed through our BCF plan implementation.	BCF delivery Group - MM / DM (S1,T3, 4)

social cares responsibility and resolving dispute can result in bed days being lost				
There is a national focus upon the 'back end' i.e DToC . It is clear that for some individuals, an admission to hospital can have a very negative impact upon their independence and wellbeing.	We will draw in and evaluate our system wide admission avoidance steps, including the delivery of hubs, information and advice and specific activity within our BCF plan– on the key principle that if more admissions were avoided in the first place then there would be fewer people to discharge and hospital / bed based acquired dependency would be, where possible, avoided. We will review all existing schemes' impact upon admission avoidance and take further steps through the BCF and JEMC governance to enhance focus on avoidable admissions. We will enhance support to care homes by improving access to community nursing, GP review and support. We will undertake monitoring to Identify high referring homes for targeting of support. We will take steps to align our	Quantify avoidable admissions BCF – admission reduction plan for 16/17 - **228** Emergency admission reduction from care homes - 16/17 - **28 admission reductions** (Maintaining the same level of reduction as in 15/16)	Commissioning partners within the BCF to develop and confirm officer resources..	JEMC and BCF Delivery Group (S4,T1,1) (S4,T2,1) (S4,T2,2) (S5,T2,1) (S6,T1,3) (S6, T1,1) (S6,T1,2) (S6,T1,3) (S3,T1,1) (S2, T1,1) (S2,T1,1) (S2,T2.3) (S2,T3,1)

	voluntary sector offer – including impacts of social isolation, living alone etc.. on admission rates			
Neuro –rehabilitation currently has a very significant impact upon delayed bed days albeit affecting a small number of individuals.	This will be escalated through wider BHR governance	Bed days attributable to inter-hospital referral (3 in 2015/16)		SM
CHC process delays – people stay in hospital 2 weeks longer than required because of delays in undertaking assessments to decide whether FNC is payable or not.	Process re-design. Improvement options paper to be considered by BCF partners. This will be escalated through wider BHR governance	Bed days attributable to NHS placements		SM

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Appendix B: BCF 2016/17 Schemes and Milestones

Narrative

One of the areas of learning from the previous year has been the management of the 11 BCF schemes described in the original plan. The number and variety of schemes proved unwieldy and introduced unhelpful barriers between related areas – for example equipment and Joint Assessment and Discharge. A number of projects have been, or are in, the final stages of completion. Based on this learning the schemes have been streamlined, refreshed and clustered under to demonstrate how each supports the key metrics – enabling an easier description of overall plans and better links between each scheme. There are now 3 themes, which provide a strategic focus for our work, and which are:

- Theme 1. Avoiding Admission to Hospital
- Theme 2. Integrated Support in the Community
- Theme 3. Discharge from Hospital

These provide a structure to the schemes of work which remain broadly consistent with those in the original plan:

- Scheme 1. Models of care
- Scheme 2. Dementia
- Scheme 3. EOLC
- Scheme 4. Carers
- Scheme 5. Mental Health
- Scheme 6. Prevention
- Scheme 7. Equipment and Assistive Technologies

Each Theme enables improvements across each scheme and is anchored to the key BCF outcomes. The following table sets out this approach in more detail and includes high level milestones for each element of the overall plan.

	THEME 1 (T1) **Avoiding Admission to Hospital**	**THEME 2 (T2)** **Integrated Support in the Community**	**THEME 3 (T3)** **Improved Discharge from Hospital**
Outcomes	**Delivery the non-elective admissions target of 228 admissions in 2016/17.**	**Improve our reablement packages of care as well reduce admissions to residential and care home.**	**Deliver the 2% reduction of Delayed Transfers Of Care from the 2015/16 outurn.**
General scheme			
SCHEME 1 (S1) Model of Care	Work with key stakeholders to develop the locality based model to tackle admissions by working with cohort most likely to be admitted. **(S1,T1,1)** **Lead: Monga Mafu** Strengthening referral routes into the Community Treatment Team(CTT) in order to avoid hospital admissions and conveyance to A&E. **(S1,T1,2)** **Lead: Stasha Jan**	Improve the referral targeting of people to benefit from active aging programmes as well consider future commissioning of these services. **(S1,T2,1)** **Lead: Lewis Sheldrake** Clarify the locality model based vision of mental health strategy and utilisation. **(S1,T2,2)** **Lead: Lewis Sheldrake**	Review the BHR wide 'discharge to assess' pilot once completed and explore whether this can be extended and more widely implemented. **(S1,T3,2)** **Lead: David Millen/Andrew Hagger** Extend the trusted assessor model to reduce handoffs and delays in on-ward referrals. **(S1,T3,3)** **Lead: David Millen** Review the targeting of key cohort of people who have high bed days and assessment delays / multiple assessment episodes. **(S1,T3,4)** **Lead: Monga Mafu**

	THEME 1 (T1) **Avoiding Admission to Hospital**	**THEME 2 (T2)** **Integrated Support in the Community**	**THEME 3 (T3)** **Improved Discharge from Hospital**
Specific schemes			
SCHEME 2 (S2) Dementia	Identification and review of admissions data for those with possible dementia diagnosis to provide support and avoid possible future admissions. **(S2,T1,1)** **Lead: Gayathri / Carla Lubin**	Hold dementia awareness raising training sessions. **(S2,T2,1)** **Lead: Arabjan Iqbal** Identify, support and involve carers to build their awareness and confidence in support of people with dementia. **(S2,T2,2)** **Lead: Arabjan Iqbal** Enabling people with dementia to live well in the community by accessing services that help maintain their physical and mental health and wellbeing and promote independence. **(S2, T2,3)** **Lead: Stasha Jan**	Review hospital discharge support for dementia patients, and post diagnosis support in the community. **(S2, T3,1)** **Lead: Stasha Jan**

	THEME 1 (T1) **Avoiding Admission to Hospital**	**THEME 2 (T2)** **Integrated Support in the Community**	**THEME 3 (T3)** **Improved Discharge from Hospital**
SCHEME 3 (S3) End of Life Care	Raise awareness and provide training for carers and nursing home staff to build confidence in managing EOLC patients without resorting to Acute settings. **(S3,T1,1)** **Lead: Michael Fenn**	Adopt a common DNR form across the borough to ensure patients are not unnecessarily moved to hospital when they are at home or in care homes. **(S3,T2,1)** **Lead: Stasha Jan**	Utilise Marie Curie staff and District Nurses to support patients within their own home, and share good practice with health and social care services. **(S3,T3,1)** **Lead: Stasha Jan**
SCHEME 4 (S4) Carers **Leads as per Carers Strategy**	Promote and highlight the role of carers in supporting and helping patients avoid unnecessary hospital attendances and admissions to GPs. **(S4,T1,1)** **Lead: Arabjan Iqbal** Improve involvement and inclusion of carers in care planning and decision making. **(S4,T1,2)** **Lead: Arabjan Iqbal**	Utilise GPs and Pharmacies to identify, support and signpost carers. **(S4,T2,1)** **Lead: Arabjan Iqbal** Further develop the online resource Carers Hub in the development of care pathway to support assessment and referral of carers. **(S4,T2,2)** **Lead: Arabjan Iqbal**	Utilise the community treatment teams to support carers so they are better able to support people when they are discharged from hospital. **(S4,T3,1)** **Lead: Arabjan Iqbal**

	THEME 1 (T1) **Avoiding Admission to Hospital**	**THEME 2 (T2)** **Integrated Support in the Community**	**THEME 3 (T3)** **Improved Discharge from Hospital**
SCHEME 5 (S5) Mental Health	Improve flow of resources in bed based Mental Health services. **(S5,T1,1)** **Lead: Michael Fenn/Cathie Kelly**	Review the current contract that supports people with mental ill health to remain well, free of crisis and on the way to gaining employment. **(S5,T2,1)** **Lead: Adrian Marshal**	Improve Independent Living beds and floating support service (supporting a 'step down' model) for people with mental health to reduce delays of transfers of care. **(S5,T3,1)** **Lead: Michael Fenn / Cathie Kelly**

	THEME 1 (T1) **Avoiding Admission to Hospital**	**THEME 2 (T2)** **Integrated Support in the Community**	**THEME 3 (T3)** **Improved Discharge from Hospital**
SCHEME 6 (S6) Prevention	Consider future commissioning of falls prevention of injuries and admissions due to falls for those at high risk. **(S6,T1,1)** **Lead: Lewis Sheldrake** Review local care packages and crisis interventions to prevent the early use of high cost care packages such as care homes. **(S6,T1,2)** **Lead: Michael Fenn** Strengthen links between the Care and Support hub and other signposting resources to better support patients and carers access to health information on what are the right services to access. **(S6,T1,3)** **Lead: Jolene Davis/Stasha Jan**	Improve early identification of people likely to need care home admission as part of assessment and discharge process. **(S6,T2,1)** **Lead: David Millen/Michael Fenn**	

	THEME 1 (T1) Avoiding Admission to Hospital	THEME 2 (T2) Integrated Support in the Community	THEME 3 (T3) Improved Discharge from Hospital
SCHEME 7 (S7) Equipment/Assistive Technology		Commission a review of the current utilisation of telecare and telehealth in Borough as well as options for improved use of telecare, telehealth, assistive technologies and other equipment. **(S7,T2,1)** **Lead: David Millen** Improve access to community equipment and daily living aids so service delays are minimised and the best procurement / store options are captured. This links with the 'trusted assessor' approach where access is less predicated upon 'professional assessment'. **(S7,T2,2)** **Lead: David Millen**	Review the current offer of rapid response equipment so that it supports reduced LOS and improved discharge planning. **(S7,T3,1)** **Lead: David Millen**

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Appendix C DTOC plan 2016/17 for NHSE submission

Barking and Dagenham Better Care Fund 2016/17 Delayed Transfers of Care improvement plan

Target improvement 2% reduction (from 2015/16 288)

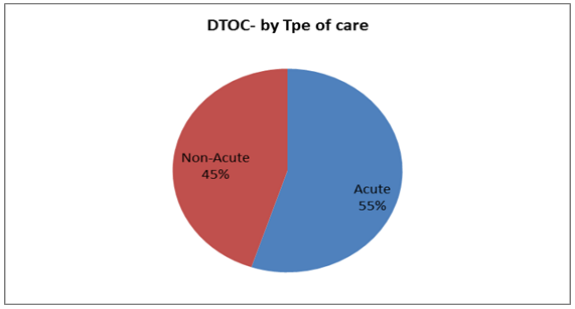
This plan reflects both our situational analysis based upon local conditions and strategic steps undertaken which saw within the previous BCF plan delivery of integrated services such as the Joint Assessment and Discharge Service, designed to markedly change the way in which acute discharges were undertaken between the partners. In 15/16 the majority of delays were drawn from acute hospital services, with a significant minority drawn from non acute beds at 45%.

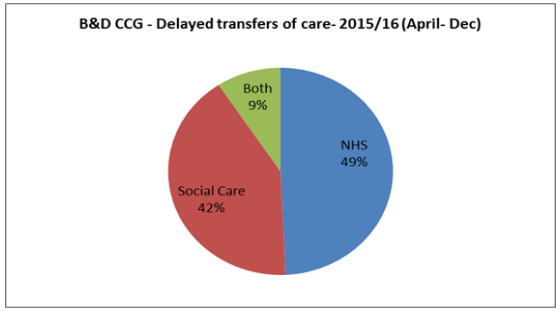
Our situational analysis has shaped the key actions which include areas such as, specific steps to improve delays for people with mental health needs, with the use of both additional funding and housing related solutions and more broadly, testing opportunities for ‘step down’ / interim service provision and delivering innovation in respect to trusted assessor roles and the delivery of low level preventative interventions to reduce the incidences and likelihood, of admissions in areas such as falls alongside further targeting of care homes where levels of acute admissions are comparatively high. The plan also reflects positive steps to improve areas such as the Councils ability to secure, where required, bed based placements through an improved fee which mitigates previous issues with inward price competition by other commissioners into the Borough. This represents, for example, 18% of current delays (417 bed days).. Analysis has also identified where there is a need for further development of processes and protocols alongside areas for further work by the partners and where some more intractable issues such as those of Continuing Health Care and neuro-rehabilitation, which require escalation within our broader BHR system and for which milestone plans are to be developed.

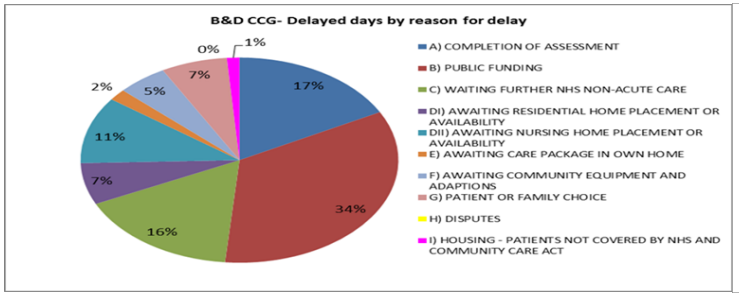
We have developed this plan in order to both provide a specific focus for local actions and to align with System wide strategic discharge planning which is currently in the process of final development across BHR.

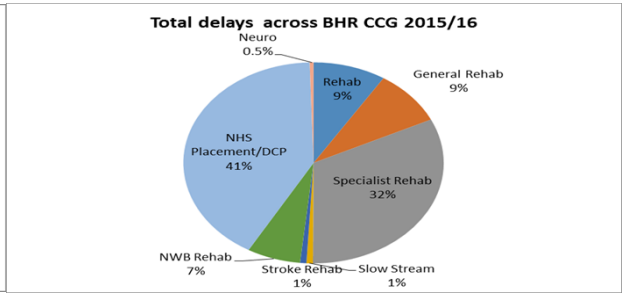
The plan and its actions are broadly reflected within the BCF milestone plan but also includes broader steps beyond our BCF, and provides, ‘at a glance’, the range of actions we are taking forward to improve current performance for the system as a whole and deliver better outcomes for individuals.

DTOC 15/16









	Rehab	General Rehab	Specialist Rehab	Slow Stream	Stroke Rehab	NWB Rehab	NHS Placement/DCP	Neuro
Total delays in 2015/16	57	56	203	5	5	42	260	3

Situational analysis	Actions	Impact % /numbers	Resources	Lead and milestone plan ref.
There is a need to shift reliance upon 'professional' assessment and allocation. This free up both resources and accelerate pace. Evidence of some individuals having multiple assessments and delays between referrals.	We will extend 'discharge to assess' and trusted assessor arrangements thereby reducing 'handoffs' and delays in onward referrals	The average time taken from referral to completion of assessment reduced	Staff time- 'discharge to assess' Protocols and process revisions. 3 month pilot to commence from 1st April 16.	BCF Delivery Group- DM/ AH (S1,T3,2) (S1,T3,3)
Insufficient focus upon throughput on Length of Stay (LOS) in secondary bed based services. Significant actions have been put in place to improve acute discharges and therefore non acute is an area of new priority. Delays are significant from	Principles established within the JAD being considered within non-acute services- this would include our moving to establishing an indicative discharge date at (or closer to) the point of admission. Discharge protocols established. We will promote shared learning across trusts (incl. NELFT) We will implement a new 'sign off'	Bed day delays attributable to acute hospitals in 15/16- 1342 days (**55%**) Delays attributable to	Development of revised protocols and working practices. This will include an agreed sign off process which will ensure that DToCs are accurately recorded and owned.in line with recently released revised guidance.	TW / DM

other hospitals such as BARTS and WHIPs Cross	processes for hospital outside our health economy	BARTs and WHIPs Cross. Bed days social care 75, NHS 321		
Due to significant financial pressures and the need to improve secondary provider performance blockages have occurred in secondary bed based MH services which have impacted upon our overall DToC position.	We will Improve flow of resources in bed based Mental Health services We will complete the delivery of housing based solutions to complement the existing offer		Improve resources available through both specific BCF allocation as an investment priority for the BCF partners drawing in specific 'ring fenced' '<u>out of hospital' funding</u> agreed through BCF. (£70k allocation through BCF, deployment of under spends). Increased fund of £250k. Provision of 6 bedded house to provide a supported living/ interim housing based solution	MF/ DM BCF delivery Group (ST, T3,1)
Improvement needed in response times, alongside need for improved focus upon short term (time limited interventions). Too many people with both dementia and EoLC going into and dying within hospital based care.	We will undertake further deep dive analysis to confirm impact of EoLC and people falling outside of 'eligibility' criteria We will review hospital discharge support for people with dementia Consider and scope the provision of a community based rapid response service that would respond quickly to DToC and provide provisional support whilst	Deep dive analysis to confirm: - delayed bed days attributable to people with dementia and EoLC -delayed bed days for people falling outside of Social Care / CHC etc..	Review existing provision such as the new support at home services and provision for rapid response and identify requirements for further capacity building *To be costed and commissioned as part of <u>Out of Hospital Services</u>* <u>Out of hospital commissioned</u> 'take home and settle	BCF Delivery Group – DM (ST, T3,1)

Investment is heavily weighted in high end / high cost services	on-going solutions were sought. This would support key target groups such as people with dementia and EoLC and those currently falling outside of eligibility criteria (already BCF schemes and priorities) leave hospital and thus remove such issues as access to services/ capacity as a cause of delay. We will increase our ability to divert people through lowest intervention at least cost necessary		service'*£50 k 'take home and settle' service* Additional cost implications to be considered by the BCF partners through the Joint Executive Management Committee.	
We have identified a cohort of individuals who need to leave acute and non-acute bed based care but are not yet ready to return home	We will develop a business case for Independent Living beds and floating support service (supporting 'step down' model).	Costs to be confirmed with recommendations for the JEMC	Commissioning resources to scope and develop business case for a pilot number of 'step down' beds commissioned as a pilot	BCF delivery Group - DM
Delays in DToC due to care home availability. Migration into Borough absorbing capacity and reducing choice for local residents. Delays due to family choice	We will deliver improved capacity in care homes We will improve the early identification of people likely to need care home admission as part	Delayed days attributable to awaiting Residential home placement are currently 160 days (**7%)** Delayed days attributable to awaiting Nursing home placement are currently 257 days (**11%)** Delayed days attributable to	New fee uplifts applied Assessment capacity	BCF delivery Group MF / DM (S6,T2,1)

	of assessment and discharge process	Patient/ family choice 164 days (**7%)**		
An opportunity to improve access to both equipment and AT solutions, as part of universal offer	We will build upon the work to improve access to community equipment (including rapied response) and daily living aids so that as a jointly commissioned service delays are minimised and best procurement / store options are captured. Again this would link with 'trusted assessor' where access would become less predicated upon 'professional assessment'.		To be held within Equipment BCF scheme under development by the BCF commissioning partners.	BCF Delivery Group – DM (S7,T3,1) S7,T2,1) (S7, T2, 2)
A small number of individuals within our system disproportionately impact upon delayed days. Identified through our risk stratification Target cohort- delays due to 'neck braces'.. Therapy staff believe that on-going support post discharge is social cares responsibility and resolving dispute can	We will undertake Deep dive analysis to support the 'targeting' of a key cohort of people who have high bed days and assessment delays / multiple assessment episodes. Analysis to better understand the characteristics of high intensity users We will agree processes and shared responsibility to improve discharge flow.	Deep Dive analysis to confirm the number of delayed days currently attributable to people receiving integrated cluster support	Cluster teams….. Improved requirement for in reach to provide **'pull through' discharge** and admission avoidance through proactive case management. In centivisation of primary care to improve support independent sector providers of bed based care To be developed through our BCF plan implementation.	BCF delivery Group - MM / DM (S1,T3, 4)

result in bed days being lost				
There is a national focus upon the 'back end' i.e DToC . It is clear that for some individuals, an admission to hospital can have a very negative impact upon their independence and wellbeing.	We will draw in and evaluate our system wide admission avoidance steps, including the delivery of hubs, information and advice and specific activity within our BCF plan– on the key principle that if more admissions were avoided in the first place then there would be fewer people to discharge and hospital / bed based acquired dependency would be, where possible, avoided. We will review all existing schemes' impact upon admission avoidance and take further steps through the BCF and JEMC governance to enhance focus on avoidable admissions. We will enhance support to care homes by improving access to community nursing, GP review and support. We will undertake monitoring to Identify high referring homes for targeting of support. We will take steps to align our voluntary sector offer – including impacts of social isolation, living	Quantify avoidable admissions BCF – admission reduction plan for 16/17 - **228** Emergency admission reduction from care homes - 16/17 - **28 admission reductions** (Maintaining the same level of reduction as in 15/16)	Commissioning partners within the BCF to develop and confirm officer resources..	JEMC and BCF Delivery Group (S4,T1,1) (S4,T2,1) (S4,T2,2) (S5,T2,1) (S6,T1,3) (S6, T1,1) (S6,T1,2) (S6,T1,3) (S3,T1,1) (S2, T1,1) (S2,T1,1) (S2,T2.3) (S2,T3,1)

	alone etc.. on admission rates			
Neuro –rehabilitation currently has a very significant impact upon delayed bed days albeit affecting a small number of individuals.	This will be escalated through wider BHR governance	Bed days attributable to inter-hospital referral (3 in 2015/16)		SM
CHC process delays – people stay in hospital 2 weeks longer than required because of delays in undertaking assessments to decide whether FNC is payable or not.	Process re-design. Improvement options paper to be considered by BCF partners. This will be escalated through wider BHR governance	Bed days attributable to NHS placements		SM

Appendix D BCF Expenditure Plan 2016/17

BETTER CARE FUND (BCF) EXPENDITURE PLAN 2016-17				
Scheme Name	**Scheme Type**	**Commissioner**	**Provider**	**2016/17 Expenditure (£)**
1- Model of Care - Community Health & Social Care Services	Integrated care teams	CCG	NHS Community Provider	£4,494,000
1- Model of Care - Community Health & Social Care Services	Integrated care teams	Local Authority	Local Authority	£2,147,000
1- Model of Care - Community Health & Social Care Services	Integrated care teams	Local Authority	Local Authority	£2,570,500
1- Model of Care - Improved Hospital Discharge	Intermediate care services	Local Authority	Local Authority	£1,028,000
1- Model of Care - Improved Hospital Discharge	Intermediate care services	Local Authority	Local Authority	£991,100
1- Model of Care - New Model of Intermediate care	Intermediate care services	CCG	NHS Community Provider	£2,483,057
1- Model of Care - New Model of Intermediate care	Intermediate care services	Local Authority	Local Authority	£700,000
1- Model of Care - Integrated Commissioning	Other	Joint	Local Authority	£145,000
1- Model of Care - Care Act	Other	Local Authority	Local Authority	£100,000
2- Dementia Support	Personalised support/ care at home	Local Authority	Local Authority	£347,300
3- End of Life	Personalised support/ care at home	Local Authority	Local Authority	£105,000
4- Carers - Support for Family carers	Support for carers	CCG	Local Authority	£495,000
4- Carers - Support for Family carers	Personalised support/ care at home	Local Authority	Local Authority	£430,000
4- Carers - Care Act	Personalised support/ care at home	Local Authority	Local Authority	£517,000
4- Carers - Care Act	Personalised support/ care at home	Local Authority	Local Authority	£200,000
5- Mental Health - Mental Health Support outside hospital	Personalised support/ care at home	CCG	Charity/Voluntary Sector	£256,000
5- Mental Health - Mental Health Support outside hospital	Personalised support/ care at home	Local Authority	Local Authority	£340,000
5- Mental Health - Mental Health Support outside hospital	Personalised support/ care at home	Local Authority	Local Authority	£572,000
6- Prevention	Personalised support/ care at home	Local Authority	Local Authority	£1,191,000
6- Prevention	Personalised support/ care at home	Local Authority	Local Authority	£30,000
7- Equipment and Adaptation	Personalised support/ care at home	Local Authority	Local Authority	£1,456,009
7- Equipment and Adaptation	Personalised support/ care at home	Local Authority	Local Authority	£107,000
			Total BCF Pool 2016-17	**£20,704,966**

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HEALTH AND WELLBEING BOARD

26 April 2016

Title:	Referral To Treatment (RTT) issues in BHR
Report of Accountable Officer for BHR Clinical Commissioning Groups	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: No**
Report Author: Faith Button Joint RTT Programme Lead, BHR CCGs & BHRUT	**Contact Details:** Faith.BUTTON@bhrhospitals.nhs.uk
Sponsor: Conor Burke, Accountable Officer BHR Clinical Commissioning Groups	

Summary:

The NHS Constitution gives patients the right to access services within 18 weeks following a GP referral. Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) which runs King George and Queen's Hospitals, suspended formal reporting of its Referral To Treatment (RTT) performance in February 2014 due to a lack of confidence in the ability of the Trust to reliably report both the numbers of patients waiting.

BHR CCGs and BHRUT were tasked to develop and deliver by NHS England (NHSE) and the NHS Trust Development Agency (NTDA), an RTT recovery plan and report regularly to NHSE/ NTDA to provide the necessary assurance.

Despite BHRUT data quality not being assured its March 2016 Board papers stated that it had 1,015 patients waiting more than 52 weeks on the elective RTT pathway. This led to considerable national publicity.

An independent auditor has now been brought in to verify the data and patient numbers. Details on the precise number of Barking and Dagenham (B&D patients waiting is to be confirmed by BHRUT shortly).

Since March the number of 52 week waiters in BHRUT has reduced to reportedly just under 800. NHSE (London), has written to the BHR CCG Chairs and Accountable Officer outlining their concerns.

BHRUT does not have sufficient spare capacity to address the current backlog or the levels of referrals currently being generated by GPs.

An RTT summit took place on Thursday 14 April with BHRUT Chief Executive, Medical Director, CCGs Accountable Officer, CCG Chairs and clinical directors from both organisations and agreed a system RTT recovery plan. These actions tackle the following areas:

- Trust capacity and delivery
- Theatre productivity
- Transfer of activity to the independent sector
- Referral management

Recommendation(s)

Members of the Health and Wellbeing Board are recommended to:

1. Note that the CCGs and BHRUT have developed and agreed a refreshed RTT recovery plan to more effectively tackle the issue of long patient waits and to offer necessary assurance to all stakeholders including patients and the public.
2. The recovery plan is currently being reviewed by NHS England and NHS Improvement (formerly NTDA).

Reason(s):

The timely treatment of patients referred to secondary care by their GPs is a right under the NHS constitution and a marker for a safe, high quality, local NHS.

1. Background

1.1 The NHS Constitution gives patients the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer patients a range of suitable alternative providers if this is not possible. Even if a patient requires a range of tests and appointments this should take no longer than 18 weeks.

1.2 The number of patients waiting beyond the 18 weeks limit is formally reported by Trusts to NHS England and monitored as a key performance standard.

1.3 BHRUT, which runs King George and Queen's Hospitals, suspended formal reporting of its Referral to Treatment (RTT) performance in February 2014. This was due to a lack of confidence in the ability of the Trust to reliably report both the numbers of patients waiting, and the length of wait for elective care and treatment. A number of other trusts across England have also suspended reporting due to data issues during this time.

1.4 The Trust identified issues with the accuracy of waiting times data since upgrading their Patient Administration System which led to a backlog of patients waiting longer than the 18 week referral to treatment time standard.

1.5 As a result, the BHR CCGs and the Trust were tasked, by NHSE and the NDTA, with developing a plan to deliver the constitutional target. In additional regular reporting to NHSE and the NDTA was put in place to provide the necessary assurance on progress. The CCGs have been working closely with the Trust since that time to support their recovery plan. Despite this, the RTT performance issue has remained a high level risk.

1.6 This information was shared with stakeholders in RTT briefings from the Trust, available on its website: http://www.bhrhospitals.nhs.uk/about-us/News/issue-briefs.htm

1.7 GPs have reported awareness of the long waits for some of their patients and some have escalated these with BHRUT, but the Trust have been unable to track patient level activity due to ongoing data issues. GPs in Barking and Dagenham have also raised concerns with the CCG about availability of Dermatology appointment slots.

2. Scale of the issue

2.1 Despite BHRUT data quality not being assured, BHRUT revealed in its March 2016 Board papers that it had 1,015 patients waiting more than 52 weeks on the elective RTT pathway. The number of patients waiting over 18 weeks is cica 17,500. This is the largest number of patients in the NHS. In addition to the existing local concerns, the release of the data led to national publicity about the length of the waiting times for BHRUT patients and additional scrutiny on the local system.

2.2 The number of 52 week waiters has already reportedly come down to just over 800, but NHSE (London), has written to commissioners outlining its ongoing concerns.

2.3 An independent auditor has now been brought into BHRUT to verify the data and patient numbers. We are still waiting for confirmation of the number of B&D patients waiting for treatment having been referred by their GP.

3. Commissioner and Trust response to date

3.1 As a result, commissioners and the Trust have increased resources to address the issue and put a series of additional actions in place, forming project groups to deliver a number of urgent work streams and setting up a dedicated Project Management Office (PMO) to enable partners to effectively tackle this issue together.

3.2 Based on the current position, the cost of clearing the RTT backlog and the Trust returning to compliance with the Constitutional Standard is estimated at £9m-£14m in 16/17. No additional funding has yet been made available to Commisioners who are asked to plan for this expenditure within existing allocations and business rules.

3.3 BHRUT does not have sufficient spare capacity to address the current backlog or the levels of referrals currently being generated by GPs so commissioners are urgently setting up a response that includes.

- Outsourcing/redirection waiting patients to alternative providers
- Demand management including use of alternative providers, (including additional community provider clinics)
- Improving patients pathways to reduce delays and duplication
- Trust looking to increase capacity by recruiting 17 additional staff
- Trust looking to increase activity through its operating theatres
- Weekly assurance meetings with NHSE as well as local RTT Programme Board
- A new PMO supporting data collection/sharing and monitoring for assurance
- A communications and engagement plan which includes patients, public and other stakeholders.

3.4 An example of an action that has been taken is that a Community Dermatology Service will be running in Barking and Dagenham from 25th April. Further details on the actions being taken and the governance/programme structure in place to oversee the plan is included in Appendix 1 (the most up to date position will be shared at the meeting)

3.5 A number of principles have been agreed regarding this work including:

- not suppressing clinical necessary referrals, for example consultants will still be able to referral patients to other consultants when this is a part of the patient pathway

- not increasing the workload on primary care, without agreement for example establishing additional shared care pathways.

4. RTT summit

4.1 An RTT 'summit' took place on Thursday 14 April with CCG and BHRUT clinicians, the BHRUT CE and Medical Director and CCG Accountable Officer to:

- Approve the revised plan and governance arrangements
- Agree that there be better engagement between primary and secondary care clinicians
- That each CCG take a lead for x3 specialities and alternative arrangements on behalf of all three CCGs
- Clear communications to all affected and key stakeholders.

5. Support from the Health and Wellbeing Board

5.1 Given the scale of the problem the members of the Health and Wellbeing Board can provide valuable support in the following ways:

- In communicating the message to members of the public
- Championing BHRUT as a good place to work, supporting staff recruitment
- Supporting members of the public to choose alternative providers.

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HEALTH AND WELLBEING BOARD

26 April 2016

Title:	**London Ambulance Service NHS Trust Improvement Plan**
Report of the London Ambulance Service NHS Trust	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Terry Williamson Stakeholder Engagement Manager, London Ambulance Service NHS Trust	**Contact Details:** Tel: 0207 783 2873 E-mail: Terry.Williamson@lond-amb.nhs.uk
Sponsor: Terry Williamson, Stakeholder Engagement Manager, London Ambulance Service NHS Trust	
Summary: The London Ambulance Service NHS Trust was inspected by the Care Quality Commission (CQC) Chief Inspector of Hospitals in June 2015. The result of the inspection was that the Service was rated as “inadequate”. The report contains the Service’s Quality Improvement Plan which outlines its intention to provide a better service to patients and to become a better place to work.	
Recommendation(s) The Health and Wellbeing Board is recommended to: (i) Note the contents of the report	
Reason(s) The Board has previously expressed an interest in the performance of the London Ambulance Service and the way that it provides services to the residents of Barking and Dagenham. Following the announcement of the CQC inspection, London Ambulance Service offered to update the Board on the Service’s Quality Improvement Plan and the impact locally.	

1 Introduction and Background

1.1 The London Ambulance Service NHS Trust (LAS), responds to over 1.9m calls and attending over 1 million incidents each year. It provides emergency medical services to the whole of Greater London, which has a population of around 8.9 million people and is the busiest emergency ambulance service in the UK. The Service employs over 4,600 whole time equivalent (WTE) staff, who work across a wide range of roles based in over 70 ambulance stations and support centres.

1.2 LAS is commissioned by 32 Clinical Commissioning Groups for London and by NHS England.

1.3 The Care Quality Commission (CQC) Chief Inspector of Hospitals inspection of The London Ambulance Service NHS Trust took place between 1st and 5th June 2015, and 17th and 18th June 2015, with further unannounced inspections on 12th, 17th and 19th June 2015. This inspection was carried out as part of the CQC‟s comprehensive inspection programme. Four core services were inspected:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services
- Resilience planning including the Hazardous Area Response Team

1.4 The CQC inspection report was published on 27th November 2015. Overall, the trust was rated by the CQC as “Inadequate‟.

1.5 In response, the LAS developed a Quality Improvement Plan to address the findings of the CQC report and improve the Inadequate rating of the Trust. The Quality Improvement Plan has identified five work streams –

- Making the London Ambulance Service a great place to work
- Achieving good governance
- Improving patient experience
- Improving environment and resources
- Taking pride and responsibility

1.6 In each of these work streams key improvement projects have been identified that will underpin our work to deliver the improvement plan. The Trust has been working intensively to deliver these projects. For these detailed projects to deliver there are five critical enablers:

- Staff engagement
- Strong programme governance
- Visible leadership
- Our partnership with Defence Medical Services
- Outcome of the 2016/17 contracting round

1.7 The LAS Quality Improvement Plan is attached in full at **Appendix A**.

2 Impact for Barking and Dagenham

2.1 LAS responds to calls in Barking and Dagenham using resources that are dynamically deployed throughout the borough, primarily from ambulance stations in

Dagenham, Ilford, Hornchurch and Romford which constitutes the North East London sector, but also using resources from neighbouring areas such as Newham, Hackney and Waltham Forest. All 999 calls are received and prioritised in our Emergency Operations Centres at Waterloo and Bow. There are approximately 200 operational staff working to cover the vehicles deployed in North East London including, Paramedics, Emergency Medical Technicians; International Paramedics and Emergency Ambulance Crews. This is managed by a North East London team of operational front line Clinical Managers and other specialist managers to support front line operations.

2.2 This year (1st January 2016 to 31st March 2016) LAS performance is at 58.3% on Category A (life threatening) calls responded to in Barking and Dagenham. This compares to 58.8% for London and 60.5% for North East London. Abbey Ward has seen the highest number of Category A calls and Parsloes Ward the least. Activity in Barking and Dagenham overall is up 4.7% for the year to date on all calls. The North East sector is currently the third highest performing area across LAS.

2.3 LAS continues to recruit Paramedics from around the world and Barking and Dagenham will be served by some of these starting in March 2016. An innovative alternative resource scheme, operated in partnership with NELFT and targeted to respond to calls from elderly fallers, continues to provide an appropriate care pathway for these patients and prevents attendance at hospital. The Quality Improvement Plan will involve our staff in all its work streams to ensure local operations maintained and improved upon.

3 Mandatory Implications

Joint Strategic Needs Assessment

3.1 Not applicable.

Health and Wellbeing Strategy

3.2 A well-rated and high-performing London Ambulance Service underpins the delivery of Barking and Dagenham's Health and Wellbeing Strategy. The actions set out in the Quality Improvement Plan support the Improvement and Integration of Services priority through improving treatment and care by benchmarking against best practice and where we identify that care has failed.

Integration

3.3 There are a number of actions identified in the Quality Improvement Plan that promote better integration between the LAS and partner organisations, including improved access to urgent care centres and working with challenged providers to drive actions to support timely hospital handovers.

Financial Implications

3.4 Not applicable.

Legal Implications

3.5 Not applicable.

Risk Management

3.6 Not applicable.

Patient / Service User Impact

3.7 Currently London residents are served by and Ambulance Service which has been rated as Inadequate by CQC. Actions set out in the Quality Improvement Plan will improve the quality of the service that residents in London receive.

List of Appendices:

Appendix A London Ambulance Service NHS Trust Improvement Plan January 2016

London Ambulance Service NHS Trust

Our quality improvement plan

Moving Forward Together

January 2016

Moving Forward Together

Contents

The context

The London Ambulance Service NHS Trust is one of 10 Ambulance Trusts (and Ambulance Foundation Trusts) in England, responding to over 1.9m calls and attending over 1 million incidents each year. We provide emergency medical services to the whole of Greater London, which has a population of around 8.9 million people. We are the busiest emergency ambulance service in the UK. The Service employs over 4,600 whole time equivalent (WTE) staff, who work across a wide range of roles based in over 70 ambulance stations and support centres.

'The London Ambulance Service NHS Trust is here to care for people in London: saving lives; providing care; and making sure they get the help they need.'

Our purpose is supported by the following values:

In everything we do we will provide:

Clinical excellence: giving our patients the best possible care; leading and sharing best clinical practice; using staff and patient feedback and experience to improve our care.

Care: helping people when they need us; treating people with compassion, dignity and respect; having pride in our work and our organisation.

Commitment: setting high standards and delivering against them; supporting our staff to grow, develop and thrive; learning and growing to deliver continual improvement.

The main role of the Service is to respond to emergency 999 calls, 24 hours a day, 365 days a year. 999 calls are received by the Emergency Operations Centres (EOC), which provides call handling, triage, disposition, emergency ambulance dispatch, hear and treat, and clinical advice. Other services provided include: Non-

Emergency Transport (NETS) for patients not requiring further assessment or intervention; Patient Transport Services (PTS) for transporting non-emergency patients between healthcare locations or their home address; NHS 111 in SE London (the non-emergency number for clinical advice); and other specialist services including the Hazardous Area Response Teams (HART) who are trained to work in challenging or difficult environments.

At its heart our Quality Improvement Plan is about delivering better care for patients and making The London Ambulance Service a better place to work. In order to achieve this, we need to fundamentally transform the Service. This document describes how we will do this.

What the Care Quality Commission said about The London Ambulance Service

The Care Quality Commission (CQC) Chief Inspector of Hospitals inspection of The London Ambulance Service NHS Trust took place between 1st and 5th June 2015, and 17th and 18th June 2015, with further unannounced inspections on 12th, 17th and 19th June 2015. This inspection was carried out as part of the CQC's comprehensive inspection programme.

Four core services were inspected:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services
- Resilience planning including the Hazardous Area Response Team

The CQC inspection report was published on 27th November 2015. Overall, the trust was rated by the CQC as 'Inadequate'.

Of the five CQC domains: Safe was rated as 'Inadequate', Effective was rated as 'Requires Improvement', Caring was rated as 'Good', Responsive was rated as 'Requires Improvement', and Well-led was rated as 'Inadequate'.

The report identifies a number of "must do" and "should do" actions for the Service and these are embedded within the section entitled: "Our Quality Improvement Plan – The Five Work Streams"

We are pleased the CQC recognised:

- That patients in London receive good clinical care
- Our staff are caring and compassionate
- Paramedics and nurses in our control room give good advice to frontline staff while our intelligence conveyance system prevents overload of ambulances at any one hospital

- In the event of a major incident we have clear systems and plans in place and an alert system for staff who have proved they are always keen to respond – even when not on duty
- We have effective systems to manage large scale events such as Notting Hill Carnival and the central London New Year's Eve event
- We are highly skilled at responding to major incidents in London and practice our response regularly with our 999 partners
- Staff were positive about local leadership and said the management style of the new Chief Executive would improve the service and staff retention.

Improvements we have already made since the CQC inspection

The CQC inspected The London Ambulance Service in June 2015. We were already acutely aware of many of the issues that the CQC inspection and report raised, and many actions were already in progress to improve the organisation for our staff and patients.

In broad terms since the inspection:

- We have 284 additional frontline staff responding to incidents in London and over 177 in training and supervision while our recruitment campaign continues. More staff will help take some of the pressure from our staff who work incredibly hard in often difficult circumstances

- Our Chief Executive and members of our Executive Leadership Team have met over 900 people during October 2015, during our staff road shows, and the discussion and feedback from these sessions have helped shaped the projects within our plan

- We have introduced the London Ambulance Service Academy to offer existing non-clinical staff the opportunity to train as paramedics and are working with universities to create more graduate paramedic places

- We have new leadership teams in place that are resolutely determined to create a positive working environment for everyone

- We have trained all of our most senior managers on how to tackle inappropriate behaviour in the work place.

In detail - progress since the inspection

Between the CQC inspection in June 2015 and December 2015 we have taken action and made significant progress in five particular areas across the Service:

- Resilience
- Medicines Management
- Risk and Governance
- Culture
- Workforce and staff morale

There is still work to do in each area and this is described later in this document in an overview of the Quality Improvement Plan, but it is important to emphasise the progress that has already been made to deliver better care for patients and provide a supportive working environment for our staff.

This progress was discussed at The London Ambulance Service CQC Quality Summit and our stakeholders, in particular our Clinical Commissioning Group lead commissioners, NHS England (London) and the Trust Development Authority, have asked that their appreciation of the progress made already by the Service was acknowledged in this document.

Resilience

CQC said we must :

Recruit to the required level of Hazardous Area Response Team (HART) paramedics to meet its requirements under the National Ambulance Resilience (NARU) specification.

Progress as of January 2016

- Recruited to all of of the 84 HART posts; 83 of these posts will have completed national HART training and be fully operational by 31 March 2016
- We have issued a guidance document setting out the rare occasions when HART resources can be used on the frontline. This has been communicated to all relevant staff
- The Major Incident Protocol has been revised and approved by Trust Board
- New rosters have been designed and implemented to spread skill-mix and increase capacity and flexibility
- We have reviewed staffing on rosters, and for January 2016 we were compliant 94% of the time. This figure continues to improve
- We have negotiated a formal agreement with South East Coast Ambulance Service to provide additional cover at Heathrow Airport should we need it
- Core Skills Refresher (CSR) training has now been redesigned and now includes Major Incident training for all frontline staff
- We have implemented a physical competency assessment for all HART staff
- We have set up a Resilience Action Group to ensure compliance against the HART National Ambulance Resilience Unit specification
- We have deep cleaned the HART premises and we are conducted an announced mock-inspection for medicines management
- The Executive Leadership Team have considered a proposal about HART vehicles and are now awaiting the reviewed national specification for these vehicles before making a final decision.

Medicines Management

CQC said we must improve its medicines management including:

Formally appoint and name a board director responsible for overseeing medical errors and formally appoint a medication safety officer; Review the system of code access arrangements for medicine packs to improve security; Set up a system of checks and audit to ensure medicines removed from paramedic drug packs have

been administered to patients; Set up control systems for the issue and safekeeping of medical gas cylinders.

Progress as of January 2016

- Appointed a medicines safety officer in August 2015, and the Medical Director is the executive lead for medicines safety on the Board
- Undertaken a review and process- mapped the journey of a drug from when it arrives in the Service to when it is administered to a patient. As a result we have implemented audits at key points during this journey
- Medicines management communication campaign started called “Shut it, Lock it, Prove it” co-designed with Clinical Team Leaders and supported by communication with clinical staff
- We are working with the Trust Development Agency (TDA) and CQC to review and update the guidance for administering drugs by paramedics in the UK.

Risk and Governance

CQC said we must:

Improve the system of governance and risk management to ensure that all risks are reported, understood, updated and cleared regularly; Address under reporting of incidents including the perceived pressure in some departments not to report incidents

Progress as of January 2016

- Baseline audit of the status of all local risk registers completed for all departments and all group stations

- Designed a risk-management training programme for all managers, which launched in November 2015 and we will have trained all managers by 31 March 2016
- The Governance Team are attending local meetings to raise the profile of risk management and provide advice and support
- All local risk registers will be updated by the end of March 2016
- HART and EOC risk registers have been reviewed and updated
- As a result of the new operational management structure being fully implemented in September 2015, clear accountability for risk management and governance is now specified and understood
- Duty of Candour training has been underway since the end of 2015 for staff leading Serious Incident investigations. We are beginning to see evidence of the application of Duty of Candour for serious incidents and potential serious incidents
- To simplify and improve incident reporting we are in the final stages of preparation for the launch of *Datix Web*, a new electronic risk management system for all staff to use, in April 2016 and full implementation will be complete by June 2016.

Culture

CQC said we must:

Develop a detailed and sustained action plan to tackle bullying and harassment and a perceived culture of fear in some parts.

Progress as of January 2016

- Awareness training in bullying and harassment has been completed for the Executive Leadership Team and the Senior Leadership Team
- An independent Telephone Advisory Service has been in place since July 2015

- In November 2015 we appointed a specialist Bullying and Harassment Lead
- We commissioned independent investigators to lead on any bullying allegations within the Service
- We have designed and launched simple and easy-to-follow guidance for staff to understand and report bullying and harassment
- We appointed an Organisational Development Specialist in November 2015 to support our work on changing the culture within the Service
- We have designed a training course for all staff on bullying and harassment which is currently being tested with key staff groups
- We have appointed a Non-Executive Director to lead on bullying and harassment.

Workforce and Staff Morale

CQC said we must:

Recruit sufficient frontline paramedic and other staff to meet patient safety and operational standards requirements; Improve staff morale

Progress as of January 2016

- By the end of December 2015, since the CQC inspection in June 2015 we have an additional 284 frontline staff responding to patients
- Further 177 in training and supervision
- 297 more staff to join by end of March 2016
- Frontline staff turnover has decreased from 15.1% in April 2015 to 12.6% in December 2015
- Frontline sickness is 6.5% compared to 6.9% at the same point last year
- Over 5,000 more patient facing vehicle hours per week than last year
- The 2016/17 recruitment plan has been designed to ensure that the Trust maintains its staffing levels

- The new operational management structure has now been implemented (September 2015) and we now have dedicated local management teams in place to lead and support staff
- Since the 1 July 2015, our Clinical Team Leaders have had 50% of their time protected to support frontline clinicians
- We have submitted a bid to Health Education England to support the training and development of our clinical staff
- We have agreed with commissioners and Local Education and Training Boards (LETB) bursary funding for graduates training in London if they then agree to take up a role at The London Ambulance Service in qualifying
- In January 2016 we opened The London Ambulance Service Academy to train non-registered clinical staff to become our paramedics of the future
- We have met 900 people at the staff road shows in October 2015 their feedback has shaped our work plan for the coming months
- The second round of VIP nominations with category winners has been announced and a celebration event has taken place.
- To improve our non-pay benefits offer to staff we have launched new bicycle and lease car schemes

An overview of the London Ambulance Service Quality Improvement plan

The Board of The London Ambulance Service welcomed the CQC report and its findings and will make sure swift and comprehensive action is taken to improve for Service for patients and make it a better place to work for staff.

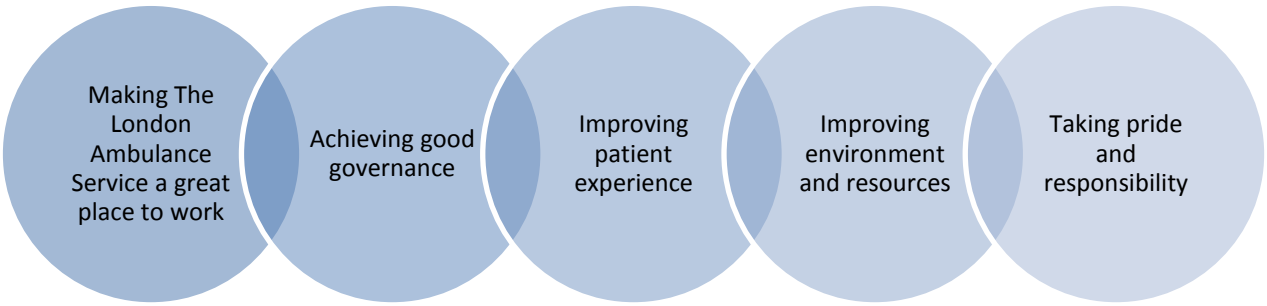
Our Quality Improvement Plan has five work streams:

- Making The London Ambulance Service a great place to work
- Achieving good governance
- Improving the patient experience
- Improving the environment and resources
- Taking pride and responsibility

The following pages summarise the projects for each work stream and how we will measure delivery on each.

Our Quality Improvement Plan – The Five Work Streams

The following pages summarise the projects for each of our five work streams, and how we will measure delivery on each. Our detailed action plan with milestones, key sub-tasks, and lead responsibilities can be found on our website and intranet.



Making The London Ambulance Service a great place to work

Executive Lead – Paul Beal, Director of Human Resources

The CQC said the Trust must:

- *Recruit sufficient frontline paramedic and other staff to meet patient safety and operational standards requirements*
- *Develop and implement a detailed and sustained action plan to tackle bullying and harassment and a perceived culture of fear in some parts.*

The CQC said the Trust should:

- *Review development opportunities for staff*
- *Ensure all staff have sufficient opportunity to complete their mandatory training including personal alerts and control record system*
- *Communicate clearly to all staff the trust's vision and strategy*
- *Increase the visibility and day to day involvement of the trust executive team and board across all departments*
- *Provide NICE cognitive assessment training for frontline ambulance staff.*

- *Review trust equality and diversity and equality of opportunity policies and practices to address perceptions of discrimination and lack of advancement made by trust ethnic minority staff*
- *Ensure all staff receive an annual appraisal.*

We have identified seven key improvement projects under this theme that will collectively deliver our plan to make LAS a great place to work. The Trust has been working intensively to deliver these projects. They are:

- Advert to Action
- Bullying and Harassment
- Training
- Equality and Diversity
- Vision and Strategy
- Supporting staff
- Retention of staff

Advert to Action

- The aim of this project is to deliver the agreed recruitment plans to ensure we have sufficient staffing capacity to meet patient needs and national ambulance targets.
- This project will build on our recruitment success over the last year and includes international recruitment drives, a strengthening of our graduate offer and process, as well as local London recruitment of trainee emergency ambulance crew.
- To work with Health Education England nationally, to ensure that paramedic education and recruitment remains a high national priority.

Bullying and Harassment

- This project builds on phase one of our bullying an harassment action plan and aims to change the culture within the organisation to one that supports and respects individuals and sets realistic targets.
- Through this project we will deliver all staff training programmes, training for bullying and harassment investigators, set key performance targets and time frames for handling investigations, identify what is, and what is not bullying and harassment and an internal communications campaign to raise awareness and understanding.
- To support greater informal and timely resolution to issues this project will explore mediation support to assist managers and staff.

Training

- This project aims to make it easier for staff to complete their mandatory training and offer new e-learning modules. We will roll-out Individual Learning Accounts for non-operational staff that protect time for 'learning activities', and procure a new system to enable increased e-learning.
- Through this project we will redesign the corporate induction programme and the core skills training programme will include subjects such as cognitive and mental health assessment, and safeguarding vulnerable people.

Equality and Diversity

- This project aims to ensure that the Trust is as an equal opportunities employer, and that staff from all backgrounds feel included and part of the workforce. This will include running focus sessions across all staff to gather opportunities for improvement, ensuring equality objectives are embedded within the appraisal process and updating mandatory training for all line managers to include equality and diversity.
- We will also review recruitment processes, particularly in relation to internal promotion opportunities.

Vision and Strategy

- This project will review the Service's values and engage with staff in their development.
- This project will drive the development of a staff charter which will be co-designed with staff
- This project will also deliver improved visibility of the senior leadership across the organisation.

Supporting Staff

- This project will focus on ensuring staff are supported and have opportunities to develop within the Trust. This will include completing appraisals, development of a competency framework, and we will look to enhance our training offer for staff, including the use of e-learning. These, along with a training needs analysis, will support the delivery of an annual training plan.

Retention of Staff

- This project will focus on improving how we recognise and value our staff through strengthened staff engagement to make our organisation a better place to work. We have already developed a staff retention strategy that has been in place throughout 2015/16, and we will be further strengthening this as we move into 2016/17. As part of this project, we will design a London Package for staff to encourage them to stay with the Service. This package will focus on two areas, the banding of paramedics and non-pay benefits for all staff.

We will know that we have been successful when…

We will measure success against the following indicators:

- Reduced staff turnover and sickness absence rates
- Recruiting to 3,169 WTE frontline establishment
- Improved statutory and mandatory training rates.
- The number of Trainee Ambulance Crew staff working towards formal paramedic qualifications
- Improved feedback scores through the staff opinion survey on bullying and harassment
- Improved annual appraisal completion rate
- Increase number of BME staff within the Service

Achieving good governance

Executive Lead: Sandra Adams, Director of Corporate Affairs

The CQC said the Trust must:

- *Improve the system of governance and risk management to ensure that all risks are reported, understood, updated and cleared regularly.*

The CQC said the Trust should:

- *Review the capacity and capability of the trust risk and safety team to address the backlog of incidents and to improve incident reporting investigation learning and feedback to the Trust and frontline staff*
- *Review and improve trust incident reporting data*
- *Address under reporting of incidents including the perceived pressure in some departments not to report some incidents*
- *Set up learning to ensure all staff understand Duty of Candour and their responsibilities under it*
- *Review staff rotas to include time for meal breaks, and administrative time for example for incident reporting*
- *Develop a long term strategy for the EOCs*
- *Ensure better public and staff communication on how to make a complaint including provision of information in emergency and non-emergency ambulances.*

Projects and work in progress to make improvements

We have identified six key improvement projects under this theme that will collectively deliver our plan to improve quality governance. The Trust has already been working intensively to deliver these projects. They are:

- Risk management

- Capability and capacity of the health, safety and risk function
- Improve incident reporting
- Duty of candour
- Operational planning
- Listening to patients

Risk management

- This project will focus on improving the system of governance and risk management across the Trust, and has already completed a number of key milestones:

    - A risk register review was carried out by the Risk and Audit Manager in conjunction with risk 'owners' during October 2015.
    - The risk management policy is in the process of being reviewed and will be signed off by the Trust Board by March 2016.
    - A programme of risk management training was implemented in November 2015 to provide operational managers with more detail on managing risk, Trust processes and escalation procedures.
    - All managers will have been trained in risk management by March 2016

- Further milestones for the project include a strategic risk review, completing the training programme for all operational and corporate staff and establishing a Risk and Assurance Committee to report into the Executive Leadership Team (ELT).

Capability and capacity of the health, safety and risk function

- This project will focus on ensuring the Trust's capability and capacity to deliver the required risk management and governance activities is sufficient, and is providing the right level of support to managers across the organisation. The review has commenced and will report back with recommendations by March 2016.

Improve incident reporting

- The aim of this project is to improve incident reporting from front line staff, and ensure that clinical incidents as well as health and safety incidents are reported.
- This project will also ensure the smooth implementation of *Datix Web,* and other ways to simplify and increase incident reporting.
- A review has been completed to assess the current incident reporting awareness across the Trust, and a number of user friendly tools have been introduced for staff, with further plans to consider a 24 hour helpline and other engagement tools for staff.

Duty of Candour

- This project will focus on ensuring staff understand their role in duty of candour, and feel confident in applying this. An additional training module will be built into the core skills training programme for 2016/17, having been successfully piloted with staff in December 2015.
- This project will also ensure that staff leading serious incidents investigations are trained in the Duty of Candour.

Operational planning

- This project will review the operational plans for the Trust, to ensure that sufficient time is built into rotas to complete administrative tasks, training and supervision, and allow staff to have appropriate rest breaks. This project will also look over the longer term to ensure we are providing the best service we can that meets the needs of London's population and the changing demographic needs.
- This project will also focus on developing long term strategies for teams where this does not currently exist, to ensure this is aligned to the Trust strategy. This

includes the development of a strategy for the Emergency Operations Centre (EOC).

Listening to patients

- The project will focus on ensuring patients have access to the right information so they know how to feedback complaints or compliments about our Service. The project will also establish systems to gain feedback on our complaints process to make sure this is clear and easy to use. We will review how complaints feedback is fed into Service committees so that we learn from those experiences.

We will know that we have been successful when…

We will measure success against the following indicators:

- Audits shows monthly updates to all risk registers
- Increased numbers of incidents reported
- Decrease in rates for incidents resulting in injury to staff and patients
- There is not a backlog of incidents waiting to be inputted
- An increase in the number of staff able to take a rest break and time to complete non-patient facing tasks
- Improved staff satisfaction surveys
- Improved patient experience feedback
- Improved response time to complaints

Improving patient experience

Executive Lead: Zoë Packman, Director of Nursing

The CQC said the Trust should:

- *Review and improve patient waiting times for Patient Transport Service (PTS) patients*
- *Ensure PTS booking procedures account for the needs of palliative care patients*
- *Develop operational plans to respond to the growing bariatric population in London*
- *Review operational guidelines for managing patients with mental health issues and communicate these to staff*
- *Review patient handover recording systems to be more time efficient.*

Projects and work in progress to make improvements

We have identified three key improvement projects under this theme that will collectively improve the experience of patients in our care. The Trust is committed to delivering these projects. They are:

- Patient Transport Service
- Meeting people's needs
- Response times

Patient Transport Service

- This project will look at improving the performance of Patient Transport Services, to ensure that all patients receive a timely service. This will include the development, trial and implementation of pan-London process for pre-booking

and to ensure that consistent service is provided across the capital. The needs of palliative care patients will receive particular attention.

Meeting people's needs

- We will review our current policies to support an increase in the number of bariatric patients. We will re-assess whether the plans to develop our fleet of vehicles in the future are robust enough for the needs of this group of patients.
- We will update our guidance on managing people with mental health problems and ensure that front line staff receive sufficient skills training to meet the needs of this patient population.

Response times

- One of the most significant challenges we face to providing safe, sustainable care is the high number of patients who are delayed in handover to acute hospitals. We will continue to work with NHS England to address handover times at hospitals and will provide relevant information concerning delays/issues about handover times

We will know that we have been successful when…

We will measure success against the following indicators:

- Reduction in PTS patient waiting times
- Improved Friends and family test results for PTS
- Quicker hospital handover times
- Positive experiences reported by Mental Health Focus group

Improving environment and resources

Executive lead: Andrew Grimshaw, Director of Finance and Performance

The CQC found that the Trust must:

- *Recruit to the required level of HART paramedics to meet its requirements under the National Ambulance Resilience Unit (NARU) specification*

The CQC found that the Trust should:

- *Improve access to computers at ambulance stations to facilitate e-learning and learning from incidents.*
- *Ensure full compliance with bare below the elbow requirements.*
- *Ensure adequate and ready provision of protective clothing for all ambulance crews.*
- *Review and improve ambulance station cleaning to ensure full infection, prevention and control in the buildings and in equipment used to daily clean ambulances.*
- *Improve equipment checks on vehicles and ensure all equipment checks are up to date on specific equipment such as oxygen cylinders.*
- *Improve blanket exchange system pan London to prevent re-use of blankets before cleaning.*
- *Review maintenance of ambulances to ensure all are fully operational including heating etc.*
- *Review arrangements in the event of ambulances becoming faulty at weekends.*
- *Ensure consistent standards of cleanliness of vehicles and instigate vehicle cleanliness audits.*
- *Ensure sufficient time for vehicle crews to undertake their daily vehicle checks.*
- *Ensure equal provision of ambulance equipment across shifts*

- *Increase training to address gaps identified in the overall skill, training and competence of HART Paramedics*

Projects and work in progress to make improvements

We have identified five key improvement projects that will collectively deliver our plan to improve the environment and equipment for both patients and staff:

- Fleet and vehicle preparation
- Information, management and technology
- Infection, prevention and control
- Facilities and estates
- Resilience function

Fleet and Vehicle Preparation

- This project will develop a fleet strategy which will inform future vehicle requirements. This will inform the development of a strategic outline case for the period from 2017/18 to 2022/23 which will cover the number of vehicles required, the type of vehicles, the mode of procurement and delivery of maintenance.
- In the short term, this project will review the current contract in regards to vehicle preparation and equipment maintenance.

Information Management and Technology

- We will review the current provision of IT across the Service but particularly for front line staff and develop a long term strategy to support service delivery. This will include an options appraisal of hand held and vehicle devices for accessing and recording information, improving communication with our mobile staff who are adept at using information in this way.

Infection prevention and control

- This project will focus on improving infection, prevention and control across the Trust. This will include a review of current guidance on bare-below-the-elbow, protective clothing, and local monitoring for infection control.

Facilities and Estates

- This project will focus on urgently reviewing all stations to understand the scope of works required to achieve infection control standards, and review cleaning contracts to meet requirements
- The project will also consider how we make our vehicles ready for use, where responsibilities sit for fleet and equipment
- The project will see the development of a fleet strategy and the purchasing of new vehicles
- The project will also address issues with ambulance vehicle blankets.

Resilience Functions

- This project will lead the improvement of our HART service so that it meets the requirement of the national specification
- This project will ensure that all HART staff are trained to national requirements.

We will know that we have been successful when…

We will measure success against the following indicators:

- Improved compliance with vehicle cleaning standards
- Improved compliance with vehicle equipping standards
- Revised blanket system in place
- Reduced out of service vehicle hours

- Long term strategy in place to provide suitable vehicles
- Improved compliance against the national HART specification
- Improved compliance of “bare-below-the-elbow”
- Revise protective clothing pack in place for staff
- Improve compliance with station cleanliness measures
- Improved results of infection control audits
- 84 wte HART staff employed.

Taking pride and responsibility

Executive lead: Fenella Wrigley, Interim Medical Director

The CQC said the Trust must:

- *Improve medicines management including:*
  - *Review the use of PGDs to support safe and consistent medicines use.*
  - *Formally appoint and name a board director responsible for overseeing medical errors*
  - *Review the system of code access arrangements for medicines packs to improve security*
  - *Set up a system of checks and audit to ensure medicines removed from paramedic drug packs have been administered to patients*
  - *Set up control systems for the issue and safekeeping of medical gas cylinders.*

The CQC said the Trust should:

- *Improve training for staff on Mental Capacity Act assessment*
- *Ensure all staff understand and can explain what situations need to be reported as safeguarding*
- *Set up a system of regular clinical supervision for paramedic and other clinical staff*

Projects and work in progress to make improvements

We have identified four key improvement projects under this theme that will underpin excellent clinical practice across the organisation. The Trust has been working intensively to deliver these projects.

- Clinical supervision

- Delivery the Mental Capacity Act and supporting patients with Mental Health issues
- Medicines Management
- Safeguarding

Clinical supervision

- This project will ensure that a system of regular clinical supervision is in place for clinical staff, to make sure that they have workplace reviews, feedback and support.

Delivering the Mental Capacity Act and supporting patients with mental health issues

- This project will strengthen the training we provide to staff on the Mental Capacity Act and put in place a support network for staff to ensure they are confident in carrying out mental capacity assessments and able to seek clarification and guidance easily where required.

Medicines Management

- This project will review medicines management governance arrangements and ensure that the Board receives robust assurance on medicines management, it will ensure that individual responsibility for medicines management is clear, and that staff take personal responsibility for the security of medicines. The project will consider the medicines management facilities at our sites and how these can be strengthened.

- The project will also seek to clarify national policy on Patient Group Directives for oral Morphine and rectal Diazepam in partnership with the Trust Development Authority, the CQC and the national pharmacy lead.

Safeguarding

- This project will focus on ensuring all staff receive the appropriate level of safeguarding training and will also look to strengthen safeguarding links with safeguarding boards, social services and other relevant organisations. The project will also guide the implementation of safeguarding supervision for staff.

We will know that we have been successful when…

We will measure success against the following indicators:

- A programme of clinical audit which tests the points raised by the CQC and audit findings which demonstrate continuous improvement.
- Increase mandatory training compliance rate
- Spot checks on compliance with the medicines management policy
- Improved compliance with drug pack forms
- Improvement in clinical practice indicators
- Unannounced spot-checks highlight high level of compliance with control and security of medical gases
- Improvement in safeguarding key indicators, including numbers of staff trained in safeguarding
- Increased appraisal and personal development plan completion rates

How we will deliver our Quality Improvement Programme

For these detailed projects to deliver there are five critical enablers:

- Staff engagement
- Strong programme governance
- Visible leadership
- Our partnership with Defence Medical Services
- Outcome of the 2016/17 contracting round

Staff engagement

To be successful, we need all our staff to understand and own our improvement journey. We will continue to engage our staff so that everyone clearly understands what our improvement plan sets out to achieve and the actions we are taking to get there.

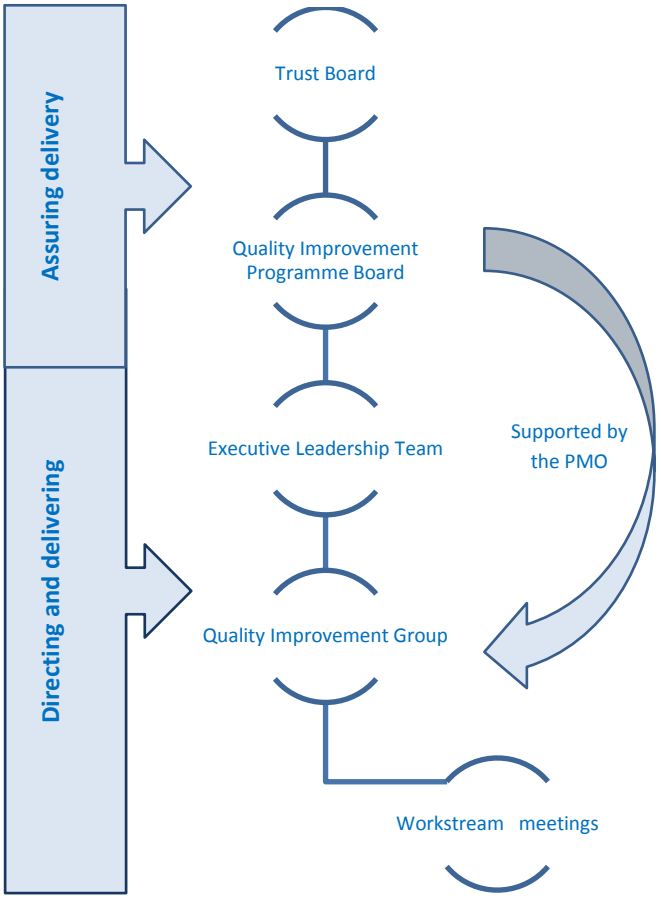
The staff road shows throughout October 2015 gave around 900 staff the opportunity to meet members of the leadership team and hear about the Trust's strategy, the vision for the future, organisational values, how the trust is tackling bullying and harassment, recruitment and the Chief Executive's commitments to staff.

We will hold local sector/departmental sessions to develop local implementation plans so that each part of the Service delivers towards our improvements. Key roles will have "action cards" to ensure that individuals are clear on what the service needs them to do. We will work closely with our managers to support them and their local teams to improve the working environment and to encourage engagement and involvement.

We will continue to update our staff, partners and other stakeholders on progress so that everyone is sighted on both our achievements and the work we still need to do.

Strong Programme Governance

We have established a clear programme of delivery, accountability and governance, led by the Director of Transformation and Strategy, and supported by a Programme Management Office (PMO), to ensure oversight and leadership in the delivery of our quality improvement plan. The diagram below identifies how the programme will be governed.



The Trust Board will have oversight of the delivery of our improvement plan through the **Quality Improvement Programme Board**. The Programme Board, chaired by the Chairman, will review progress towards the quality improvement plan and key performance indicators on a monthly basis. A formal report from the Quality Improvement Programme Board will be presented at each formal meeting of the Trust Board.

The Executive Leadership Team oversees delivery and approves any changes to the projects.

The **Quality Improvement Group**, chaired by the Chief Executive, will meet monthly to review progress against the whole plan and each of the five work steams individually, assessing risks and directing interventions to ensure deadline delivery. This group will report to the Executive Leadership Team.

Each of the five work streams is led by an Executive Director. Executive Directors will hold monthly **work stream meetings** to ensure delivery against actions and milestones.

A report detailing performance against our plan will be submitted to the Clinical Quality Review Group (CQRG), chaired by the nominated quality lead from London's Clinical Commissioning Groups, as well as the Regional Oversight Group jointly chaired by the NHS Trust Development Authority (NHS Improvement) and NHS England (London).

Programme Management Office (PMO)

The PMO will:

- Closely monitor the progress of our plan and ensure that this progress along with issues and risks are reported and managed
- Hold the baseline data, delivery dates and target trajectories so that can progress can be effectively measured
- Capture any changes to planned delivery and ensure they are authorised by the Executive Leadership Team.

Specifically the PMO will track progress against:

1. Delivery

We have developed detailed action / milestone plans for each of our improvement areas. Each improvement action has a nominated lead Executive Director and a local owner who together will take accountability for the delivery of the milestone. Progress against milestones will be reviewed on a monthly basis at the work stream meetings and the Quality Improvement Group.

2. Performance metrics

In addition to key national standards, we have developed a set of measures to determine whether our improvement projects are succeeding. These measures will enable us to track progress, ensure delivery of the planned improvements and demonstrate success.

Where performance is not in line with the plan, the local owner will provide exception reports and change requests with clear remedial actions and a delivery impact assessment for approval by Executive Leadership Team.

Visible leadership

The Executive Leadership Team recognises that it needs to be more visible across the organisation and able to demonstrate that it is engaging and listening to staff. The clinical directors all carry out regular clinical shifts, as do members of their teams. The Chief Executive is a doctor and also undertakes regular clinical shifts. They and their deputies participate in clinical on-call and are available to provide clinical leadership and support to our staff.

The non-clinical executive directors undertake observational shifts with front line and control room staff and regular meetings with their management teams and wider groups of staff.

A programme has been developed and will be implemented in February 2016, to assign each executive director to a sector or support service. This will enable each director to build an understanding of the sector and support services and the issues being faced, as well as recognising the good practice and achievements that exist.

The Chairman and Non-Executive Directors also undertake observational shifts and visits to meet and talk to members of staff. In October 2015, we commenced a programme of Board meetings held at other Trust sites. This enables Board members to visit other sites and to meet local teams in a more informal setting. Staff are also invited to present local initiatives and share their experiences at these Board meeting.

Our partnership with Defence Medical Services

We recognise that we have a great deal to do, and to learn. We can't do this alone.

We are very fortunate and excited to be working with Defence Medical Services, who have experience of leading teams to deliver improvements in difficult and adverse

conditions. For example, they set up the Hospital in Camp Bastion, Afghanistan, that dealt with large volumes of patients with complex injuries. Their development of new processes and a new management approach motivated teams to deliver clinical and workplace improvements that led to better patient outcomes. We are looking forward to co-designing a leadership programme with them, for the London Ambulance Service, during January and February 2016, to be rolled out immediately.

The outcome of the 2016/17 contracting round

We work in close partnership with London's 32 CCGs who have supported the development of The London Ambulance Service over the last two years.

The resource implications of this plan will be discussed in detail with commissioners as part of the year's contracting round. The detailed actions within this plan may therefore, be subject to change, and are dependent upon financial support from CCGs.

Working in partnership to ensure delivery

At its heart our Quality Improvement Plan is about delivering better care for patients and making The London Ambulance Service a better place to work for our staff. In order to achieve this, we need to fundamentally transform the Service. We are clear that we cannot deliver our plan without the support and co-operation of our staff, patients and stakeholders. This quality improvement plan will make every part of our organisation stronger but there must be an acceptance that change and transformation on this scale will not happen over-night.

Trade Union Colleagues

Our trade union colleagues are critical to our success. We acknowledge we need to build better and closer relationships with them. We need to make a fresh start and co-design new arrangements for partnership working so that together, we get back to being the best ambulance service in the UK.

System Partners

At the CQC Quality Summit for The London Ambulance Service, we were joined by a number of our partners across London. We were struck by the support for the Service across the Capital. It was clear that everyone at the summit wanted The London Ambulance Service to improve and succeed, and to help us do this a number of commitments were made by key partners. The commitments organisations made included:

NHS England (London) and lead CCG Commissioners will support us:

- To improve access to urgent care centres
- To work with challenged providers to drive actions to support timely hospital handovers.
- To modernise our estate and information technology
- To develop a “London Package” to help retain our staff
- To develop a staff charter to outline what people can expect as an LAS employee and what is expected of an LAS employee.

Health Education England has supported our aim to develop a leadership arm of The London Ambulance Academy and has agreed to share training advice and learning resources.

We are grateful to those people and organisations who invested their time to help us shape our Quality Improvement Plan.

Clinical Commissioning Groups

We work in close partnership with London's 32 CCGs who have supported the development of The London Ambulance Service over the last two years.

The resource implications of this plan will be discussed in detail with commissioners as part of the year's contracting round. The detailed actions within this plan may, therefore, be subject to change and are dependent upon financial support from CCGs.

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HEALTH AND WELLBEING BOARD

26 April 2016

Title:	**Care City Programme Update**
Report of the Strategic Director for Service Development and Integration	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Helen Oliver Managing Director Care City	**Contact Details:** Tel: 0300 555 1201 Ext 66228 E-mail: Helen.oliver@nelft.nhs.uk

Sponsor:

Anne Bristow, Deputy Chief Executive & Strategic Director for Service Development and Integration

Summary:

Following Care City launch two months ago, we have continued to move at pace, recruiting to our team, securing inward investment and raising the profile of the local system. These include confirmation of our NHS Innovation Test Bed, Barking Riverside designation as an NHS Healthy New Town site, and emerging collaborations with national and international groups. Our three priorities for spring 2016 are to demonstrate delivery as we launch our programmes of work, secure further inward investment, and establish a more formal mechanism to enable partners to actively shape the evolving programme.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) To note the contents of this report.

1 INTRODUCTION AND BACKGROUND

1.1 Following Care City launch two months ago, we have continued to move at pace, recruiting to our team, securing inward investment and raising the profile of the local system. These include confirmation of our NHS Innovation Test Bed, Barking Riverside designation as an NHS Healthy New Town site, and emerging collaborations with national and international groups. Our three priorities for spring 2016 are to demonstrate delivery as we launch our programmes of work, secure further inward investment, and establish a more formal mechanism to enable partners to actively shape the evolving programme.

2 CARE CITY COMMUNITY WORKSTREAM

2.1 Healthy New Towns

Care City co-ordinated the successful proposal for Barking Riverside to be designated as London's first NHS Healthy New Town. The scheme will deliver 10,800 new homes over the next 15 years, at a rate of 500-900 homes per year from 2017. Particular commendation was given to the role of the community through the Community Interest Company. We await full confirmation of the support package provided by NHS England but it will include an initial grant allocation of up to £150,000, followed by a more detailed technical support offer in phase two. Simon Steven's announcement on 1st March 2016 sparked significant media interest some of which is captured in **Appendix A.**

2.2 Asset Based Community Engagement

Creating an on-going dialogue with the population, maintaining mechanisms for community participation in the evolving programme of work, and mobilising community assets are critical to achieving our community ambitions. The work will begin in a defined ward in Barking. The approach will provide a model of principles and a toolkit which can be adapted and replicated for different communities and system needs.

3 CARE CITY INNOVATION WORKSTREAM

3.1 On January 22nd Care City was awarded a grant of £1,830,000 as London's only NHS England Health and Social Care Innovation Test Bed. Thank you for your support and participation in the application process. It was agreed via the ICC that system partners were committed to overseeing the adoption of the nine innovations, selected by a panel of local system partners and stakeholders, within appropriate clinical and social care settings over the next two years. Please see **Appendix B** for a high level workplan. The national launch of the programme took place on Wednesday 16th March. A briefing note on the test bed is also attached as **Appendix C.**

3.2 We will be recruiting co-researchers from the community to join the team to provide input from a user's perspective, and to participate in research activities. We are working closely with the data and informatics teams to ensure appropriate access to information for implementation and evaluation purposes.

4 CARE CITY RESEARCH WORK STREAM

4.1 Care City seeks to advance the application of cutting-edge research into practice by bringing research to local people, and facilitating new models of research. Our short term focus is to create a data intelligence function that will enable researchers to securely access anonymised connected data. This will also support local functions that stakeholders have highlighted as being important to them, including: A BHR Public Health Intelligence function, Local use of Clinical Effectiveness Group tools and templates to support primary care improvement, Ongoing access to connected data to support evaluation and tracking of system wide transformation.

4.2 On 02 March 2016 Professor Andrew Morris facilitated a Frontiers meeting with key stakeholders from NELFT, LBBD, LBR, BHR CCG, UCLP, QMUL, GLA and Care City. The aim of the discussion was to learn more about programme in Scotland and explore local opportunities building on the existing informatics infrastructure, data analytical capability and our collective usage ambitions. The group agreed that there are multiple shared business intelligence' functions and an opportunity to deliver greater ambitions through connecting different data sets within and across health and social care settings. Professor Morris reiterated that there was huge potential locally through the neutral space that Care City offers of linking health with social care and wider local authority data to facilitate research investment and activity. Notes of the meeting are included in **Appendix D**.

4.3 Over the coming weeks Care City will work with local stakeholders and Professor Morris to develop a proposal for a Care City Intelligence Hub to perform research and analytical function (including predictive analytics of local data) on behalf of the system. This requires access to data connected on the individual level, but much of the functions can be performed without identifiable data. This is therefore distinct, but linked to, the development of the digital roadmap, which will set out the local health economies delivery of "fully interoperable digital records".

4.4 Care City is also in discussions with BHR CCG on 23rd to discuss appropriate links with the Digital Roadmap.

5 CARE CITY EDUCATION WORK STREAM

5.1 Skills Escalator

We understand that those in employment are healthier and that if we were able to support local unemployed people into fulfilling roles then health and wealth improvements would follow. Therefore a priority of our education work stream has been to secure funding to conduct a labour force analysis which will allow us to better understand the profile and existing skill set of unemployed people locally so that we can develop our approach to supporting more of them into emerging gaps within the health and social care workforce. We submitted a proposal to the Integrated Care Coalition in March which was not successful but we continue to scope alternative funding opportunities to take this work forward.

5.2 Understanding Care Needs

We are working with B&D Carers, NEFLT, UCLPartners, and QMUL to understand better how carers access help with developing their understanding of the carer role and the skills needed to be a carer. This includes 1:1 semi-structured interviews

with up to 80 carers. Results will be shared as part of carers week (6-12 June 2016) and will inform further work within Care City to support carers.

Appendices

Appendix A - HEALTHY NEW TOWNS MEDIA INTEREST

Appendix B - INNOVATION TEST BED WORKPLAN AND QUARTERLY MILESTONES

Appendix C - INNOVATION TEST BED BRIEFING DOCUMENT

Appendix D - FRONTIERS MEETING WEDNESDAY 2nd MARCH 2016

APPENDIX A: HEALTHY NEW TOWNS MEDIA INTEREST

National press:
We were approached by journalists from the Sun and The Daily Mail. It was also covered in the following papers
http://www.standard.co.uk/news/london/barking-riverside-development-selected-as-nhs-fatfighting-town-to-curb-britains-obesity-crisis-a3192241.html
http://www.cambridgenetwork.co.uk/news/health-and-well-being-at-heart-of-northstowe/
http://www.fylde.gov.uk/news/2016/feb/290216whyndyke/
http://www.telegraph.co.uk/news/health/elder/12178462/Theme-parks-can-inspire-new-towns-to-beat-childhood-obesity-says-NHS-boss-Simon-Stevens.html
http://www.belfasttelegraph.co.uk/news/uk/ten-areas-to-become-antiobesity-dementiafriendly-healthy-towns-34500484.html
http://www.westerndailypress.co.uk/8203-areas-country-picked-healthy-towns/story-28830044-detail/story.html

Television Interviews:
Hugh Pym at the BBC, travelled to Barking Riverside to interview Cllr Darren Rodwell (Leader of the council). Cllr Rodwell was also interviewed in Milbank for Sky News.

Radio Interviews
The leader also gave a live telephone interview to Shelagh Fogarty at LBC and Time FM and did a pre-recorded piece for the Vanessa Feltz programme on BBC London

Local Press
Barking and Dagenham Post also interviewed Helen Oliver which appeared online the following day:
http://www.barkinganddagenhampost.co.uk/news/barking_awarded_healthy_new_town_status_1_4437919

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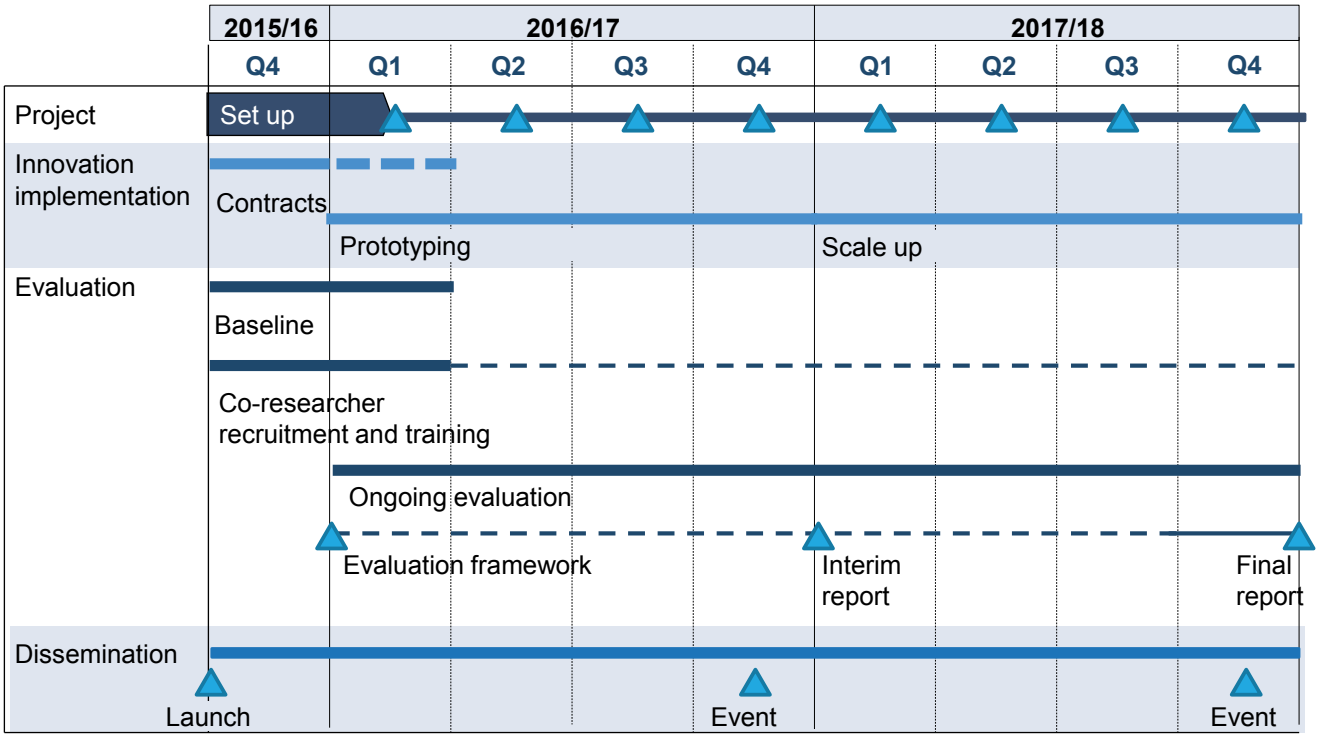
APPENDIX B: INNOVATION TEST BED WORKPLAN AND QUARTERLY MILESTONES



1 Year 1 (2015/16) Q4: Activities and Outputs, Funding Allocation: £508,782

2015/16 Q4	Activity	Key milestones /Outputs
Project set up	Recruitment - Commence fixed term recruitment for test bed staff - Secure interim staff as required via secondments - Confirm subcontract with UCL and put in place research team - Front line staff panel and service user panels recruited for each of the three clusters Governance - Monthly reporting to Care City Executive - Quarterly reporting to Integrated Care Coalition	• Central test bed team in place • Primary Investigator in post • Staff and user panels in place • Internal reports available, Compliance with NHS England project reporting cycles

2015/16 Q4	Activity	Key milestones /Outputs
Innovation Implementation	Contracts and commercial agreements - Procure expert advice on contracts with innovators to ensure appropriate commercial arrangements - Put in place contracts with each of the innovators, including agreed IP and commercial arrangements Contracts with system providers and commissioners - Identify initial implementation cohorts for each of the three clusters - Confirm costs and set up contracts with system providers and commissioners as required Data platfrom - Confirm NELFT ICT resource for Interoperability platform development - Conduct assessments of data interface requirements by innovation cluster	• Agreed innovator data flow with NELFT ICT
Evaluation	Create evaluation framework Baseline - Conduct Interviews with key stakeholders - Source baseline data and information Co-researchers - Launch co-researcher specification and commence recruitment Evaluation - Confirm data infrastructure for ongoing data collection and analysis	• Evaluation framework for innovators defined
Dissemination	Host Copenhagen delegates National announcement National launch	• Visit hosted • Local press coverage • Participation in national launch

2 Year 2 (2016/17) Q1: Activities and Outputs, Funding Allocation: £167,523

2016/17 Q1	Activity	Key milestones /Outputs
Project	Governance - Monthly reporting to Care City Executive - Quarterly reporting to Integrated Care Coalition	• Internal reports
Innovation Implementation	All contracts finalised, resolving any outstanding enquiries as required Commence implementation in each cluster, with initial cohorts.	• Innovator contracts in place with Care City • Innovator contracts in place with system providers and commissioners • Evidence of prototyping

2016/17 Q1	Activity	Key milestones /Outputs
Evaluation	Baseline - Ongoing data collection of baseline, activity and cost data Co-researchers - Co-researcher curriculum in development - Co-researcher training commenced	• Curriculum for training co-researchers in place
Dissemination	Develop communication plan Set up active communication tools to keep system informed of progress on the test bed Stakeholder engagement event	• Communication plan agreed • Stakeholder engagement event

3 Year 2, 2016/17, Q2, Q3, Q4, Year 3, 2017/18, Q1, Q2, Q3: Activities and Outputs, Funding Allocation: £167,523 per quarter

Year 2 Q2 – Year 3 Q3 have been included in one table due to the overlap in activities and outputs.

2016/17 Q2 – 2017/18 Q3	Activity	Key milestones /Outputs
Project	Governance - Monthly reporting to Care City Executive - Quarterly reporting to Integrated Care Coalition	• Internal reports
Innovation Implementation	Ongoing implementation in each cluster, with progressive cohorts of service users and ongoing adjustment of the implementation model Focus on scale up in Year 3, increasing the size of additional cohorts	• Evidence of prototyping
Evaluation	Baseline data collection completed Co-researchers - Expansion of cohort and training as required Evaluation - Formative feedback on prototyping and causal chains - Ongoing data collection - Interim evaluation report (Yr 2, Q4)	• Baseline data collection complete (Q2) • Quarterly Evaluation reports (Yr 2 Q2, Q3, Q4 (Interim report), Yr 3 Q1, Q2, Q3)
Dissemination	Ongoing communication Open learning event for national/ international peers (Year 2, Q4)	• Event held • Write up of event

4 Year 3 (2017/18) Q4: Activities and Outputs, Funding Allocation: £167,523

2017/18 Q4	Activity	Key milestones /Outputs
Project	Governance - Monthly reporting to Care City Executive - Quarterly reporting to Integrated Care Coalition Agree ongoing support for innovation and sources of funding for sustainable support model	• Internal reports
Innovation Implementation	Ongoing implementation in each cluster	• Evidence of prototyping

2017/18 Q4	Activity	Key milestones /Outputs
Evaluation	Evaluation - Formative feedback on prototyping and causal chains - Final analysis conducted - Evaluation report	• Evaluation report
Dissemination	Ongoing communication Open learning event for national/ international peers (Year 3, Q4) Support dissemination of programme at cluster and innovator, locally, nationally and internationally	• Event held • Write up of event

APPENDIX C: INNOVATION TEST BED BRIEFING DOCUMENT

What is the test bed?

In January 2016 Care City were awarded £1.8m and successfully selected as one of five national health and social care test beds (the only one in London).The Care City Innovation Test Bed seeks to test a combination of devices and software alongside new approaches to service delivery and patient participation to assess whether we can measurably improve the wellbeing and resilience of older people with long term conditions, older people with dementia, and carers.

Which innovations will we be testing?

Cluster	Product	Description
Older people with Long Term Conditions	AliveCor	A mobile ECG
	Kinesis	A device which measures mobility and gait to identify people at risk of falling
	Health Navigator	Targeted proactive health coaching for those at risk of Long Term Conditions
Older people with Dementia	My Brainbook	User led support plan and reminiscence tool
	Join Dementia Research	Dementia Research register portal
	Health Unlocked	Peer network website
Carer Resilience	Canary	Home sensor monitoring and notification system providing round the clock reassurance for families
	St Bernard	Geo tracking monitoring device to safeguard people when they are out and about
	Supportspace	Web portal to support the recruitment of Personal Assistants

Our Objectives

The objective of the Care City Innovation Test bed is to increase independence, enhance self-care and improve carer resilience for our population. Our 11 innovations have been clustered around three themes:

- Cluster 1: Older people with LTCs (Health Navigator, Kinesis, AliveCor);
- Cluster 2: Older people with Dementia (My Brain Book, Join Dementia Research, Healthunlocked);
- Cluster 3: Carer resilience (supportspace, Canary Care, St Bernard).
- Orion and Health Analytics, who have developed our local integrated clinical and social electronic care records, will work as partners across all clusters.

The expected outcome of cluster 1 is to accelerate self-efficacy, and support better outcomes and patient safety through earlier identification of risks and better management of LTCs. The expected benefits are:

- Improved self-reported quality of life (Isolation, loneliness and depression);
- Increased self-efficacy (confidence and knowledge)
- Improved health outcomes;
- Earlier detection;
- 30-40% Reduction in falls (lowering rates of injury and hospitalization);
- Reduction in stroke related disabilities.
- 20-40%reduction in unplanned hospital activity;
- 10-30% reduction in LTC related GP visits;
- Reduction in fall and stroke related ambulance calls;
- Growth in local health and social care community enterprise.

The expected outcome of cluster 2 is to reduce isolation for individuals through peer networks, support patients to receive more appropriate care through patient led support plans and reminiscence tools and encourage greater participation in dementia research - accelerating research findings into practice. The expected outcomes are:

- Improved self-reported satisfaction with services (Confidence, needs met, reduction in agitation);
- Improved self-reported quality of life (isolation. Loneliness and depression);
- 25% of the dementia population using digital services, facilitated where necessary by younger family members, friends etc;
- 10-30% fewer clinical service visits (self-reported);
- 70-90% reporting peer support 'useful' in the management of their condition;
- Improved access to information and advice.
- 30-50% increase in local participation in dementia research
- Reduction in admissions;
- Reduction in care giver burden;
- Real time population need insight.

The expected outcome of cluster 3 is to maximise independence and increase resilience through remote monitoring of real time activity inside and outside the home, and enhanced access to services which can support care givers.The expected outcomes are:

- Improved self-reported quality of life for patients and carers
- Improved self-reported quality of life and wellbeing for carers;
- Improved management of risk;
- Growth in carer employment retention;
- Reduction in delayed discharges;
- Reduction/delay in care home admission;
- Reduction in missing person incidents.

What is happening over the next 3 months?

Care City will be working across the system to identify areas for initial implementation, recruit to Care City Evaluation and Implementation team, identify local sponsors for each innovator, create logic chains for each innovation, secure funding for testing and recruit the first cohort of community members and create the baseline for current response.

For more information on the Test Bed or to express and interest in getting involved please contact the Care City Test Bed Project Manager Katharine.Langford@Innovationunit.org or Helen.Oliver@nelft.nhs.uk Interim Care City Managing Director.

APPENDIX D: FRONTIERS MEETING WEDNESDAY 2nd MARCH 2016

Care City Informatics Frontiers Meeting, 2nd March 2016

Discussion notes, Care City, March 2016

Chair: Professor Andrew Morris
Attendees: Anne Bristow, John Brouder, Prof. Peter Fonagy, Umesh Gadhvi, Vicky Hobart, Dr Phil Koczan, Rob Meaker, Helen Oliver, Paul Pugh, Dr. John Robson, Jenny Shand, Mark Tyson, Prof. Martin Utley, Dr Fiona Wright.
Apologies: Conor Burke, Jane Gateley, Glen Oldfield, Daniel Ray
The aim of the discussion was to agree collective usage ambitions for connecting data across BHR, and where to focus Care City efforts.

1. Setting the Context

- Examples of work in Scotland demonstrate the impact connected data and technology can achieve for population benefit.
- Co-location and collective ambition created a 'cluster effect' for tripartite investment from industry, grant funders and the public sector
- An efficient and coordinated system to deliver data science can support public health reform and economic growth
- Locally there are ongoing programmes of work to better connect data for multiple uses, including the Community Solutions service at LBBD, the increased functionality of connected records through Orion at NELFT, and the system wide strategy (Digital Roadmap) for delivering interoperable digital records.
- Care City provides a platform to bring together system wide ambitions and uses for data, and create a common access point for research investment and activity

2. Scoping collective ambitions

Across the system, multiple needs for connected data were discussed. These included:

- Innovation Test Bed implementation and evaluation
- Joint Public Health Intelligence function
- ACO modelling and on-going evaluation
- Primary Care Quality Improvement
- Enhanced risk stratification for targeting interventions
- Integration of clinical Information across teams (focus of the digital roadmap)

It was agreed by the group that Care City would be well placed to provide an "Intelligence Hub" function for the system. This could support intellectual productivity and predictive analytics of local data together with channeling research from industry and academia into practical application. This would ensure no alteration to existing data infrastructure and ownership, but a mechanism for extracting pseudonymous connected data into a safe environment for research purposes.

3. Next steps

- Prof. Morris to support Care City to develop a specification for the Intelligence Hub
- Continue conversations with stakeholders to maintain co-development of priorities for usage of connected data and the programme of work for the Intelligence Hub
- All participants to engage with Capita colleagues on the development of BHR Digital Roadmap

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HEALTH AND WELLBEING BOARD

26 April 2016

Title:	Public Health Programme Board Strategic Delivery Plan Update
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: All	**Key Decision: None**
Report Author: Matthew Cole, Director of Public Health	**Contact Details:** Tel: 0208 532 3657 Email: matthew.cole@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	

Summary:
This report seeks to give assurance to the Health and Wellbeing Board on the work plan being delivered by Public Health Programmes Board (PHB). The deliverables in the work plan of the PHB come to the Health and Wellbeing Board for discussion and decision:

The PHB has an important sub-committee called the Health Protection Committee that has an oversight responsibility on the national programmes for immunisation and screening. This report focuses on the performance and issues in national immunisation and screening programmes in Barking and Dagenham and London. The national programmes operate as a London system.

Section one of the report focuses on the national screening programmes. Screening tests are used to identify those at higher risk of a health problem. Early intervention can reduce mortality, morbidity and economic cost of lifelong treatment and support from health, education and social services. The tests can help in decision making about care or treatment. The cancer screening programmes (bowel, breast and cervical) are the primary area of concern where none are delivering the national targets.

Further actions to improve performance against national standards in the Antenatal Newborn Screening programmes at both Barking Havering and Redbridge University Hospitals NHS Trust and Barts Health NHS Trust are required in the following programmes:

- Foetal anomaly screening
- Sickle Cell and Thalassaemia screening
- Newborn bloodspot screening
- Newborn and infant physical examination

The other non-cancer screening programmes of abdominal aortic aneurysm and diabetic retinopathy are performing well.

Section two of the report focuses on the London system for the national immunisation programme. Vaccination continues to have a historical place on a par with the provision of clean water and improved sanitation as one of our society's most fundamental tools in

the continuing battle for better public health. Vaccination remains the safest and most effective way of protecting you against serious diseases. Areas of concern are the uptake of the childhood immunisation programme at 24 months and 5 years as well as uptake of the seasonal flu programme. The delivery of the Neonatal BCG programme has been seriously affected by the global shortage of vaccine. The London Immunisation Board has agreed a range of actions to improve uptake and our Health Protection Committee has agreed and monitors the Barking and Dagenham action plan.

NHSE London provide quarterly reports on the national screening and immunisation programmes to the Director of Public Health and are scrutinised by the Health Protection Committee and the Council's Assurance Group to provide a level of assurance that the programmes and measures to prevent and manage communicable disease continues to be effective.

Recommendations

The Health and Wellbeing Board is asked to:

(i) Note and discuss the contents of the report.

(ii) Request that Health and Social Care Commissioners provide performance updates as part of the Board's quarterly performance report on the measures being taken to prevent Health Care Associated Infections within both the hospital and community settings.

(iii) Request that NHS England London provide a quarterly performance report on the actions to improve coverage figures for antenatal screening and immunisation.

(iv) Request that the NHS agrees clear arrangements to manage babies moving into their area without full newborn screening.

Reason(s)

Under the Health and Social Care Act 2012 the statutory Health and Wellbeing Board has a duty to protect the health of the population. This includes assuring that steps are taken to protect the health of their population. The Director of Public Health (DPH) has a duty to 'provide information and advice to every responsible person and relevant body within, or which exercises functions in relation to, the authority's area, with a view to promoting the preparation of appropriate local immunisation and screening arrangements'. In order to undertake this duty, and to provide appropriate advice as to the adequacy of local health protection arrangements, the DPH needs to be assured and satisfied that there are adequate health protection immunisation and screening plans in place to protect the local population.

NHS Public Health Functions Agreement (Section 7A or s.7A) of the NHS Act 2006, as amended by the Health and Social Care Act 2012, outlines the specific responsibilities of NHS England for the commissioning of certain public health services as part of the wider system design to drive improvements in population health. In terms of plans for the national immunisation and screening programmes. NHS England (NHSE) is accountable for delivery. Public Health England is responsible for providing public health advice on the specification of the national programme, and also a quality assurance function with regard to screening.

1.0 Background

The Public Health Programmes Board (PHB) was created as part of the governance structure to provide assurance and oversee a number of statutory responsibilities and specific areas of governance that are inherent in our Public Health programme. The outputs of work programme go directly to the Health and Wellbeing Board for discussion and decision: The programme to date has delivered the following to the Board:

- Quarterly health and wellbeing system performance reports
- June 2016 – Statement on the allocation of the Public Health Grant 2015/16
- April 2016 - Public Health Procurement Plan for contracts over £500k for 2016/17
- January 2016 – Procurement Strategy for 5-19 Healthy Child Programme
- September 2015 – Joint Strategic Needs Assessment 2015
- September 2015 – Procurement Strategy for the Integrated Sexual Health Services
- July 2015 – Annual Health Protection Profile
- July 2015 – Health and Wellbeing Year End Performance Report
- May 2015 - Refresh of the joint Health and Wellbeing Strategy 2015 to 2018 and Delivery Plan
- March 2015 - Procurement Plan and Commissioning Intentions 2015/16

Over the last two years the Health Protection Committee has been working with NHS England London and Public Health England to produce assurance reporting on the national immunisation and screening programmes in view of their importance to improving the health of the borough. The recently established quarterly reporting now gives us a clear picture of the performance and issues inherent in these national programmes. The Board will not have seen the following detailed overview before.

SECTION ONE – National Screening Programmes

2.0 Introduction

Screening tests are used to identify those at higher risk of a health problem. Early intervention can reduce mortality, morbidity and economic cost of lifelong treatment and support from health, education and social services. The tests can help in decision making about care or treatment.

This report provides the Health and Wellbeing Board with an update on the work of the NHSE London. This includes an update on 2016/17 commissioning intentions, actions, plans and progress on a number of contract retenders.

3.0 Cancer Programmes

Cancer screening programmes coverage and uptake in Barking and Dagenham is RAG rated **RED**. Barking and Dagenham is much lower than the England average of the cancer screening programmes and London is the only region with screening coverage below the NHS Cancer Screening Programmes minimum standard. The following outline performance and mitigations being undertaken by NHSE.

3.1 Breast Screening Uptake and Coverage

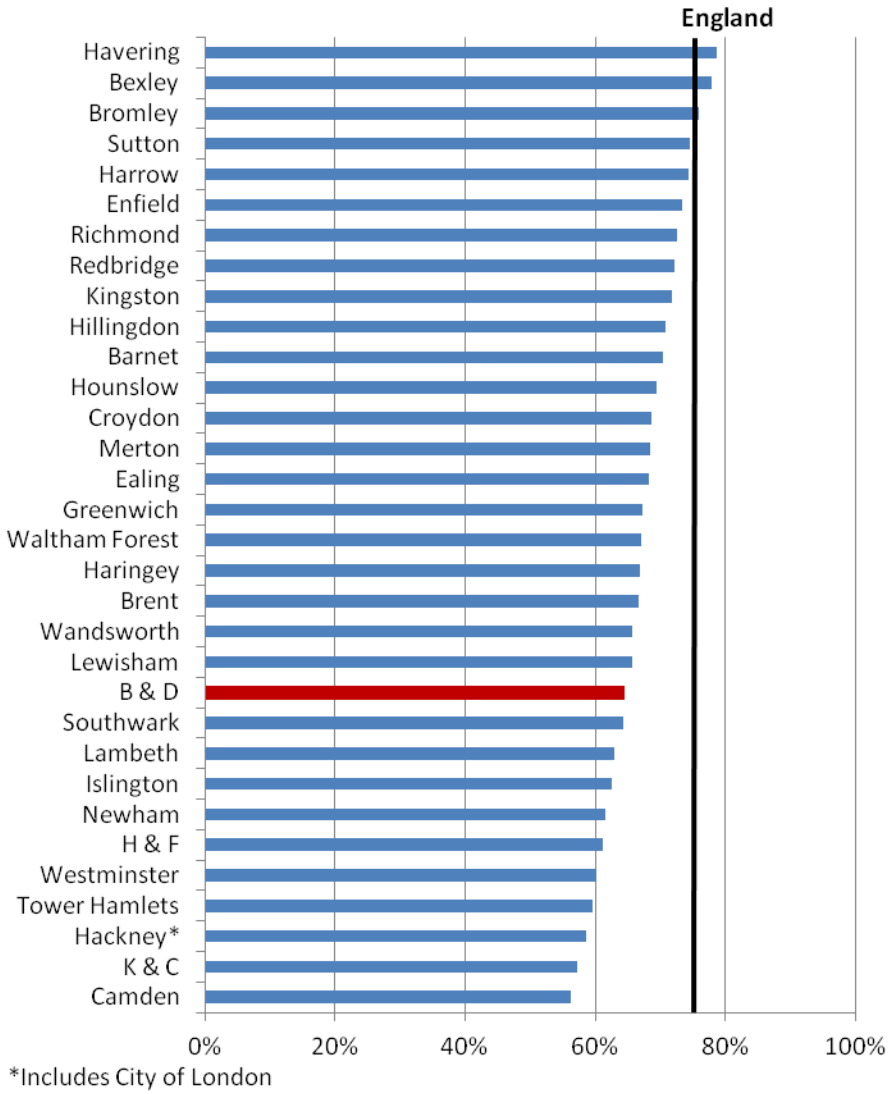
Table 1: Breast screening for 2014/15 is as follows:

Area name	Breast screening coverage within last 3 years (53-70 years)
Barking and Dagenham	64.3%
London	68.3%
England	75.4%

Source: HSCIC

Barking and Dagenham is performing worse than both national and regional averages.

Chart 1: NHS Breast Screening Programme: coverage of women aged 53-70 by Local Authority, at 31 March 2014 and 2015



On 24 February 2016 the Health and Social Care Information Centre published statistics on the NHS breast screening programme in England, 2014-15. This statistical bulletin summarises the information about the NHS Breast Screening Programme England at national and regional level. The data include those invited for breast screening, coverage, uptake of invitations, outcomes of screening and cancers. **The key points for London:**

- As at 31st March 2015, 475,253 women aged 53-70 were screened in London, giving rise to a breast screening coverage of 68.3% of women eligible for breast screening who were screened adequately within the previous three years. This is much lower than the England average of 75.4%, and London is the only region with screening coverage below the NHS Cancer Screening Programmes minimum standard of 70.0%.
- Over the past decade, the proportion of women aged 50-70 who took up the invitations to screen increased from 61.3% to 62.6% in London, which is in contrast to the slight reduction in screening uptake in England (from 74.4% to 71.3%).

- However, between 2013/14 and 2014/15 there was a small reduction in the proportion screened in both London (0.6 percentage points) and England (0.4% percentage points), continuing the downward trend from 2012.
- The rate of cancer detected among women who were screened in London was the same as in England (both 8.3 per 1,000).

There are inequalities between London boroughs in the percentage of women eligible for breast screening who were screened adequately within the previous three years. As at 31 March 2015, figures ranged from 56.3% in Camden to 78.7% in Havering. Barking and Dagenham is 64.3%.

3.2 Breast screening Hub Mobilisation

The Director of Public Health has received details of the 6 Clinical Providers of London's breast screening service, noting the only change currently is the move of provider responsibility from Barking Havering and Redbridge University Hospitals NHS Trust to InHealth and that the Central and East London contract, currently provided by Barts Health NHS Trust was not awarded and will be retendered. The Royal Free London NHS Foundation Trust (Royal Free) was awarded the contract to provide an administrative hub function across the 6 clinical services.

For various reasons (one of which is set out below; Breast Screening Select) NHSE have had a slow mobilisation process. NHSE have decided in the interests of continuity and safety to go live with the 3 North East London services i.e. the North London, Central and East London and InHealth services. NHSE are currently working with Screening Quality Assurance, PHE and the Royal Free to resolve some IT issues to ensure connectivity and access to data by the new hub service.

3.3 Breast Screening Select

One of the delays to mobilisation has arisen because Public Health England have decided to take the opportunity of changes to the NHSE primary care support services contract (PCSS), which has now been awarded to Capita to move away from the existing call and recall function on the Exeter System and introduce a new system, Breast Screening Select. The new system is due to be introduced in June across England. Providers were invited to a workshop in March to discuss changes and to undertake some preparation work. The new system requires services to call by practice rather than individual GP. NHSE have been informed there should be no down time during the system change, but we will need to monitor this carefully given our poor performance on breast screening coverage and uptake already.

3.4 Bowel Cancer Screening Uptake and Coverage

Table 2: Bowel screening for 60-69 year olds, the 2014/15 data:

Area name	Bowel screening uptake within last 12 months (60-69 years)
Barking and Dagenham	39.7%
London	47.8%
England	57.1%

Source: HSCIC

We are, like all London boroughs except for Richmond-upon-Thames, performing significantly worse than the national average. Only Hackney, Newham and Tower Hamlets have lower rates than Barking and Dagenham in London.

Uptake and Coverage in London overall increased by 1.2 and 1.6 % respectively. This was partly the result of the following actions:

- A multi-stakeholder Bowel Screening Uptake Improvement Task and Finish Group led by NHSE has been meeting regularly to develop initiatives to address uptake.
- NHSE is working with the London Hub to implement the use of GP endorsed letters invitation letters. This will increase uptake by 1% using the ASCEND banner, which has been demonstrated to increase uptake by around 1%. Difficulty in gaining approval from the National Team has led to a delay in delivery of this initiative. NHSE is now planning to launch this in April 2016 following completion of the National ASCEND 2 trial, which will evaluate the impact of using a GP endorsement banner on kit letters.
- A London wide pilot of screening using faeco-immunochemical testing is underway. This pilot will evaluate the impact on uptake using this FIT test instead of the FOB Test. One in twenty participants will be sent a FIT test by the London Hub over the course of six months. It is likely that the results along with those from other areas where this has already been trialled will lead to a national decision to implement this test instead of the FOB test.

3.5 Cervical Cytology Screening

The cervical screening programme is predominantly delivered by General Practice. Table 3: Cervical screening for the 25-49 age group the figures for 2014/15:

Area name	Cervical screening uptake within last 3.5 years (25-49 years)
Barking and Dagenham	68.2%
London	65.6%
England	71.2%

Source: HSCIC

Barking and Dagenham has a rate that is lower than the national average, but higher than the regional average. In the twelve months to August 2015, cervical screening coverage declined across England (0.6%) and London (2%). The reasons for this are not yet clear. The decline is greater in younger women.

There are several initiatives that will improve coverage in London:

- The GP contact (PMS) review currently underway across London, has included cervical screening coverage in the core specification.
- Development and cascade of the cervical screening primary care best practice guide will improve uptake and coverage in practices that implement the key recommendations related to cervical screening
- Imperial are currently undertaking a randomised controlled trial of texting within the cervical screening in programme in Hillingdon.
- Queens University is designing an HPV self-sampling trial for London.

3.6 Sample Handling Policy

NHSE began collecting information on sample handling errors in June 2015 to monitor progress on the implementation of the *Sample Handling Guidance*, issued in March 2015. To support continuous improvement, laboratory staff have been asked to monitor inadequate samples and the late receipt of samples

The aim of collecting data on sample handling errors is helping us to identify individual sample takers, GP practices and clinics who are contributing to the breach of the NHS Cervical Screening Programme (CSP) standard that 98% of women should receive their test results within 12 days. The information gathered will help to inform plans to improve performance in the 14-day TAT (Turn-around Times). As we start to get a bank of data we are able to identify issues with providers and will be working with CCGs to support practices as part of their role in co- commissioning primary care.

To date labs have a rejection rate of between 0.1-6.9%, or overall 3% which is the equivalent to requiring 20,000 smears to be re-taken across London. Given the current challenges with the uptake of cervical cytology this is an area where NHSE can drive improvements. A work plan has been agreed between the labs, NHSE and practices to support this work.

3.7 62 Day Cancer Screening Performance

Achieving the overall 62 day cancer waiting target is a key priority for NHSE London. By supporting work to reduce and then eliminate any breaches of people identified through screening programmes being admitting to the relevant treatment pathway within 62 days of the referral being made. A separate report on BHRUT referral to treatment times is included in the Board's agenda pack.

In the last four quarters (Q4 2014/15 –Q3 2015/16):

- ***Breast screening performance against target has improved***. This is as a result of NHSE working with breast screening units to develop Cancer Waiting Times (CWT) guidance and patient trackers lists. With the support of the London Cancer Alliance, NHSE and units now routinely monitor all breaches and audit the pathway of all screen-detected breast cancers on a quarterly basis.
- ***Bowel screening performance remains variable***. The first 28 days of the 62 day pathway are within the screening programme. There are very few breaches across London during this period. The bottleneck appears to occur post-colonoscopy and after referral to treatment services. NHSE is working with the delivery team to identify the reasons and consider joint actions to support improvement.
- ***Cervical screening performance is good but incomplete***. Approximately 70% of women with screen-detected cervical cancers are not put on the urgent 62 day pathway. NHSE convened a Task and Finish Group which undertook a baseline assessment of current cervical cancer CWT pathways across London. Using the responses from providers, the Group has developed guidance and an FAQ which be circulated to all Trusts' in March.

Screening services and screen detected cancers are not incorporated in many Trusts' cancer governance arrangements. The pathway to treatment and general performance and quality have not benefited from the rigorous internal and external monitoring that other urgently referred cancers. NHSE London team are working with providers and systems resilience fora to support the integration of cancer screening quality and performance with broader cancer governance structures within London Trusts'. In addition, the NHSE have instigated a number of practical steps to help Trusts' including:

- Implementation of an explicit performance improvement framework with the use of contract levers and joint working with CCGs and PHE Screening QA.
- Clinically led pathway redesign and improvement e.g. 62 day waits guidance.
- Development of polices, guidelines and protocols.
- Improvements in reporting and join up of system e.g. with sample handler error reporting.
- Supporting Trusts in terms of integrate governance structures.

NHSE aim for 2016/7 is to minimise if not eliminate 62 day screening cancer breaches.

4.0 Antenatal and Newborn Screening

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.

Screening tests are used to find women and babies at higher risk of a health problem. Early intervention can reduce mortality, morbidity and economic cost of life long treatment and support from health, education and social services. The tests can help in decision making about care or treatment during pregnancy or after the baby is born. Some screening tests are offered within a matter of hours after the baby born.

There are six Antenatal and Newborn screening programmes, screening for a total of 30 conditions:


Foetal Anomaly Screening Programme


Infectious Diseases in Pregnancy Screening Programme


Newborn and Infant Physical Examination Screening Programme


Newborn Bloodspot Screening Programme


Newborn Hearing Screening Programme


Sickle Cell and Thalassaemia Screening Programme

4.1 Antenatal and Newborn screening programmes RAG rated RED:

Foetal anomaly screening (FASP, includes Down's Syndrome, Edwards' Syndrome and Patau's Syndrome). The two components to this programme were outlined in the Dec 2015 update. The FASP key performance indicator (KPI) measures the completeness of the information provided in the request form, which is needed for the risk calculation. The acceptable target for this is 97.0% and achievable is 100%. BHURT at 92.3% is one of the 6 maternity providers in London region that did not meet the acceptable standard, with three of these not having met the target at all in the past two years.

Timely referral of hepatitis B positive women for specialist assessment
Women found to be Hep B positive should be referred to a liver disease specialist within 6 weeks, for full assessment, treatment if indicated, and to plan for the birth of the baby. This is a KPI, with the acceptable standard for this 70% of women seen within 6 weeks and the achievable standard 90%. Achieving this standard is a challenge for many units. Due to small numbers, quarterly KPI data is not published for this indicator below regional level.

Table 4: KPI ID2 - Antenatal infectious disease screening – timely referral of hepatitis B positive women for specialist assessment.

KPI ID2	Q1 2014/15	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16
England	**69.2%**	**65.8%**	**69.2%**	**67.9%**	**73.2%**	**73.3%**
North	66.5%	68.8%	71.4%	72.4%	74.8%	70.2%
South	79.1%	71.6%	75.4%	77.3%	71.7%	80.0%
Midlands & East	77.2%	73.5%	76.5%	82.0%	77.8%	81.9%
London	63.2%	58.6%	60.5%	56.1%	70.2%	67.8%

Source: https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2014-to-2015

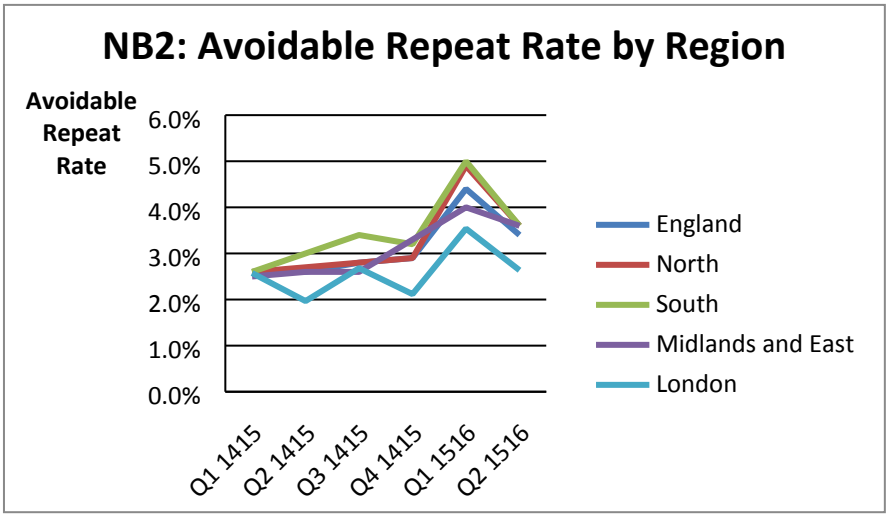
NHSE are working with CCG commissioners to ensure that maternity services are able to access timely referral to appropriate specialist assessment for women in those areas where this is a problem. London has a higher proportion of women who screen Hep B positive, so the poorer performance in London is a particular problem. This will continue to be a focus in 2016/17, with those units which are worst performing being targeted.

Timeliness of Sickle Cell and Thalassaemia (SCT) testing
The importance of the SCT testing being dome as early in pregnancy as possible was outlined in the Dec 2015 update. The acceptable target for this is 50% and achievable is 75%%. BHRUT is currently at 34.5% and Barts Health NHS Trust is 8.1%. This requires urgent attention looking at bookings by 10 weeks, in line with the SCT target and NICE guidance.

Newborn Infant Physical Examination (NIPE)
In preparation for reporting KPIs for the NIPE programme, providers are required to install IT systems with functionality to meet national specifications and provide failsafe for the NIPE programme by the end of March 2016. Once installed, KPI data should be submitted. Providers in London Region overall have been slower than the other regions in establishing data reporting, with below 30% reporting by

Q2 2015/16. However, all providers have action plans in place to commence reporting by April 2016.

Newborn bloodspot testing
NHSE London has focused strongly in 2015/16 on reducing the proportion of babies having an avoidable repeat bloodspot sample taken. Information on the reasons behind the avoidable repeats has been fed back to each provider, and a trajectory agreed with each so that all can meet the acceptable standard of 2.0% by the end of 2015/16. The work towards this started in mid-2015, and the impact can be clearly seen on the overall performance of London compared to other regions from Q4 2014/15 onwards.



This has mitigated the impact of the more stringent new standards introduced in April 2015, and London has a smaller percentage of babies requiring an avoidable repeat test than any other region. However, in Q2 1516 there were 898 babies who did require an avoidable blood sample, causing distress to the baby and family and cost to maternity services. This will continue to be a focus for 2016/17, and trajectories will aim for the achievable standard of 0.5%. Both Barts and BHRUT have work to do to achieve the standard and the high number of repeats suggests a training need for midwives.

4.2 Antenatal and Newborn Screening programmes RAG rated GREEN:

- Newborn hearing screening coverage
- Antenatal sickle cell and thalassaemia screening - completion of FOQ
- Antenatal sickle cell and thalassaemia screening – coverage
- Antenatal infectious disease screening - HIV coverage

5.0 Other programmes

In contrast to Cancer and some of the Antenatal and Newborn Screening programmes the following programmes are RAG rated as **GREEN**:

Diabetic Retinopathy Screening
For Diabetic Retinopathy the most recent information is for 2013/14 and is as follows:

Area name	Diabetic retinal screening uptake
Barking and Dagenham	85.2%
London	82.5%
England	82.6%

Source: QOF

We are performing significantly better than the national figure for diabetic eye screening, and have the tenth highest rate of all London boroughs.

Alternatively, there is 2014/15 data by provider with data as follows:

Area name	Diabetic retinal screening uptake
City & Hackney, Redbridge and Barking & Dagenham Diabetic Eye Screening Programme	85.8%
London	81.9%
England	82.9%

As part of the re-procurement of London programme NHSE oversaw the reconfiguration of 17 programmes into 5 across London. All the 5 programmes are in the process of establishing Data Extraction from GP systems to identify patients with diabetes. Programme Boards begin in Q1 2016-17. Hospital Eye Service referral locations remain as prior to re- procurement.

The current nationally produced data for the programme relates to Q2 2015/16 which is before the new services started. We are looking forward to the release of the Q3 data which will reflect the new programmes.

Abdominal Aortic Aneurysm Screening Programme
For Abdominal Aortic Aneurysms**,** the most recent data is for 2014/15 and is as follows:

Area name	AAA uptake
Barking and Dagenham	78.0%
London	74.4%
England	79.5%

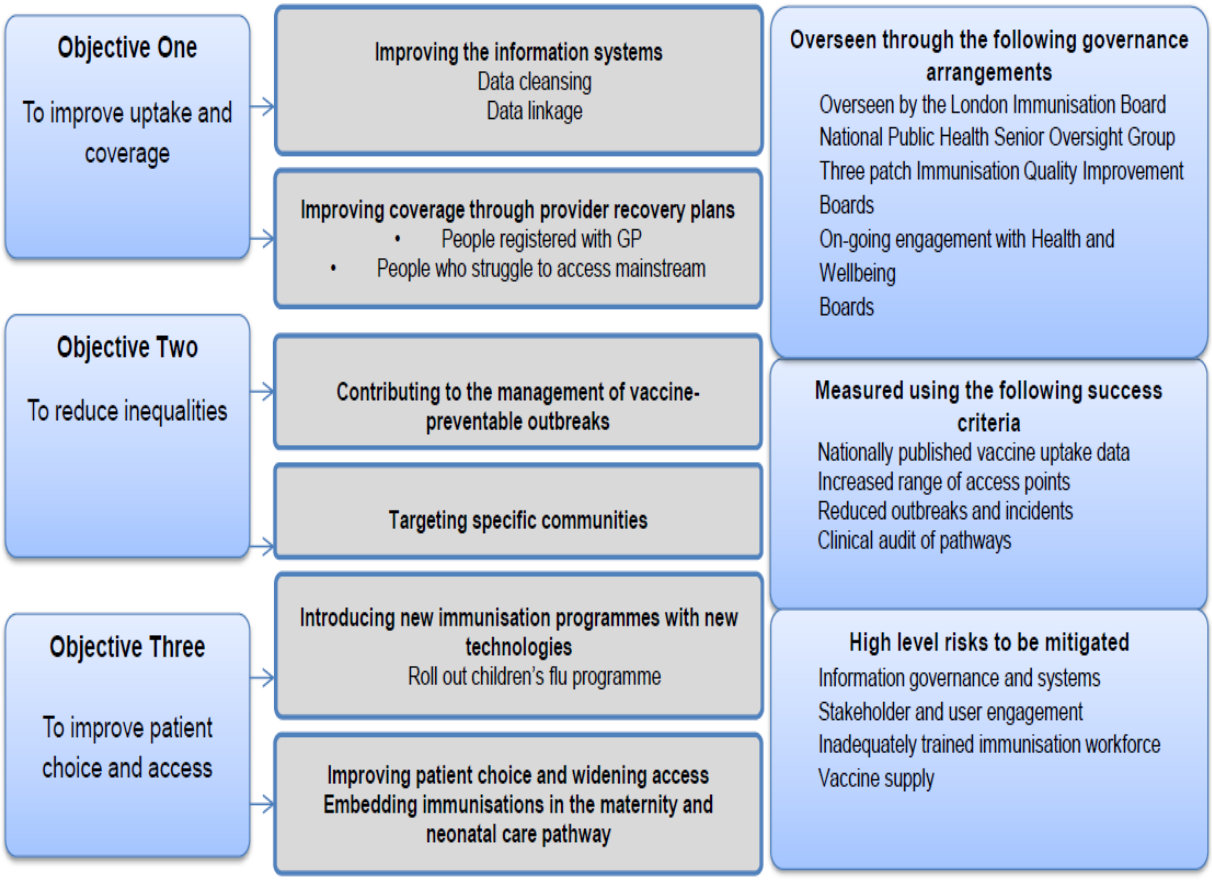
Source: NHS screening programmes in England via Screening Management and Referral Tracking (SMaRT)

We are performing slightly worse than the national average, but higher than the London average. The national standard for uptake is as follows: >=75% is deemed acceptable, while>=85% is deemed achievable.

SECTION TWO – National Immunisation Programmes

6.0 Introduction

Vaccination continues to have a historical place on a par with the provision of clean water and improved sanitation as one of our society's most fundamental tools in the continuing battle for better public health. The borough has, for many years, had lower than average vaccination coverage levels, often markedly so. NHSE London vision is to empower Londoners to eliminate vaccine-preventable diseases from London by:



7.0 Quarterly performance report (December 2015)

The London Immunisation Boards latest quarterly report (December 2015) details the performance of the London system and Barking and Dagenham's within this context. We are currently **RED** RAG rated on:

- **Diphtheria, tetanus, pertussis, pneumococcal, haemophilus influenza type b (DTaP/IPV/Hib)**. The borough is below the national target of 95% but achieving above the London average for at 12 months with 93% uptake in Q2 15/16 compared to 90.2% for London and is similar to the England average of 93.5%.
- **24 month vaccinations**. The uptake is below the national target of 95%, with 86.6% uptake for the pneumococcal (PCV) booster and measles, mumps and rubella (MMR1), and 86.4% for the haemophilus influenza type B and meningitis C (Hib/MenC) booster.

- **5 year vaccinations.** Uptake is below the national target of 95% at 84.1% for the DTaP/IPV booster, and 83.6% for the MMR2.
- **Seasonal flu programme** is currently performing below national targets.
- **Shingles vaccination programme** is currently performing below the London average for shingles uptake.
- **Hepatitis B vaccination** rates are below the London averages. Two children in each cohort had not completed vaccinations in Q3.

We are currently **GREEN** rated on:

- **Pertussis** vaccinations in pregnant women are performing above the London average but remain below the England average for uptake.
- **Human papilloma virus (HPV**) vaccination is achieving above the London average for uptake. England uptake rates for 2014/15 are not currently available.

8.0 Meningococcal B (Men B) vaccination programme

Data from the first six months of the Men B vaccination programme have been published. London exceeded its aim of vaccination of >50% with 89.45 for one dose of Men B in six month old babies and 78.5% for the second dose. Barking and Dagenham has performed well with % with one dose 90.8% and % vaccinated with two doses 79.9%. The drop for the 2nd dose suggesting that not all 6 month old babies are having their vaccines in accordance to the routine schedule. Work on the consolidation of the Men B vaccination programme continues.

9.0 Neonatal BCG vaccination programme

The universal neonatal programme provided by NELFT across Barking and Dagenham, Havering and Redbridge is RAG rated **RED** with currently a backlog of 2,820 babies. The reason for the backlog is the vaccine stock shortage for BCG and NELFT having to prioritise those babies in line with guidance. There is a global shortage of vaccine due to manufacturing problems with the Pharma provider. There are no other arrangements to procure the vaccine nationally. This is an issue affecting the whole of London and NHSE are working with providers to understand what BCG vaccine stocks we have across London and they are requesting this data from each provider:

(a) the number of vials of BCG vaccines they currently hold in stock and are expecting for imminent delivery.

(b) the number of planned appointments due to be delivered next week.

NHSE will await PHE advice on any possible reprioritisation and lines to inform patient/parent communications. The situation is being monitored through the Health Protection Committee.

The local programme has been effected and there is a risk that current stocks run out by the end of the month. As a mitigation the Medicines and Healthcare Products Regulatory Agency (MHRA) have extended the listed expiry date of the vaccine from 29 February 2016 to 31 August 2016 so that BCG vaccinations programmes can continue. This does not affect the efficacy of this vaccine.

10. Procurement of School Aged Vaccinations

NHSE are now concluding procurement for school-aged vaccinations, including School Yrs. 1, 2 and 3 universal offer of child flu vaccinations. The new providers will be known by 10th April 2016.

11. Rubella Infection in pregnancy and congenital Rubella

Cases of Congenital Rubella Syndrome (CRS), Congenital Rubella Infection (CRI) and Rubella Infections in Pregnancy have been very rare in the UK, since the addition of the Measles, Mumps and Rubella (MMR) vaccine to the childhood immunisation schedule in 1988 with rapid achievement of high coverage. A single dose of Rubella-containing vaccine confers around 95 -100% protection against Rubella. Between January 2005 and December 2015, there were 23 Rubella infections in pregnancy in England and, were known, 62% of infections were acquired abroad. Of these 23 infections there were 7 cases of CRI/CRS, 4 pregnancies were terminated before term, 2 intra-uterine deaths and 10 non-infected infants.

Investigation of the 3 recent cases led by the Local Health Protection teams has highlighted common missed opportunities:

- MMR vaccine status of children and women of child bearing age entering the UK was not checked and vaccination was not offered routinely at GP registration or school checks.
- Incorrect management of a rash illness in pregnancy including a lack of understanding of the appropriate diagnostic tests and their interpretation.
- Incorrect interpretation of ante natal Rubella susceptibility screening results.
- Lack of documentation of rash illness in pregnancy and lack of communication and information sharing between primary care and maternity links.

Implications and recommendations for the Council: Since 2013 the Council has been responsible for commissioning public health services for school aged children (5-19) and assumed responsibility for commissioning health visiting from 1st October 2015. As part of the universal offer health visitors have a responsibility to check maternal MMR status at the new baby review (by 14 days old), 6-8 week and 9-12 month baby assessments and to refer the mother for MMR vaccination as appropriate. The Council has made sure that the contracts for school nursing and health visiting services include MMR status and seek assurance that contractual responsibilities are being fulfilled with our current provider North East London NHS Foundation Trust.

In addition, the Council is continuing to work with partners to ensure plans are in place to maximise the uptake of MMR vaccine and where necessary challenge performance and escalate concerns to the Health Protection Committee.

12. Heightened Seasonal Influenza and Scarlet Fever Activity in England March 2016

Levels of Scarlet Fever in England have been higher between week 37, 2015 and week 9, 2016 than for the same period in the previous two seasons. 1153 Scarlett Fever notifications were reported in week 11. This is the third consecutive season

in which increased incidences of Scarlet Fever have been observed in England. This observed Scarlet Fever activity coincides with peak seasonal Influenza activity in England, which has occurred later than usual this year. In week 11, there were 77 new acute respiratory outbreaks, including 49 reported in schools and 15 from care homes.

The Council through the Director of Children's Services will be sending a briefing reminding schools and childcare settings to inform our Health Protection Team about clusters of Scarlet Fever cases or Influenza among pupils and staff as per existing arrangements.

13 Measles Clusters in London and East of England, 2016

Measles activity in England has been at historically low levels since the MMR catch up campaign in 2013. However, an increase in Measles was observed in South East England, one was associated with travel from Somalia (5 confirmed) and the second following travel from Spain (25 confirmed) between October 2015 and January 2016. Since the beginning of February 2016, cases of Measles have been confirmed across London and the East of England (Cambridge, Hertfordshire and Essex), predominately in unimmunised adolescents and young adults (aged 14-40 years) without a history of recent travel. Many of these cases have been admitted to acute medical wards without isolation including one in intensive care.

Implications for the Council: Staff in nursery, school and college settings should be aware of the recent increase in Measles cases and the importance of reporting cases to their local Health Protection Team. They are also asked with their colleagues to raise awareness of the importance of the MMR vaccination. With the marked increase in Scarlet Fever activity across England, since the beginning of 2016 Scarlet Fever is characterised by a rash, which is usually accompanied by a sore throat and maybe confused with Measles. Therefore, it is essential that staff in the Council, nurseries, schools and college settings are aware of the importance of prompt notification of all suspected Scarlet Fever or Measles cases to their local Health Protection Team in order to undertake an appropriate risk assessment. A briefing was given to the Director of Children's Services to be cascaded.

14. Consultation

Performance discussed at the Health Protection Committee.

15. Mandatory Implications

15.1 Joint Strategic Needs Assessment

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

15.2 Health and Wellbeing Strategy

This report is part of the performance framework of the joint Health and Wellbeing Strategy and delivery plan for 2015-2018.

15.3 Integration

Currently, health protection at the local level is delivered by a partnership of the NHSE, CCG, PHE and local authorities. The national immunisation programmes operate as a London system. NHSE is responsible for commissioning the programmes and accountable for their delivery. PHE is responsible for providing public health advice on the specification of the national programme, and also a quality assurance function with regard to screening. The local Director of Public Health has the mandated assurance role.

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

15.4 Financial Implications

Implications completed by: Olufunke Adediran, Group Accountant, Finance

There are no financial implications arising from the recommendations in this report.

15.5 Legal Implications

Implications completed by: Chris Pickering, Principal solicitor, Employment & Litigation

As this report is for noting and recommends regular reporting but does not make proposals for the spending of public money, there are no legal implications to this report.

15.6 Risk Management

Health protection needs constant appraisal and will always be in need of strengthening. There is great value in joint working and good communication, to maintain and/or heighten awareness, identify issues and provide for a more robust and effective response to problems, both current and emerging.

Directors of Public Health will advise on whether the programme in their area is meeting the needs of the population, and whether there is equitable access. They will provide challenge and advice to the NHSE on its performance, for example through the joint strategic needs assessment and discussions at the health and wellbeing board on issues such as raising uptake of screening, and how outcomes might be improved by addressing local factors. NHSE are accountable for responding appropriately to that challenge, and for driving improvement.

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HEALTH AND WELLBEING BOARD

26 April 2016

Title:	Contracts: Procurement and Commissioning Plan 2016/17
Report of the Strategic Director for Service Development and Integration	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: No**
Report Authors: Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham Mark Tyson, Group Manager Integration and Commissioning, London Borough of Barking and Dagenham	**Contact Details:** Tel: 020 227 3861 Email: matthew.cole@lbbd.gov.uk

Sponsor:

Anne Bristow, Strategic Director for Service Development and Integration, London Borough of Barking and Dagenham

Summary:

The report advises the Health and Wellbeing Board on commissioning plans for 2016/17. A small number of Council contracts over £500k will naturally come to an end during the financial year 2016/17. The procurement strategy for these contracts will be recommended to the Board on a case by case basis by the Council's Procurement Board at the appropriate time during the financial year. Children's Services procurements will be presented to the Cabinet at the direction of the Corporate Director of Children's Services.

Recommendation(s)

The Health and Wellbeing Board is asked:

- To note the list of contracts over £500k that are set to expire during the financial year.

Reason(s)

The Health and Social Care Act 2012 introduced the requirement for health and wellbeing boards to prepare joint health and wellbeing strategies for their local areas. The Joint Health and Wellbeing Strategy should provide an over-arching framework to ensuring a strategic response to the health and social care needs of the local population.

The tendering process will enable the Council to procure new contracts on the best terms available in the current market and should lead to a reduction in cost, better supplier performance and greater opportunities for local people and suppliers.

1. Introduction

1.1 This report sets out LBBD's commissioning plans around Public Health and Adult Social Care for 2016/17, including information on any contracts over £500k that are due to expire in the coming year.

2. Context for commissioning within Barking and Dagenham

2.1 Commissioning of public health and adult social services within Barking and Dagenham are done within the context of the national, regional and local strategies and agreed priorities, which shape the types of services that LBBD commission and provide. These strategies and priorities are set out below.

Joint Health and Wellbeing Strategy

2.2 The Council and its partners have already agreed a Joint Health and Wellbeing Strategy and mapped out the actions and outcomes which are needed to address the priorities for improving the health and wellbeing of local people. These priorities are based on the needs identified in the Joint Strategic Needs Assessment and the national and local priorities identified in the various outcome frameworks (Public Health, Adult Social Care, NHS and the local Children and Young People's Plan). These priorities shape the commission of services.

2.3 The outcomes contained within the Strategy are:

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

2.4 Priority themes identified within the Joint Health and Wellbeing Strategy include:

- Care and Support
- Protection and Safeguarding
- Improvement and Integration of Services
- Prevention

Commissioning Priorities for Barking and Dagenham

2.5 The Board agreed and prioritised the following commissioning intentions at its meeting on 8th September 2015 as part of the Joint Strategic Needs Assessment:

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

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

BHR Five Year Strategy

2.6 The BHR health economy is comprised of partners from NHS Barking and Dagenham Clinical Commissioning Group ("CCG"), the Council, Barking Havering and Redbridge University Hospitals NHS Trust ("BHRUT") and North East London NHS Foundation Trust ("NELFT"); who have come together to agree, refine and implement a "vision" improving health outcomes for local people through best value healthcare in partnership with the community. They have the following priorities:

- To reduce the number of years lost by 18%
- To improve health related quality of life for those with more than one long term condition by 4%
- To reduce avoidable time in hospital through integrated care by 13%
- To increase the percentage of older people reporting poor experience of in-patient care by 12%
- To reduce the percentage of people reporting poor experience of primary care by 15%
- To reduce hospital avoidable deaths; reducing expected mortality by 9%.

NHS Five Year Forward View

2.7 The Forward View published in October 2014 sets out four key strategic strands:

- Do more to tackle the root causes of ill health. The future health of millions of children, the sustainability of the NHS and the economic prosperity of Britain will all now depend on a radical upgrade in prevention and public health. The Forward View backs hard hitting action on obesity, alcohol and other major health risks.
- Commit to giving patients more control of their own care, including the option of combining health and social care, and new support for carers and volunteers.
- The NHS must change to meet the needs of a population that lives longer for the millions of people with long term conditions, and for all patients who want person centered care. It means breaking down the boundaries between GPs and hospitals, between physical and mental health and between health and social care. The Five Year Forward View sets out new models of care built around the needs of patients rather than historical or professional divides.
- Action needed to develop and deliver the new models of care, local flexibility and more investment in our work force, technology and innovation.

3. Legislative background

The Care Act 2014

3.1 The Care Act 2014 places duties on commissioners of services and on local authorities to help improve people's independence and wellbeing. The Council must provide or

arrange services that help prevent people developing needs for care and support or delay people deteriorating, such that they would need ongoing care and support.

3.2 Commissioners need to consider various factors:

- What services, facilities and resources are already available in the area (for example local voluntary and community groups), and how these might help local people.
- Identifying people in the local area that might have care and support needs that are not being met.
- Identify carers in the area who might have support needs that are not being met.

3.3 Under the Care Act, the Council took on new function to make sure that people who live in their areas:

- Receive services that prevent their care needs from becoming more serious, or delay the impact of their needs.
- Can get the information and advice they need to make good decisions about care and support.
- Have a range of providers offering a choice of high quality, appropriate services.

Children and Families Act 2014

3.4 The Children and Families Act 2014 seeks to improve services for vulnerable children and supporting strong families. It underpins wider reforms to ensure that all children and young people can succeed, no matter what their background.

3.5 The changes to the law give greater protection to vulnerable children, better support for children whose parents are separating, a new system to help children with special educational needs and disabilities, and help for parents to balance work and family life. It also ensures that changes to the adoption system can be put into place, meaning more children who need loving homes are placed faster. Reforms for children in care can be implemented including giving them the choice to stay with their foster families until their 21st birthday.

4. Partner Commissioning Intentions 2016/17

NHS England (London) Commissioning

4.1 The commissioning intentions for NHS England (London) were brought to the meeting of the Health and Wellbeing Board on 8 December 2015. Here the Board were informed of a number of issues around commissioning, including:

- Changes to antenatal and new born screening,
- Immunisation programmes (particularly for meningitis and influenza)
- Cancer screening (including concern over a drop in cervical screening rates)
- Implementing 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)
- Working with the CCGs to develop and improve the pathways and access for mental health patients particularly for children and adolescents

Barking and Dagenham CCG Commissioning Intentions 2016/17

4.2 Barking and Dagenham Clinical Commissioning Group brought their commissioning intentions for 2016/17 to the Health and Wellbeing Board on 8th December 2015. The CCG commissioning priorities for 16/17 are based on national planning guidance and policy, outputs from service reviews, stakeholder engagement and existing commissioning plans. They also use the Joint Strategic Needs Assessment and Health and Wellbeing Strategy, so CCG priorities will overlap with Council priorities. The CCGs commissioning priorities are:

- Better Care Fund 2016/17
- Mental health – parity of esteem, Improved Access to Psychological Therapy Services (IAPT), Early Intervention in Psychosis, Crisis Care Concordat
- Child and Adolescent Mental Health services (CAMHS) –delivery of CAMHS transformation plans, Children and Young People's IAPT services and perinatal mental health
- Learning disabilities – achieving the standards set in the Transforming Care Programme
- Urgent and Emergency Care – delivery of the NHS constitution standards; transformation of the urgent and emergency care pathway
- Planned care –five year cancer strategy priorities/NHS constitution standards, redesign of elective care pathways, King George Hospital Elective Care Treatment Centre service; improve stroke rehabilitation pathway
- Primary care transformation – taking forward priorities for high quality, accessible and pro-active care.

5. Procurement

5.1 When commissioning contractors, the Council is required to comply with the requirements of the Public Contracts Regulations 2015, which have recently replaced the previous 2006 regulations, in addition to the Council's Constitutional requirements for competitive tendering, as set out in the Contract Procedure Rules

5.2 This report is requesting that the Board note the intended or proposed routes for the commissioning and procurement of the identified services which may include contracts. The report author proposes to bring a return report in the form of a Procurement Commissioning Report, for the HWBB to specifically approve in relation to particular contracts. Legal Services will provide specific comment on the procurement and commissioning implications at that time.

5.3 The re-commissioning of the new services will require an intensive procurement programme to ensure the process complies with both the Council's Constitution and where applicable, the Public Contracts Regulations which came into force 26th February 2015. It will also be necessary for officers to comply with the Public Services

(Social Value) Act 2012 requirements prior to commencing any procurement process and/or to formalize existing arrangements.

5.4 For each identified category a sourcing strategy will be agreed with the relevant stakeholder to formalise the overall evaluation criteria and weighting for each tender, the options and gain sign off before engaging with the market.

5.5 For each contract with a value with a value over £100,000 a detailed Procurement Strategy Report will be prepared and submitted to the Councils Procurement Board.

6. Procurement for 2016/17

6.1 Listed below are contracts that are valued at over £500k or which will come to the Health and Wellbeing Board due to their importance or sensitivity. Following discussion at the meeting these contracts will be added to the Forward Plan of the Health and Wellbeing Board.

Public Health Procurement

Public Health Services: 0-19 Healthy Child Programme
Current Provider: North East London NHS Foundation Trust
Annual contract value: £6,224,000 (0-5 £5,024,000 and 5-19 £1,200,000)
Contract end date: 30/09/2017

6.2 The Healthy Child Programme[1] (HCP) is an evidenced-based early intervention and prevention public health programme for children and families. It sets out the recommended framework of services for children and young people aged 0 -19 years (including during pregnancy) to promote optimal health and wellbeing, prevent ill health and provide early intervention when required.

6.3 Effective implementation of the programme improves a range of public health outcomes including improved sexual health, reduced numbers of teenage pregnancies, healthy diet and exercise, improved educational outcomes, smoking prevention and cessation, substance misuse prevention, and awareness and improved emotional health and wellbeing.

6.4 The commissioning of Healthy Child 0-5 programme (Health Visiting and Family Nurse Partnership Programme) services transferred from NHS England and became the responsibility of the Council in October 2015. The service is currently provided by North East London NHS Foundation Trust at an annual cost of £5,024,000. The contract is due to expire on 30th September 2017.

6.5 Responsibility for the commissioning of Healthy Child Programme 5-19 (School Nursing and NCMP) service was transferred to the local authority on the 1 April 2013. The service delivered by school nurses, offers school aged children a schedule of health and development reviews, screening tests, immunisations and health promotion, as well as tailored support for children and families. NCMP is a mandated public health programme for the Local Authority. The service is currently provided by

1 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf.

North East London NHS Foundation Trust at an annual cost of £1,200,000. The contract is due to expire on 30th August 2016.

6.6 There is an ongoing procurement exercise for the 5-19 HCP for a 13 month contract starting on 1st September 2016 until 30th September 2017. This will align the end dates of both the 0-5 and 5-19 HCP contracts and gives the Council the opportunity to join up the commissioning of both services as a fully integrated 0-19 Healthy Child Programme.

6.7 The integration of the 0–19 HCP is expected to deliver both financial and operational efficiencies to the Council, a more streamlined service and better outcomes for children, young people and families. It will allow the introduction of a new service delivery model for specialist Community Public Health Nursing Service to be more focused on improving health and wellbeing outcome, and provides an opportunity for a joined up approach and improved seamless pathway for children, young people and families where health and wellbeing issues are assessed, identified and when necessary supportive interventions implemented. It will provide an opportunity to develop effective partnerships with local services advocating and delivering change to support improvements in services for children's health and well being.

6.8 A 0-19 project steering group was established in October 2015 to steer the transformation process over the next 12 months and devise a market development strategy that describes the approach the Council will adopt in the analysis and management of the early years health and care system in the borough. The work of this group is still on-going and the recommendations with an options appraisal which considers the various options for integration will feed into a more detailed procurement strategy to be presented to the board in September/ October 2016.

6.9 The service falls within the description of services covered by the Light Touch Regime under the Public Contracts Regulations 2015. Because the estimated value of the contract is higher than the set threshold (currently EUR 750,000), it needs to be opened up to competition and be advertised in the Official Journal of the European Union (OJEU) as required by the Regulations The recommended procurement route will be competitive open tender procedure; the tender opportunity will be advertised on the OJEU, Contracts Finder and the Council's website. The process will widen the competition and ensure the Council gets best value for money for this service.

6.10 Under the Council's Contract Rules all procurements above £500k as defined in clause 28.8 shall be taken before the Health and Wellbeing Board for ratification. A detailed procurement strategy seeking the approval for the Council to proceed with the procurement will be presented to the Procurement Board and Health and Wellbeing Board at a later date (around September / October 2016).

Adult Social Care Procurement

Extra Care Schemes
Provider: Triangle (Formally known as TLC, now merged with Friends of the Elderly)
Annual contract value: £1,333,980
Contract end date: 31/10/2016

6.11 The contract for extra care was initially due to expire on 31 October 2015 however permission to extend (as permitted in the contract) was sought from the HWBB. The Integration and Commissioning Team have been in protracted negotiations with the

provider regarding the rates paid under this contract as they have expressed their concerns of the viability of the original contract terms. Negotiations are now being conducted via both parties' legal representatives and the Council are currently awaiting the commissioned provider's response to our offer of what we feel to be a realistic and affordable increase.

6.12 The Council's Housing Department, in partnership with the Integration and Commissioning Team have commissioned an in depth review of the Borough's older people housing pathway. The specification for the review has requested an overview of best practice models relating to extra care, going beyond "traditional" extra care with a focus on personalisation. The report from this review is due to be completed in May 2016 and will be used to inform the specification used to re-commission the service.

Mental Health Vocational Support
Provider: Richmond Fellowship
Annual contract value: £191,600
Contract end date: 31/10/2016

6.13 The mental health vocational support contract falls under the scope of the Better Care Fund (BCF) and is jointly funded by the Council and the Barking and Dagenham Clinical Commissioning Group (CCG).

6.14 The contract was initially due to expire on 31 October 2015 however this was extended for one year. The contract has a further option to extend for a period of up to one more year.

6.15 Work is currently underway to develop the Borough's Mental Health Strategy which includes the remodelling and re-commissioning of this service. Early discussions have indicated that the re-commissioned service will once again focus heavily on employment support.

Healthwatch Barking and Dagenham
Provider: Harmony House
Annual contract value: £125,000
Contract end date: 31/03/2017

6.16 Under the Health and Social Care Act 2012, the Local Authority has a duty to commission a fully operational Healthwatch, which will provide engagement for residents around health and social care services in the borough, giving citizens and communities a stronger voice to influence and challenge how health and social care services are provided.

6.17 The contract has been extended to 31 March 2017, which is the final year of the contract with no scope for further extension. Work is starting to recommission Healthwatch to reflect the developments that have been made in the health and social care sector locally and the development of Healthwatch across the country.

Children's Services Procurement

6.18 Children's social care procurement goes to the Cabinet for approval as directed by the Corporate Director of Children's Services.

7. Mandatory Implications

Joint Strategic Needs Assessment

7.1 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.

Health and Wellbeing Strategy

7.2 The Health and Wellbeing Board mapped the outcome frameworks for the NHS, Public Health, and Adult Social Care with the Children and Young People's Plan. The Strategy is based on four priority themes that cover the breadth of the frameworks and in which the priorities under consideration are picked up within. These are Care and Support, Protection and Safeguarding, Improvement and Integration of Services, and Prevention. Actions, outcomes and outcome measures are mapped across the life course against the four priority themes.

Integration

7.3 One of the outcomes we want to achieve for our Joint Health and Wellbeing Strategy is to improve health and wellbeing outcomes through integrated services. The report makes several recommendations related to the need for effective integration of services and partnership working.

Financial Implications

Financial Implications completed by: Richard Tyler (Interim Group Finance Manager)

7.4 The Commissioning intentions for 2016/17 highlighted in this report for Social Care would be funded from existing general fund budgets and all Public Health plans will be funded from the ring-fenced Public Health grant for 2016/17.

Legal Implications

Legal Implications completed by: Bimpe Onafuwa, Contracts and Procurement Solicitor

7.5 This report sets out the commissioning requirements of the Council's public health and adult social services departments over the 2016/2017 period.

7.6 The Council has a duty to ensure that all contracts are procured in accordance with relevant legal procedures set out in the Public Contracts Regulations, and in line with the competitive tendering requirements of the Council's Contract Rules.

7.7 The recommendation of this report is that Board notes the list of contracts commissioned by the departments.

7.8 The report author also proposes to submit Procurement Strategy Reports in respect of the commissioning of new contracts to the Procurement and the Health & Wellbeing

Boards for consideration, as relevant. The Law and Governance Team is able to provide legal implications on the commissioning of services as they arise.

Risk Management

7.9 Delivery of the commissioning intentions is a key dependency in the delivery of the Public Health, NHS and Adult Social Care Outcome Frameworks challenge as well as the delivery of the Children and Young People's Plan.

HEALTH AND WELLBEING BOARD

26 April 2016

Title:	**Systems Resilience Group Update**
Report of the Systems Resilience Group	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: NO**
Report Author: Andrew Hagger, Health and Social Care Integration Manager, LBBD	**Contact Details:** Tel: 020 8227 5071 E-mail: Andrew.Hagger@lbbd.gov.uk

Sponsor:

Conor Burke, Accountable Officer, Barking and Dagenham Clinical Commissioning Group

Summary:

This purpose of this report is to update the Health and Wellbeing Board on the work of the Systems Resilience Group. This report provides an update on the Systems Resilience Group meetings held on 29th February 2016 and 30th March 2016.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

- Consider the updates and their impact on Barking and Dagenham and provide comments or feedback to Conor Burke, Accountable Officer to be passed on to the Systems Resilience Group.

Reason(s):

There was an identified need to bring together senior leaders in health and social care to drive improvement in urgent care at a pace across the system.

1 Mandatory Implications

1.1 Joint Strategic Needs Assessment

The priorities of the group is consistent with the Joint Strategic Needs Assessment.

1.2 Health and Wellbeing Strategy

The priorities of the group is consistent with the Health and Wellbeing Strategy.

1.3 Integration

The priorities of the group is consistent with the integration agenda.

1.4 Financial Implications

The Systems Resilience Group will make recommendations for the use of the A&E threshold and winter pressures monies.

1.5 Legal Implications

There are no legal implications arising directly from the Systems Resilience Group.

1.6 Risk Management

Urgent and emergency care risks are already reported in the risk register and group assurance framework.

2 Non-mandatory Implications

2.1 Customer Impact

There are no equalities implications arising from this report.

2.2 Contractual Issues

The Terms of Reference have been written to ensure that the work of the group does not impact on the integrity of the formal contracted arrangements in place for urgent care services.

2.3 Staffing issues

Any staffing implications arising will be taken back through the statutory organisations own processes for decision.

3 List of Appendices

System Resilience Group Briefings:

Appendix A: 1 February 2016

Appendix B: 30 March 2016

System Resilience Group (SRG) Briefing	Meeting dated – 29 February 2016
	Venue – Board room, Trust HQ, Queens Hospital
Summary of paper	This paper provides a summary of the key issues discussed at the System Resilience Group meeting. The meeting was chaired by Conor Burke (Chief Officer, BHR CCGs) and attended by members as per the Terms of Reference.

Agenda	Areas/issues discussed
Matters arising	Members were updated on latest flu uptake and progress for neuro-rehab.
Performance reporting	Key areas from the dashboard were highlighted.
A&E front/back door	Members received an update on plans to improve the front and back door of A&E.
Trust Improvement Plan	Members received a brief update on the latest developments of the Trust Improvement Plan.
Strategic Development	Members noted the latest position of the Urgent and Emergency Care Vanguard .
Planned Care	Members were updated on the RTT and Cancer improvement plan.
AOB	Members noted the letter around the upcoming junior doctor's strike.
Next meeting:	Wednesday 30th March 2016 10am – 12pm Committee room 3A, Havering Town Hall, Main Road, Romford, RM1 3BB

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System Resilience Group (SRG) Briefing	Meeting dated – 30 March 2016
	Venue – Committee room 3A, Havering Town Hall
Summary of paper	This paper provides a summary of the key issues discussed at the System Resilience Group meeting. The meeting was chaired by Conor Burke (Chief Officer, BHR CCGs) and attended by members as per the Terms of Reference.

Agenda	Areas/issues discussed
Matters arising	Members were updated on latest flu uptake and progress for neuro-rehab.
Planned Care	Members were updated on the RTT and Cancer improvement plan.
Performance reporting	Key areas from the dashboard were highlighted.
Review of SRG Governance and Delivery arrangements	Members were advised that the governance and delivery arrangements of these meetings were under review.
Resilience arrangements	Members were updated on performance over the Easter period.
A&E front/back door	Members received an update on plans to improve the front and back door of A&E.
Strategic Development	Members noted the latest position of the Urgent and Emergency Care Vanguard.
Trust Improvement Plan	Members received a brief update on the latest developments of the Trust Improvement Plan.
AOB	No other business.
Next meeting:	Monday 25th April 2016 1pm - 3pm Board room A, Becketts House, 2-14 Ilford Hill, Ilford IG1 2QX

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HEALTH AND WELLBEING BOARD

26 APRIL 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: Andrew Hagger, Health and Social Care Integration Manager, LBBD	**Contact Details:** Telephone: 020 8227 5071 E-mail: Andrew.Hagger@lbbd.gov.uk
Sponsor: Councillor Maureen Worby, Chair of the Health and Wellbeing Board	

Summary:

At each meeting of the Health and Wellbeing Board each sub-group, excluding the Executive Planning Group, report on their progress and performance since the last meeting of the Board.

Please note that there is no report for Public Health Programmes Board and Integrated Care Sub Group, as they have not held a meeting since the last Health and Wellbeing Board.

Recommendations:

The Health and Wellbeing Board is asked to:

- Note the contents of sub-group reports set out in the appendices and comment on the items that have been escalated to the Board by the sub-groups.

List of Appendices

— Appendix 1: Children & Maternity Group

— Appendix 2: Mental Health Sub Group

— Appendix 3: Learning Disability Partnership Board

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Children & Maternity Group

Chair: Sharon Morrow, Chief Operating Officer

Items to be escalated to the Health & Wellbeing Board

None save that papers from the CMG on Children's Therapies and Children and Young People's Mental Health Transformation Plan will go to June HWB.

Performance

The HWB indicators were reviewed. Key areas for performance improvement were identified obesity, infant mortality, 12 week booking and immunisation although a delay in data/data accuracy was also highlighted as an issue.

Meeting Attendance

8 people attended - 42%

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

The Sub-Group met to take a detailed review of the Children and Young People's mental health and wellbeing needs assessment report and recommendations. Various comments were received to help shape the report content and recommendations.

The Group also reviewed a draft HWB paper on Children and Young People Mental Health Transformation Plan. The focus of the discussion was on ensuring that the developing plan responded to and aligned with recommendations coming out of the needs assessment, ensuring on-going engagement in the development of plans and focusing on outcomes for young people rather than posts.

The need to review the work plan and related agenda setting was highlighted – the group having focused significant time on the children's mental health agenda during the winter. The May meeting will review the high level work plan and take stock in particular against HWB key indicators.

Action and Priorities for the coming period

The following items will be reviewed in May 2016 meeting by the Group

- SEND/Children's Therapies
- Looked After Children
- CMG delivery plan

Contact: Dawn Endean, Locality Admin Support

Tel: 020 3644 2378 **Email:** bdccg@barkingdagenhamccg.nhs.uk

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Mental Health Sub Group

Chair: Melody Williams – Integrated Care Director NELFT

Items to be escalated to the Health & Wellbeing Board

(a) To note the content of this report back to the HWBB

Performance

The Section 75 Executive Group monitors the performance outcomes against the indicators for the adult mental health services. These are currently all performing in line with the targets with the exception of the delayed transfer of care target – as reported in the last indicators presented to the full board. However this position is now a much improved position. For CAMHS services the Indicators are monitored via the CCG Service Performance and Review Meeting and these are also in alignment with targets with the exception of the DNA rate experienced within the services – there is an action plan agreed with the CCG to improve this in line with the national benchmark and therefore maximise the availability of the services.

Meeting Attendance

Date of last meeting: 07.03.16

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

(a) Reviewed and updated the terms of reference and membership of the group

(b) Reviewed the outcomes of the Mental Health Workshops looking at My Life, My Home, My Care

(c) Reviewed and provided feedback on the CAMHS needs assessment

(d) Suicide prevention discussed and to be incorporated into the Mental Health Strategic document

(e) Undertook a visit to the Lambeth Services to explore the model in use and how this might form an option for service development in B&D

Action and Priorities for the coming period

(a) Mental Health Strategy – draft strategic document to be produced taking account for the recent developments in the Health Commissioning, the Local Authority Ambition 2020, the Mental Health Needs Assessment and the CAMHS Needs Assessment findings

(b) CAMHS Transformation programme developments in conjunction with the BHR wide plans for this priority area

(c) Review the 15-16 action plan, mapping all progress and gaps

Contact: Melody Williams

Tel: 0300 555 1201 ext 65067; **Email:** melody.williams@nelft.nhs.uk

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APPENDIX 3

Learning Disability Partnership Board

Interim Chair: Bill Brittain, Group Manager Intensive Support, London Borough of Barking and Dagenham

Items to be escalated to the Health & Wellbeing Board

None.

Attendance:

22 March 2016 – 88% (16 out of 18) member attended.

Performance issues

There are no issues at this time.

Action(s) since last report to the Board

(a) Glynis Rogers Divisional Director Commissioning and Partnerships has retired from the Council and Chair of the Learning Disability Partnership Board. The LDPB thanked Glynis for her leadership and support. Bill Brittain, Group Manager, Intensive support has accepted the interim role as the chair and further discussions will be had around chairing arrangements for the Board in the longer term.

(b) The level of attendance from the subgroups has improved. Membership of the providers subgroup has been opened to all providers of Learning Disability services, both current and potential providers operating in the Borough. The service user subgroup has changed its location and preferred day and had attendance from 25 service users at the last subgroup meeting, a significant improvement on attendance. The number of participants at the carers forum has also improved following closer worker and integrating the meetings with established carer support groups in the borough.

(c) The Learning Disability Partnership Board is presented with an update on the strategic delivery plan at each LDPB meeting. In particular, the LDPB focuses on areas of concern that are RAG rated as RED or AMBER. These are:

- GP Health Checks
- Autism Diagnostic Pathway
- The Independent Housing Strategy

The improvement plan to support GPs on increasing the number of health checks commenced in January 2016 following discussion at the Health and Wellbeing Board. The Community Learning Disability Team (CLDT), Public Health, Clinical

Commissioning Group and Integrated Commissioning are all working together to improve and support the GP surgeries. The importance of health checks has been presented at a number of health forums and health led working groups. In addition there have been 1:1 meetings to support and raise awareness directly with the GP practices. At the start of the improvement plan the percentage of people with a learning disability know to GPs with a health check was 25%. As at the last LDPB meeting (22 March 2016), the updated position was 39%. At the time of submitting this report, the current percentage is 50%. The Board will continue to monitor improvements.

The Clinical Commissioning Group has begun discussions with North East London Foundation Trust, GPs and Integrated Commissioning on developing a local Autism diagnostic service. The board will be presented with updates on this as it is progressing.

The Independent Housing Strategy remains rated at a RED as there has not been a significant progression or a draft presented to the Learning Disability Partnership Board for consultation/comments. This is being discussed with Housing and a discussion at the LDPB is scheduled on this item at the May meeting.

(d) The Board was presented with an update on the Barking Havering and Redbridge Transforming Care Partnership 3 Year Plan. The LDPB will continue to inform the plan and the TCP is a standing item on the agenda.

(e) The Board was presented with the agreed changes to the Council's charging policy. Due to the importance this has to members, the carers forum were also presented with the changes to the charging policy where they had more time to raise more detailed questions.

(f) The LDPB have begun to plan for Learning Disability Week, which will take place in the Summer. Dates are being finalised with senior manages to ensure the week is well supported by a wide range of stakeholders.

Action and Priorities for the coming period

(a) Update and approval of the implementation of the Learning Disability Strategic Delivery plan.

Contact: Karel Stevens-lee, Integrated Commissioning Manager – Learning Disabilities

Tel: 020 8227 2476 **Email:** karel.stevens-lee-lee@lbbd.gov.uk

HEALTH AND WELLBEING BOARD

26 April 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: Andrew Hagger, Health and Social Care Integration Manager	**Contact Details:** Tel: 020 8227 5071 Email: Andrew.Hagger@lbbd.gov.uk
Sponsor: Councillor Maureen Worby, Chair of the Health and Wellbeing Board	
Summary: Please see the Chair's Report attached at Appendix 1.	
Recommendation(s) The Health and Wellbeing Board is recommended to: a) Note the contents of the Chair's Report and comment on any item covered should they wish to do so.	

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Chair's Report

26 April 2016

In this edition of my Chair's Report, I talk about the Sustainability and Transformation Plans, the next development session for the Board on 19th May and Women's Empowerment Month. 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

Sustainability and Transformation Plans

The NHS Shared Planning Guidance which was released late last year has asked every health and care system to come together to create their own local blueprint for accelerating implementation of the NHS Five Year Forward View. Sustainability and Transformation Plans (STPs) will be place-based, multi-year plans built around the needs of local populations, which the NHS hopes will drive sustainable transformation in patient experience and health outcomes over the longer-term. STPs cover all areas of NHS England and CCG-commissioned activity, including how better integration can occur with local authority services. The plans will need to address a series of 'national challenges' which include improving health and wellbeing, improving quality and developing new models of care, and improving efficiency to achieve financial balance.

44 STP geographical footprints have been agreed across England. It is important to note that the footprints are not statutory boundaries. Our STP area is North East London, which includes ourselves, Havering and Redbridge as well as Waltham Forest, Newham, Tower Hamlets and City and Hackney. As members of the Health and Wellbeing Board will be aware, we work closely across Barking and Dagenham, Havering and Redbridge already and our own BHR health and social care economy, including our devolution proposals in the form of our work on the Accountable Care Organisation Business Case, will form a significant part of the North East London STP. Our other transformation plans, including the Primary Care Transformation Strategy which is on the agenda for the Board today, will also need to feed into the STP.

As you can see, developing the STP is a complex process, but is important as STPs will become the single application and approval process for being accepted onto programmes with transformational funding.

Each STP area submitted information as an 'early checkpoint' on 15 April, which provided information about the leadership, decision-making processes and supporting resources that are in place to make progress in developing and delivering the STP, as well as information about the major areas of focus and the big decisions that the system needs to make in order to drive transformation.

The full Sustainability and Transformation Plans are due for submission at the end of June 2016 and a draft version of the STP is scheduled to come to the Health and Wellbeing Board at its next meeting.

Health and Wellbeing Board Development Session – 19th May

The Health and Wellbeing Board will be hosting a Development Session on 19th May at Care City in Barking to bring key people from across the partnership together to discuss some of the big issues we are facing. The main area of focus will be on the upcoming transformation programmes and projects we are currently shaping and embarking upon, including the Sustainability and Transformation Plans mentioned above, the Accountable Care Organisation, the Council's own Ambition 2020 transformation programme and many others that impact on health and social care.

The event will be hosted by the Board and I would encourage members of the Board to attend if possible. The session is targeted at those key officers and professionals who will be delivering the changes and transformation in services, so I would ask Board members to allow time for their staff to attend the session so they can get the most out of it.

Health and Wellbeing Board Development Session: 11am – 3pm, 19th May 2016, Care City, Barking.

Women's Empowerment Month

Barking and Dagenham has become the first Council in the country to adopt a Gender Equality Charter following its launch event on 10 March 2016, which was one of the key events in the recent Women's Empowerment Month.

The charter is a commitment on behalf of the council and partners to create a fair and just society where people are treated equally, discrimination is tackled and the barriers to achieving equality removed. It places a strong emphasis on ensuring that everyone has the same chance to succeed, regardless of their gender.

Women's Empowerment Month lasted for the whole of March with events centred around International Women's Day on 8 March, including an exhibition about Ordinary and Extraordinary Women at Valence House and a Quilting Bee event at William Bellamy Children's Centre where service users and professionals came together to design a square, colour or write something special to them.

Women's Empowerment Month culminated in the Women's Empowerment Awards 2016 on 30th March, an awards ceremony recognising and celebrating the outstanding achievements and hard work of women of all backgrounds in the borough. Finalists were chosen by a panel of judges who also had the hard task of choosing ultimate winners for nine categories and then an overall winner for the 'Woman of the Year' awards.

Nusrat Zamir scooped overall woman of the year for her work with the Chadwell Heath Asian Women's Network (CHAWN).

The ceremony also celebrated, mum of the year Karen Brown, who underwent a six-hour transplant to give one of her kidneys to her daughter Emily.

News from NHS England

Resource to support early detection and secondary prevention in primary care

The second edition of the CVD Primary Care Intelligence Packs has just been launched by the National Cardiovascular Intelligence Network (NCVIN). This is a resource that will help CCGs and practices drive improved outcomes in cardiovascular disease by identifying key gaps and opportunities in primary care. CVD prevention is important because it is responsible for a quarter of all premature deaths in England and because it has such an impact on the lives of millions of people. Detecting and managing high risk conditions such as high blood pressure, atrial fibrillation, diabetes and chronic kidney disease is a major element of the work of GPs and nurses as these conditions put patients at significant risk of early death and disability.

The Intelligence Packs, one for every CCG in England, show how well areas are doing and where the opportunities for improvement lie in each of these high risk conditions. The packs tells a story about variation in care and outcomes, recognising that some variation may have legitimate explanations such as population differences, but also that much variation cannot be explained in that way. For each indicator in the Intelligence Pack, the magnitude of variation between CCGs and between practices is identified, and calculations are made to show how many more individuals with high risk conditions in the CCG would be detected and effectively managed if all practices performed as well as the top 25%. The Intelligence Packs also acknowledge that most improvement is not about individual clinician performance, but about taking a systematic approach across a CCG or other footprint.

New whistleblowing guidance for primary care

At the start of April NHS England took significant steps to make it easier for primary care staff to raise concerns so that action can be taken and improvements made.

New whistleblowing guidance has been drawn up, which comes after Sir Robert Francis recommended that the principles outlined in his Freedom to Speak Up report be adapted for primary care, where smaller work settings can present challenges around anonymity and conflicts with employers. The proposals include named Freedom to Speak Up Guardians who can offer support and listen to staff raising a concern, proactive approaches in preventing any inappropriate behaviour such as bullying or harassment and that all NHS primary care providers should review and update their local policies and procedures to align with the agreed guidance.

Health and Wellbeing Board Meeting Dates

Tuesday 14 June 2016, Tuesday 26 July 2016, Tuesday 27 September 2016, Tuesday 22 November 2016.

All meetings start at 6pm and are held in the conference room of the Barking Learning Centre.

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HEALTH AND WELLBEING BOARD

26 April 2016

Title:	**Forward Plan**
Report of the Chief Executive	
Open	**For Comment**
Wards Affected: NONE	**Key Decision: NO**
Report Authors: Tina Robinson, Democratic Services, Law and Governance	**Contact Details:** Telephone: 020 8227 3285 E-mail: tina.robinson@lbbd.gov.uk
Sponsor: Cllr Worby, Chair of the Health and Wellbeing Board	

Summary:

The Forward Plan lists all known business items for meetings scheduled for the coming year. The Forward Plan is an important document for not only planning the business of the Board, but also ensuring that information on future key decisions is published at least 28 days before the meeting. This enables local people and partners to know what discussions and decisions will be taken at future Health and Wellbeing Board meetings.

Attached at **Appendix A** is the next draft edition of the Forward Plan for the Health and Wellbeing Board. 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 17 May 2016. Any changes or additions to the next issue should be provided before 6.00 p.m. on 11 May.

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

List of Appendices
Appendix A – Draft Forward Plan

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HEALTH and WELLBEING BOARD
FORWARD PLAN

DRAFT June 2016 Edition

Publication Date: 17 May 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 Council municipal year, in accordance with the statutory 28-day publication period:

Edition	Publication date
June 2016 edition	17 May 2016
July 2016 edition	27 June 2016
Sept 2016 edition	26 August 2016
November 2016 edition	24 October 2016
January 2017 edition	23 December 2016*
March 2017 edition	13 February 2017
May 2017 edition	10 April 2017

Confidential or Exempt Information

Whilst the majority of the Health and Wellbeing Board's business will be open to the public and media organisations to attend, there will inevitably be some business to be considered that contains, for example, confidential, commercially sensitive or personal information.

This is formal notice under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 that part of the meetings listed in this Forward Plan may be held in private because the agenda and reports for the meeting will contain exempt information under Part 1 of Schedule 12A to the Local Government Act 1972 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it. Representations may be made to the Council about why a particular decision should be open to the public. Any such representations should be made to Alan Dawson, Democratic Services Manager, Civic Centre, Dagenham, Essex RM10 7BN (telephone: 020 8227 2348, email: committees@lbbd.gov.uk).

Key to the table

Column 1 shows the projected date when the decision will be taken and who will be taking it. However, an item shown on the Forward Plan may, for a variety of reasons, be deferred or delayed.

It is suggested, therefore, that anyone with an interest in a particular item, especially if he/she wishes to attend the meeting at which the item is scheduled to be considered, should check within 7 days of the meeting that the item is included on the agenda for that meeting, either by going to http://moderngov.barking-dagenham.gov.uk/ieListMeetings.aspx?CId=669&Year=0 or by contacting contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@lbbd.gov.uk .

Column 2 sets out the title of the report or subject matter and the nature of the decision being sought. For 'key decision' items the title is shown in **bold type** - for all other items the title is shown in normal type. Column 2 also lists the ward(s) in the Borough that the issue relates to.

Column 3 shows whether the issue is expected to be considered in the open part of the meeting or whether it may, in whole or in part, be considered in private and, if so, the reason(s) why.

Column 4 gives the details of the lead officer and / or Board Member who is the sponsor for that item.

Decision taker/ Projected Date	Subject Matter Nature of Decision	Open / Private (and reason if all / part is private)	Sponsor and Lead officer / report author
Health and Wellbeing Board: 14.6.16	**CAMHS Transformation Plan and Needs Assessment** : Community The report will inform the Board of the CAMHS Transformation Plan which was developed by the Children and Maternity Sub-Group as well as presenting the CAMHS Needs Assessment. The Board will be asked to discuss and note the CAMHS Transformation Plan and to discus and agree the recommendations set out in the CAMHS Needs Assessment. • Wards Directly Affected: All Wards	Open	Sharon Morrow, Chief Operating Officer (Tel: 020 3644 2378) (Sharon.Morrow@barkingdagenhamccg.nhs.uk)
Health and Wellbeing Board: 14.6.16	**Domestic and Sexual Abuse Strategy** : Framework The Board will be asked to discuss and approve the Domestic and Sexual Abuse Strategy. • Wards Directly Affected: All Wards	Open	Sonia Drozd, Drug Strategy Manager (sonia.drozd@lbbd.gov.uk)
Health and Wellbeing Board: 14.6.16	**Obesity and Physical Activity Strategy** : Community The Board will be asked to approve the Obesity and Physical Activity Strategy. • 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: 14.6.16	**Sustainability and Transformation Plan** : Community The Board will be provided with the Sustainability and Transformation Plan, which is a multi-year plan showing how local services will evolve and become sustainable over the next five years and how health and care organisations will work together to narrow the gaps in the quality of care, their population's health and wellbeing, and in NHS finances. The plan covers nine boroughs across North East London. The Board will be asked to approve the plan for submission to NHS England. • Wards Directly Affected: All Wards	Open	Sharon Morrow, Chief Operating Officer (Tel: 020 3644 2378) (Sharon.Morrow@barkingdagenhamccg.nhs.uk)
Health and Wellbeing Board: 14.6.16	**Accountable Care Organisation (ACO)** : Community,: Financial Barking and Dagenham, Havering and Redbridge were recently successful in their bid to be a pilot area for exploring the creation of an Accountable Care Organisation across the three boroughs, as part of the London health devolution agreement. The report will provide the Health and Wellbeing Board with information on the next steps in developing the ACO business case and seek the necessary consents to proceed. • Wards Directly Affected: All Wards	Open	Mark Tyson, Group Manager, Integration & Commissioning (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)
Health and Wellbeing Board: 14.6.16	**Urgent and Emergency Care (UEC) Transformation** The report will provide the Board with details of the Barking and Dagenham, Havering and Redbridge System Resilience Group's plans to transform urgent and emergency care. The Board will be asked to discuss and note the transformation plans. • Wards Directly Affected: All Wards	Open	Conor Burke, Chief Officer (Tel: 020 8926 5238) (conor.burke@onel.nhs.uk)

Health and Wellbeing Board: 14.6.16	Ambition 2020 The report will provide the Board with details of London Borough of Barking and Dagenham's transformation plans, called Ambition 2020. The Board will be asked to discuss and note the transformation plans. • Wards Directly Affected: All Wards	Open	Meena Kishinani, Programme Director, Ambition 2020 (Tel: 020 8227 2786) (meena.kishinani@lbbd.gov.uk)
Health and Wellbeing Board: 26.7.16	London Fire Brigade The Board will be provided with a presentation by the London Fire Brigade around how London Fire Brigade and health and social care organisations can work more closely on key issues. The Board will be asked to note the information provided in the report. • Wards Directly Affected: All Wards	Open	Strategic Director, Service Development & Integration

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)
LBBD Borough Commander (Metropolitan Police)
John Atherton, Head of Assurance (NHS England) (non-voting Board Member)