Notice of Meeting

HEALTH & WELLBEING BOARD

Tuesday, 27 September 2016 - 6:00 pm
Conference Room, Barking Learning Centre, 2 Town Square, Barking, IG11 7NB

Date of publication: 19 September 2016

Chris Naylor
Chief Executive

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Membership

Cllr Maureen Worby (Chair)	(LBBD) Cabinet Member for Social Care and Health Integration
Dr Waseem Mohi (Deputy Chair)	(Barking & Dagenham Clinical Commissioning Group)
Cllr Sade Bright	(LBBD) Cabinet Member for Equalities and Cohesion
Cllr Laila Butt	(LBBD) Cabinet Member for Enforcement and Community Safety
Cllr Evelyn Carpenter	(LBBD) Cabinet Member for Educational Attainment and School Improvement
Cllr Bill Turner	(LBBD) Cabinet Member for Corporate Performance and Delivery (Guest)
Anne Bristow	(LBBD) Strategic Director for Service Development and Integration and Deputy Chief Executive
Matthew Cole	(LBBD) Director of Public Health
Frances Carroll	(Healthwatch Barking & Dagenham)
Dr Jagan John	(Barking & Dagenham Clinical Commissioning Group)
Conor Burke	(Barking & Dagenham Clinical Commissioning Group)
Bob Champion	(North East London NHS Foundation Trust)
Dr Nadeem Moghal	(Barking Havering & Redbridge University NHS Hospitals Trust)
Sean Wilson	(Metropolitan Police, Interim Borough Commander)
Ceri Jacob (Non-voting member)	(NHS England London Region)

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 held on 26 July 2016 (Pages 3 - 15)**

BUSINESS ITEMS

4. **Joint Strategic Needs Assessment (JSNA) 2016 - Key recommendations (Pages 17 - 45)**

5. **Healthwatch Barking and Dagenham Annual Report 2015/16 (Pages 47 - 106)**

6. **Healthy Weight Strategy (Pages 107 - 132)**

7. **Health and Wellbeing Outcomes Framework Report - Quarter 1 2016/17 (Pages 133 - 182)**

8. **Sustainability and Transformation Plan Update (Pages 183 - 200)**

9. **Improving Post - Acute Stroke Care (Stroke Rehabilitation) (Pages 201 - 243)**

STANDING ITEMS

10. **Systems Resilience Group - Update (Pages 245 - 249)**

11. **Sub-Group Reports (Page 251)**

12. **Chair's Report (Pages 253 - 257)**

13. **Forward Plan (Pages 259 - 270)**

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

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

Private Business

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

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

(i)

(ii)

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

One borough; one community; London's growth opportunity

Encouraging civic pride

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

Enabling social responsibility

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

Growing the borough

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

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MINUTES OF
HEALTH AND WELLBEING BOARD

Tuesday, 26 July 2016
(6:00 - 8:34 pm)

Present: Cllr Maureen Worby (Chair), Dr Waseem Mohi (Deputy Chair), Cllr Sade Bright, Anne Bristow, Conor Burke, Cllr Laila M. Butt, Cllr Evelyn Carpenter, Matthew Cole, Ceri Jacob, Helen Jenner, Dr Nadeem Moghal, Bob Champion and Sean Wilson

Also Present: Sarah Baker, Cllr Bill Turner and Cllr Adegboyega Oluwole

Apologies: Frances Carroll, Cllr Peter Chand and Terry Williamson

16. Apologies for Absence

17. Extension of the Meeting

At 8.00 p.m. the Chair moved that the meeting be extended by half an hour, this was seconded by Cllr Turner and agreed by all present.

18. Declaration of Members' Interests

There were no declarations of interest.

19. Minutes - 26 April and 14 June 2016

The minutes of the meetings held on 26 April and 14 June 2016 were confirmed as correct.

20. Health and Wellbeing Board Membership

The Board received the report, which explained that certain Health and Wellbeing Board (H&WB) membership was prescribed by the Health and Social Care Act 2012, with additional Board Member appointments set out in the Council's Constitution. The LBBD Corporate Director of Children's Services was one of the prescribed Board Members under the Act. The report also set out proposals to change the membership following the imminent retirement of the Corporate Director of Children's Services, as the statutory functions of that role would be transferred to the Strategic Director of Service Development and Integration; this would then leave a vacancy on the Board. The Council were, therefore, proposing that this vacancy be filled by an additional LBBD Cabinet Member, to be appointed by the Leader.

Discussions were held in regard to making a note in the Constitution of the Protocol between the H&WB and the Local Safeguarding Children and Adults Boards, including the role of the Independent Chair of those Safeguarding Boards. It was noted that currently the same person was the Independent Chair of both of the Local Safeguarding Boards.

The Board:

(i) Agreed the proposed amendments to the London Borough of Barking and Dagenham (LBBD) representation on the Health and Wellbeing Board by the inclusion of a further LBBD Cabinet Member to the Board, in place of the position occupied by the statutory Director of Children's Services following the function being transferred to the Strategic Director of Service Development and Integration.

(ii) Noted the Leader's nomination of Cllr Bill Turner, Cabinet Member for Corporate Performance and Delivery, for this position and additionally note his nomination of Cllr Sade Bright, Cabinet Member for Equalities and Cohesion for the existing complement of Cabinet Members on the Board;

(iii) Requested that the Protocol outlining Barking and Dagenham's Safeguarding Partnerships arrangements between the Health and Wellbeing Board and the Local Safeguarding Children Board and the Local Safeguarding Adults Board (set out in Minute 58, 28 October 2014) and the role of the Chair(s) of those Safeguarding Boards as an independent, non-voting, standing invited guest to the Health and Wellbeing Board were included in the changes to the Constitution.

(iv) Noted that the amendments would be the reported to Assembly and, subject to confirmation by the 5 October 2016 Assembly, would be reflected in the Council Constitution in due course.

21. Child and Adolescent Mental Health Needs (CAMHS) Transformation Plan and Needs Assessment

Cllrs Turner, Cllr Butt, Ceri Jacobs, Director Commissioning Operations NCEL NHS England London Region, and Sean Wilson, Interim Borough Commander Metropolitan Police, arrived during this item

The Board considered this agenda item and the 'Children and Young People Mental Health Transformation Plan Update report', in conjunction due to the significant crossover of the issues.

Susan Lloyd, Consultant in Public Health, presented the report and explained that NHS England had required the development of a Children and Young People Mental Health Transformation Plan to underpin the delivery of the 'Five Year Forward View for Mental Health' and 'Future in Mind' national strategy and policies. The Transformation Plan also provided details of the five key themes for specific development and investment and the additional specific investment in eating disorders and services.

The Needs Assessment had provided information on the current services delivered by CAMHS and the gaps in those services. The Director of Public Health had identified 14 areas where services could be redesigned to better meet the local needs of LBBD children and young people. Details of those gaps and areas for redesign were set out in the report. However, overall the Needs Assessment had found that the Borough was already providing a significant amount of activity around mental health resilience and prevention and that excellent work was already being delivered at building resilience for Tiers 1, 2 3 and 4 services.

The additional funding had allowed for the Transformation Plan to be revisited and it was expected that the revised Plan would be presented to the Board in Autumn 2016. The Needs Assessment had also indicated that the number of children and adolescents with mental health problems was high in LBBD when compared against both other London boroughs and national rates of incidence. In addition, the number of children with diagnosable mental health problems was projected to increase to 8,044 by 2020. The Needs Assessment would be a fundamental start point for informing the Transformation Plan and in making choices on prioritising investment at a time of austerity and increasing need.

The Board:

(i) Endorsed the findings of the Child and Adolescent Mental Health Needs Assessment and noted the areas of good provision and gaps set out in the report.

(ii) Agreed that the findings be used to support the commissioning of Children and Adolescent Mental Health Services for the residents of Barking and Dagenham.

22. Children and Young People Mental Health Transformation Plan Update

The Board discussed the report, which provided an update on the Transformation Plan and its implementation,

Work is progressing to implement of the Transformation Plan. Whilst additional resources had been provided for the Transformation Plan, those resources had come with provision requirements in regard to community services for eating disorders. The BHR CCGs had also been successful in securing non-recurrent resource, through the emergency and urgent care vanguard programme, to develop the crisis prevention pathway for children and young people. Further guidance on perinatal mental health is expected in 2016/17 which should attract additional funding.

Delivery of the Transformation Plan would need partner support. The governance process for this would be driven and monitored by the Children and Maternity Sub-Group.

One of the main threads for the Transformation Programme is shifting the focus from crisis support to early intervention. This would have the benefit of stopping young people either going into crisis or their mental health deteriorating and thus would allow them to participate more within their educational, social and home settings. Support for families would also be important to increase treatment success rates.

In response to a question from Cllr Carpenter about Tier 4 service treatment provision being unavailable at Brookside, Melody Williams, Integrated Care Director (Barking and Dagenham) NELFT, advised NELFT felt that all the actions required were now in place and negotiations were being held with NHS England, the commissioner of the service, with the aim of Brookside reopening in the imminent future. A request was made for the report on Brookside, presented to LBBD Health and Adult Services Select Committee (HASSC) on 19 July 2016, to be circulated to the Board for information.

The Board was advised that the 'Thrive' method was having a significant positive impact in Tier 1 and 2 treatments; however, there was currently no home treatment pathway model in the UK for Tier 3 treatment service. A new model had now been developed, which included a home treatment service. The new approach had been proposed to NHS England, for which their consent to continue was awaited. Ceri Jacobs was asked to follow-up this issue with her colleagues.

In response to a question from Cllr Carpenter it was clarified that the current community eating disorder service was an all age service. Investment in the service has been made to develop the model for children and young people, in recognition of their special and extra needs.

Helen Jenner, Corporate Director of Children's Services, suggested that urgent contact would need to be made with the schools governing bodies if a named individual was needed in schools to lead on mental health issues by September.

Helen also pointed out that there were already some schemes in place, which need to be mapped against the Plan.

The presence of CAMHS in the LBBD Multi-Agency Safeguarding Hub (MASH) was requested.

Cllr Oluwole asked for clarification on the support for the family. Melody advised that CAMHS would be working with the CCG to obtain additional funding to support the family at the point of crisis, which was often different in children and young people to that for adults. The aim was to have a structured intervention to work towards reducing or removing the need for admittance to a mental health support unit.

Sarah Baker, Independent Chair of Safeguarding Boards, advised that the Children's Commissioner's Lightening Review on the Access to Child and Adolescent Mental Services in May 2016 was not referenced in the reports, as it had been published after the Transformation Plan was reviewed; however, there was a need to cross reference those findings with the Plan.

Cllr Turner pointed out that the data streams also needed to be checked, for example the referral data for looked after children, as the data would be important later in order to be able to monitor and assess if the Plan and any new practices were working as expected.

Cllr Turner raised the issue of variety of available treatments compared to inner London Boroughs. Melody advised that the focus was now moving towards outcomes. In addition, the Child Outcomes Research Consortium (CORC) looked at the range and access to the facilities that were provided and the local provision for LBBD residents had been benchmarked favourable against other areas.

The Chair reiterated to Partners that the Council had concerns regarding the three borough approach, as each borough had its own individual challenges and needs. Progress would be closely monitored to make sure that LBBD residents were not getting a lesser quality service.

The Board:

(i) Noted the update on the Transformation Plan;

(ii) Requested the Director of Commissioning Operations for North Central and East London to remind her NHS England colleagues that a response was still awaited from NHS England to NELFT's proposals around a new model home treatment pathway for Tier 3 and 4 patients;

(iii) Noted that if schools were being expected to provide a named responsible individual they would need to contact quickly the governing body of each school;

(iv) Would wish to see CAMHS presence in the Multi Agency Safeguarding Hub (MASH) again; and

(v) Noted that a full report would be presented in the autumn, which would cover the issues raised by the Board.

23. 18 Week Referral To Treatment Update

BHRUT reminded the Board of the background to how the poor performance had occurred and gave a presentation on the work that had been undertaken on their 18 week Right to Treatment (RTT) Recovery and Improvement Plan and the work streams within it. In addition, they had now completed a major validation exercise on the data and now had accurate information on the patients waiting to be seen

BHRUT advised that good progress had been made to reduce the backlogs on both admitted and non-admitted patients. BHRUT had developed a trajectory to clear the longest waiting patients and by 3 April 2016 had made, better than expected progress against that target, with a 34.8% reduction in those patients waiting. The total number of patients on the Trust waiting list had now been reduced from 114,000 to 54,000. The Trust was also undertaking a review of the RTT administration roles for booking and managing patient pathways. However, even with material demand management, outsourcing, additional recruitment, improved theatre productivity and administration the size of the backlog meant that it would take until 2017 to clear.

BHRUT advised that they were also developing detailed demand and capacity plans for the specialities. These plans would allow staff to quantify weekly any capacity gaps and assist with future planning to match resources with patients' needs.

BHRUT reiterated that they had a communications strategy in place.

CCG advised that their role was to hold the BHRUT to contractual delivery and ensure that the Trust adhered to the Improvement Plan. Havering CCG, as the lead on contracting body for BHRUT, had been issued with legal directions in June by NHS England. The CCG also had a role in averting 30,000 GP Outpatient referrals in high demand sections out of BHRUT. The Board's attention was also drawn to the work which was being undertaken to design new clinical pathways for 10 key areas.
The escalated position had provided extra support to focus on the RTT problems. A robust, overarching recovery plan from the Trust with a CCG Demand

Management Plan would need to be signed off and reported to NHS England in September 2016.

Cllr Carpenter asked for clarification in regard to the backlog taking till 2017 to clear and what affect that would have on new patient referrals. BHRUT responded that both current backlog and new patients were being taken into consideration and assessed to determine clinical priority and any problems were also being resolved in regards to incorrect pathway data.

Cllr Butt indicated that despite raising this issue with the BHRUT Chief Executive at his recent attendance at the Board, she was dismayed to see individuals were still being referred to by BHRUT as 'waiters', rather than people or patients. BHRUT apologised for this and gave an undertaking that this would not happen again.

Cllrs also raised concern about the value of the additional leadership and administrative roles and if the cost of this would be taking resources away from treatment. BHRUT responded that this area had been under resourced for some time, and it was felt that the lack of overview was probably a contributory factor as to why the situation had occurred. The structure would be needed to deliver the Plan, in addition some of the leadership roles also had clinical functions.

Cllr Turner reminded BHRUT that their Chief Executive had given a commitment to provide details on the number of patients in each specialist area and how many of those patients were LBBD residents. Cllr Turner repeated the request for those details and the current number of LBBD residents still on the waiting lists. BHRUT apologised and said they could provide locality data, down to a General Practice level, and would do so by the next meeting.

Councillor Bright raised concern on the communication strategy as a number of people had spoken to her about being referred to Queens and nearly two years later they were being sent back to their GP. In that time they had either not heard anything from Queens or were now being told they could go private; but many could not afford to do so. The Chair commented that this meant that either the BHRUT communication was not getting to the correct people, there was a lack of good quality communication or it was not being explained well, which meant that patients had not understood what the options were. The Chair suggested that as the Council regularly communicated on mass with residents, that expertise could have been useful in making the letters and other communications easier to understand, for example when there was mention of the private 'Roding' hospital patients would have assumed they would need to pay, when it would in fact have been funded fully by BHRUT. Anne Bristow, Strategic Director of Service Development and Integration, raised the issue of Stakeholder communication and consultation and said it was no good telling Partners after the event and this must be undertaken earlier in order that partners input could be given, so the message would get across to the public.

BHRUT advised that they would be looking at communicating with GPs to make sure that they understand that the alternative providers would be free to the patients and would take the issue of consulting earlier with Partners back to their colleagues.

BHRUT gave an assurance that Clinical reviews were undertaken of each

individual on the waiting list to ensure they suffered no additional clinical harm.

In response to a question from Cllr Oluwole, BHRUT advised that any private / independent providers used would be checked to ensure that they meet the clinical and other governance capacities required by the NHS.

Anne commented on the 780 extra operations expected to be undertaken by the end of September as this was not a huge number considering the 54,000 people on the waiting list and the historic recruitment issues in many specialisms. Anne asked BHRUT how many of the new approved posts were actually filled. BHRUT advised they were ahead of the trajectory target for treatment and recruitment was ongoing but where there were gaps locums and the independent sector were being used.

Sean Wilson asked if the individual patient's issues were becoming more complex and also if direct employees could not be recruited was the outsourcing more expensive. Dr Moghal advised that patient issues were increasingly more complex often needing input from a number of specialist areas. The costs of outsourcing all or some parts of more cases was not necessarily any more expensive than dealing with all aspects of treatment within BHRUT facilities.

Conor Burke, Accountable Officer, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups, suggested setting up a sub-group to consider the issues in more detail.

The Board

(i) Noted that the number of people waiting for their appointment had now been reviewed and BHRUT confirmed that this now stood at 54,000 patients;

(ii) Noted that BHRUT had not yet recommenced reporting its Referral to Treatment performance to NHS England;

(iii) Requested BHRUT to provide an update on patients' Referral to Treatment waiting times to every Board meeting until the NHS Constitution standard, which gives Patients a legal right to start non-emergency NHS consultant-led treatment within a maximum of 18 weeks following a GP Referral, was achieved and embedded at BHRUT.

(iv) Suggested that consultation with the Council would have been helpful in drafting the communications with the patients waiting for appointments. Particular concern was raised in regards to the lack of understanding by patients that alternative treatment provided outside of Queens and King George hospitals would still be paid for via the NHS and that there would be no charge to patients for accessing these services at private facilities

(v) Reminded BHRUT that the Board was still awaiting details of:

(a) The numbers of patients in each specialist area and how many of those patients were Barking and Dagenham residents.

The Board also now required details of the current number of LBBD

residents that were included in the outstanding 54,000: and

(b) Evidence to substantiate the previous anecdotal claim by BHRUT that patients were prepared to wait longer to be seen within BHRUT rather than being treated by other providers.

The Board now also required details of the number of LBBD residents that had already been referred to independent / private providers or non BHRUT hospitals.

(vi) Reminded BHRUT of the previous request made by the Board for them not use the term 'waiters' in their future reports and that 'patients' or 'people' was more appropriate.

24. Update on Commissioning of Eye Care Pathway

Further to Minute 32, 20 October 2016, Sharron Morrow, Chief Operating Officer, Barking and Dagenham CCG, reminded the Board that the review had been undertaken in response to concerns that people may have experienced difficulties in obtaining care and as a result would miss treatment that could prevent sight loss. Key findings had included the lack of assurance that all those who should have had a sight test do get one, the current arrangements were too complex for patients to understand and the treatment pathway did not promote choice and control by the patients.

Sharon drew the Board's attention to an number of issues, including:

- Diabetic retinal screening had been reviewed and re-specified and there was now a new London wide model which had been put in the new NHS contracts in November 2015.

- A partnership Vision Strategy Group had been set up by LBBD and this had now met three times.

- Joint procurement process for community based eye services for the management of minor conditions, cataracts and glaucoma had been concluded in March 2016 however, it had not been possible to award a contract as a suitable provider could not be selected.

- The ophthalmology pathway review was now being taken forward in the context of the RTT programme across BHR CCGs and BHRUT, as ophthalmology had been identified as one of the top ten specialities needing further work and sustainability.

- Each CCG was leading on three pathway reviews.

- For stable glaucoma patients a new pathway with community services would be implemented by December 2016, which in turn would increase capacity for secondary care for patients with complex glaucoma.

- Service users via the Bridge to Vision (B2V) had increased and so far 107 had been seen this year.

- The commissioning of an "Eye Care Liaison Officer" recommended in Recommendation three of the review had not yet been progressed.

- Recommendation four of the review had asked for consideration improvements to local low vision services at King George's and Queens Hospitals. This had been investigated and as those improvement required a small amount of funding this had been progressed.

- The Magnifier Lighting Workshop had now seen 300 clients and over 50 referrals had been made. The sensory staff were now promoting the service in the local mosques.

- Recommendation five was for a local communication campaign on the importance of having an eye test. The background work to the campaign had been undertaken and the Campaign was due to run in September.

- Recommendation six was to make every contact count with children. Current performance reports suggested a 66% achievement rate and the lack of parental consent was the main factor to be overcome.

  The Board raised concerns about this very low sight test rate and the impact on other health checks undertaken on children. Sharon indicated that it may be necessary to undertake further investigation on the data accuracy and Matthew Cole advised he would arrange for the data to be triangulated to see if it was the same children missing all checks or some children attending for some check but not others.

The Board:

(i) In view of the very low test rate achieved, requested the Barking and Dagenham Clinical Commissioning Group (CCG) Chief Operating Officer, to check if there were any potential data inaccuracy and report back in due course; and

(ii) Asked the Director of Public Health to check and report back in due course as to whether those children not having eye tests were also missing the hearing / general health check.

25. Healthwatch Barking and Dagenham Annual Report 2015/16

Deferred to 27 September 2016 meeting.

26. Systems Resilience Group - Update

Conor Burke, Accountable Officer, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups, presented the report and explained that Emergency Care and achieving the 95% four hour waiting target consistently was still a challenge. System leaders had also recently met to look at what else could be done in the short and medium-term to reduce demand at Accident and Emergency (A&E)

The Chair advised that a question had been raised at the Council's 13 July Assembly on the trial at Queen's Hospital that had seen patients assessed at the door and those that required non-emergency were referred to their GP or pharmacist. The Chair said that the Council had worked hard to build a relationship with local health care providers and was concerned that nobody had thought about consulting with the Council before putting the pilot into testing and extending that for a further two weeks. Given the scale of the Council's ambition to transform local health and social care services the pilot at A&E would not fix the problems around medical advice or treatment when GP's were already under enormous pressure. The Chair made the point that to stop people turning up at A&E more effective local provision, including accessible GPs and out-of-hours services, were needed.

Conor advised that the initially the method had originated as a tool to deal with demand during the Junior Doctors Strike and the pilot had been agreed at the SRG, at which Council officers were present. The SRG had subsequently agreed at its July meeting to keep the pilot going in order to collect more representative data and to enable tracking of those referred elsewhere. Conor stressed that the initial data suggested that up to 60% of people that attended A&Es do not need treatment of any sort.

Dr Moghal explained that there had been a huge surge in demand at A&E departments, both locally and nationally, by those not needing urgent care and this had caused resource challenges in dealing with the critically ill. During the pilot 50 to 60 patients per day were triaged by a consultant and / or a GP. The parents of some 21% of children that had attended were assured that they could wait for a non urgent GP appointment. The priority had to be those that were critically ill, and that was best served by ensuring resources were not deflected to non urgent attendees.

The Chair said that she did not disagree with the need to target resources to the critically ill, however, before others were turned away there needed to be somewhere consistent, open and available for non urgent patients to go to. In addition, advice from 111 also needed to be significantly better.

Cllr Oluwole asked if the approach had been piloted elsewhere or only at BHRUT and if there had been any follow up to find out what had happened to those sent elsewhere. For example, had the re-entered the system later in a more acute condition or not sought any medical advice or treatment. Cllr Oluwole also wished to know if the pilot was being extended to paediatric A&E.

Dr Moghal advised that the model was being tried elsewhere. There had been a significant drop in A&E attendance during the Junior Doctor strike, which clearly indicated that there was a lot of personal choice about why people attend A&E, rather than a real clinical need. Dr Moghal advised that many of paediatric cases could be dealt with by self-care or at primary care and did not need A&E advice or treatment. In addition, audits were undertaken to find out why people attended A&E and during the pilot tracking and the patient experience would be part of the considerations of the outcome of the pilot.

Cllr Turner asked for clarification on the 25% of people who had been attended A&E at least once before in the past year. Mr Moghal advised that in the majority of cases these were elderly readmissions.

The Board:

(i) The Board received and noted the report on the work of the System Resilience Group (SRG), which included the issues discussed at the SRG meeting held on 23 May 2016;

(ii) Requested further details and data on the pilot scheme at Queens A&E, where people were being assessed by a Consultant / GP as to whether they require emergency or urgent care and directed to the appropriate setting. The Board also reminded those present of the need to improve service provision within Primary Care, which in turn would reduce the demand from residents feeling they needed to attend A&E.

(iii) Noted that this issue would be considered at the next Board development session.

27. Sub Groups - Update

The Board noted that no Sub-Groups had held meetings since the last Health and Wellbeing Board,

28. Chair's Report

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

- Learning Disability Week – 18 to 22 July 2016.
- Spotlight on Adoption
- News from NHS England
  - Increase in positive experiences of GP services
  - Be Clear on Cancer campaign

29. Forward Plan

The Board noted the interim draft August edition of the Forward Plan and that the interim edition would be published on 1 August 2016. The deadline for changes for the next full issue of the Forward Plan was 23 August.

30. Update on North East London Sustainability and Transformation Plan (NEL STP)

Councillor Turner left the meeting during this item.

Conor Burke reminded the Board of the context of the North East London Sustainability and Transformation Plan (NEL STP) and drew the Board's attention to a number of issues, including:

- The Plan had been submitted on 30 June but it could not be published as it

was still in development.

- NEL area was facing challenges on a number of health outcomes.
- Outturn would be measured against the previous agreed Plan.
- The next steps, set out in the report, had already been progressed within BHRUT, However, other local authorities in NEL needed to progress actions.
- There could be at least a £850m shortfall between anticipated provision costs and funding if we did nothing. This would not be sustainable and the 'do something' approach was essential to meet the growing demands. Whilst significant productivity challenges had been achieved over several years, such improvements were increasingly difficult to find and they would no longer offer a long-term solution. It was now necessary to do more to meet future demand but more importantly it would require providers and service users to do things differently.
- To meet the challenges, the Business Case for the BHR Accountable Care Organisation (ACO) and the LBBD Ambition 2020 were linked.
- The details provided on the strategy for residents' looking after themselves, the primary care approach, the two major hospitals delivering their required savings, the place based care system(s) and localities, which would allow micro, rather than borough level, care and pathways to treatment.

The Chair highlighted that the STP process has no sign-off for local councils of the strategy and policy, despite the recognition that the STP needs to closely involve councils. The Chair raised a concern at the disparity in this apparent need to involve councils but not give them any say over the final product. Ceri Jacobs advised that a similar message was coming through from many councils. It was clear that the public sector needed to come together to jointly delivery sustainable change. Ceri agreed to take the concerns raised back to NHS England.

The Board discussed a number of issues, including the national framework, gaps in resources, who would be handed responsibility for funding, for example would it be shared with all local councils or with the CCG and. Conor said that he expected the funding will be recycled from many places. The Chair said she felt it was very important that the Treasury invested in the devolution, via ACOs and STPs, in order to allow the organisational set-up required and service changes be put into place to accrue the savings. The Board felt that the whole issue of funding and programme of funding needed to be much clearer and more robust.

Mark Tyson LBBD Commissioning Director, Adult's Care and Support, suggested that the Local Government Association facilitated borough based STP workshops would be a good opportunity explore the issues raised in more depth.

The Board:

(i) Provided feedback to the NEL STP Team on the draft priorities of the checkpoint submission and suggestions regarding the key principles that should underpin any NEL-wide governance for the STP:

(ii) Requested that the Director of Commissioning Operations for North Central and East London, relay the Board's concerns back to NHS England about the role of the Local Authority in the consultation and sign-off process of the STP:

(iii) Requested further clarity about what was being proposed in regards to the funding and sharing of funds between the CCG and other Local Authorities;

(iv) Noted the suggestion from the LBBD Commissioning Director, Adult's Care and Support, that the Local Government Association facilitated borough based STP workshops would be a good opportunity explore in more depth the issues raised at the meeting; and

(v) Noted that a further report would be presented to the Board in the Autumn.

(Part of this item was considered after a resolution had been passed to exclude the public and press from the meeting due to the commercially confidential nature of the information, in accordance with paragraph 3 of Part 1 of Schedule 12A to the Local Government Act 1972 (as amended).)

31. Votes of Thanks to Helen Jenner

The Board placed on record its thanks to Helen Jenner, Corporate Director of Children Services, who was attending her last Board meeting before retiring after seven years service with the Council. Helen had been actively involved in both the Board and Shadow Board.

Members of the Board paid their own tributes to Helen reflecting particularly on her inspirational leadership and ability to challenge at all levels, which had resulted in some significant improvements to the life choices of the Borough's children and young people. During her seven years at the Council Helen had overseen the Children's Centres in the Borough being classified as outstanding and 88% of the Schools classified by Ofsted as good or outstanding

The Chair reminded the Board that Helen had championed the voice and viewpoint of children and young people by constantly asking whether there had been any consultation with them or their groups, if the impact had been assessed on the young specifically, the safeguarding of young people and the needs of looked after children. A great testimony of Helen's passion was that rather than needing to be reminded, Partners now automatically had children and young people on their radar when developing strategies or service changes.

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HEALTH AND WELLBEING BOARD

27 September 2016

Title: "Our Health, Our Borough" Joint Strategic Needs Assessment (JSNA) 2016	
Report of the Corporate Director of Adult & Community Services	
Open Report	**For Decision**
Wards Affected: All	**Key Decision:**
Report Author: Dr Fiona Wright, Consultant in Public Health	**Contact Details:** Tel: 020 82273952 Email: Fiona.Wright@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	

This paper aims to do three things. It gives assurance to the Health and Wellbeing Board (HWB) board that it has discharged its duties in relation to the Joint Strategic Needs Assessment (JSNA). It will also highlight key findings of the JSNA 2016 in the context of key strategies and priorities for the borough. Finally it will make recommendations for the JSNAs for 2016 and 2017.

Summary

The London Borough of Barking and Dagenham (LBBD) faces many challenges and opportunities. It continues to experience deprivation with high rates of unemployment. The demography comprises of a young, mobile population, that is fast growing. The health of our residents is not as good as we would like it to be. A key health issue and outcome that continues to be of concern is inequalities in life expectancy and, more specifically, healthy life expectancy for which Barking and Dagenham residents continue to be below the London average. There have also been changes in the policy context since last year.

Inequalities are addressed through: improving the access and quality of health and care, prevention policies such as behavioural change and, to achieve the greatest long term impact, by tackling the social determinants of health. This document briefly outlines the approach of the JHWS and the strategies of partners in responding to the local health and wellbeing challenges, including addressing inequalities and their determinants.

The JSNA refresh for 2016 has taken a similar approach to last year. It comprises 90 sections describing the health and wellbeing of local residents and related commissioning recommendations. Led by public health, it was developed by partners and fulfils the statutory guidance for the HWB.

This paper summarises some of the key data linked to selected strategic priorities of the JHWS and key partners for each stage of the life course. The complete on line JSNA resource will contain further detail on these and other priorities and commissioning intentions.

The final section of this paper discusses potential next steps for the JSNA in 2016 and 2017.

Recommendation(s):

The Health and Wellbeing Board is recommended:

(i) To consider the implications of the findings of the JSNA in the development of strategies of partnership organisations

(ii) To support the commissioning of services by partner organisations that align with the JSNA findings and the Joint Health and Wellbeing Strategy (JHWS).

(iii) To assess the impact of the JSNA on the Delivery Plan of the JHWS by March 2017.

(iv) Require that in-line with statutory requirements the Public Health Department lead an update and refresh of the JSNA in 2017 to inform commissioning in 2017/18.

Reason(s):

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

1 Introduction and background

The purpose of this paper

This paper aims:

- To assure the Health and Wellbeing Board (HWB) board that it has discharged its duties in relation to the Joint Strategic Needs Assessment (JSNA)
- To highlight key findings of this JSNA 2016 in the context of key strategies and priorities for the borough.
- To make recommendations for the JSNAs for 2016 and 2017.

Our approach to the JSNA in 2016

Since 2007 local areas have been required, by statute to produce a JSNA as outlined in the Local Government and Public Involvement in Health Act 2007[1] and the Health and Social Care Act 2012[2] [3]. Local authorities and CCGs have equal and joint responsibilities to prepare JSNAs through the health and wellbeing board (HWB). The JSNA identifies the current and future health and wellbeing and social care needs of the population for the area of the HWB. It should include demographics, needs of disadvantaged groups and areas and wider social and environmental factors. It is key to driving strategies, priorities and commissioning of Joint Health and Wellbeing Strategy (JHWS) and partners. Our approach, this year, in line with this guidance is similar to the JSNA in 2015 that was well received. Led, by the public health department, the JSNA comprises contributions from the officers and the partners of the health and wellbeing board. The more than 90 sections comprise the most up to date information available, through the life course and on topics across the priorities of the HWB and partners. As such it provides a detailed, publicly available online resource for partners and the public and discharges the responsibility of the HWB.

The structure of this paper

This paper briefly outlines the challenges and opportunities in Barking and Dagenham in 2016. It then explores these in more detail: policy context and our developing strategies, demographic changes, inequalities in health and approaches to addressing health inequalities. A section summarising our population and their health and wellbeing includes: demographics, the key outcomes of life expectancy and healthy life expectancy as well as up to date data from this year's JSNA on selected priorities across the life course linked to our key strategies.

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[1] legislation.gov.uk, Local Government and Public Involvement in Health Act 2007, 2007 c. 28 Part 5 Chapter 1Section 116 [Online] available from: http://www.legislation.gov.uk/ukpga/2007/28/contents [Last accessed; 18 August 2016]
[2]legislation.gov.uk, Health and Social Care Act 2012, 2012 c. 7, PART 5 ,CHAPTER 2, Joint strategic needs assessments and strategies [Online] available from: http://www.legislation.gov.uk/ukpga/2012/7/part/5/chapter/2/crossheading/joint-strategic-needs-assessments-and-strategies [Last accessed: 18 August 2016]
[3] Statutory guidance 2013 - DH

The challenges and opportunities we face in Barking and Dagenham 2016 and beyond – a brief overview

This section sets a brief context of demographic changes, health challenges and policy changes. Further sections of the report expand on these issues notably section 3.1 (demographics), section 2.2 (our key strategies) and section 3 on the health and wellbeing of our residents.

Barking and Dagenham continues to be one of the fastest growing boroughs. It has a very young population and a mobile and changing population.

Whilst progress is being made on many fronts, our population still have poor health, social and economic outcomes. There are big inequalities, for example the life expectancy of residents in Barking and Dagenham is lower than any other London borough. The levels of employment and skills of our residents are well below the London average. Some population groups in Barking and Dagenham are particularly likely to suffer poor health –such as the homeless, people with severe and enduring mental illness, or victims of domestic violence.

The policy context of 2016 is challenging. We sit in a national context of economic challenges and policy changes, such as welfare reforms and the funding of the public sector. The council, for example if austerity continues, by 2020 will be spending half of what we spent in 2010. These changes mean that we have to find new ways of delivering services.

At a local level there are also opportunities. Barking and Dagenham has strong partnerships and is developing new approaches to integrated care and localities and is a NHS innovation test bed (Care City). One of our growth areas - Barking Riverside – is, appointed by NHS England as London's only Healthy New Town. We are London's Growth opportunity to which end we commissioned the Growth Commission report – a central tenet of which is to ensure there is "no one left behind" in maximising the opportunities of growth.

The next section outlines an approach to addressing inequalities and further describes our key strategies.

2 "No one left behind"- addressing inequalities

2.1 A multi faceted approach to addressing inequalities

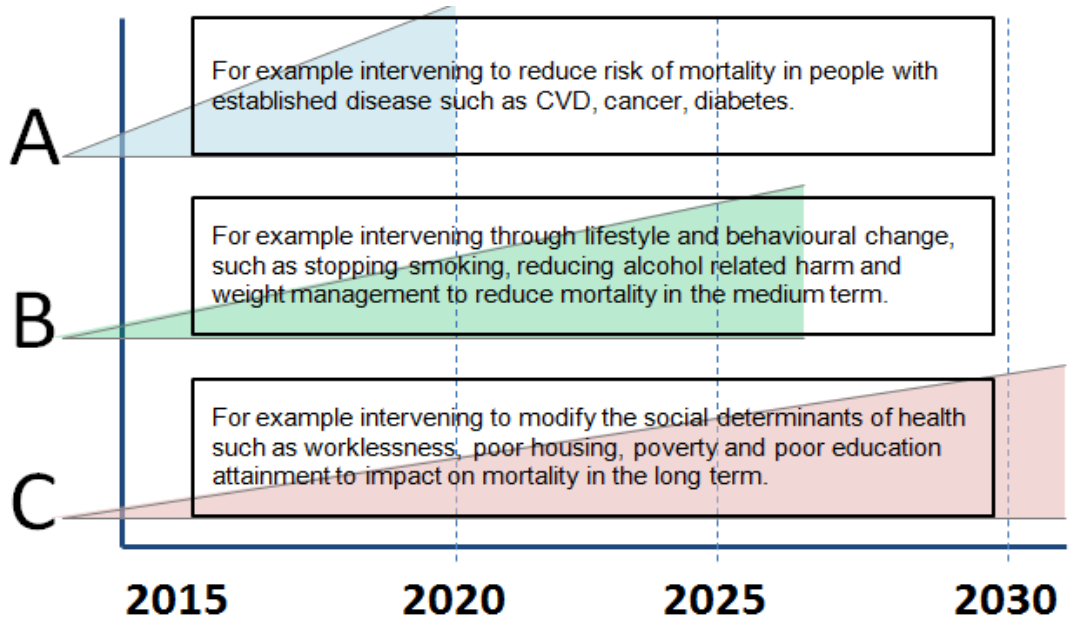
A fundamental aim of the JHWS and all partners' strategies is to reduce inequalities. As shown throughout this paper, these exist between our residents when compared to London or England and between population groups within the borough.

Figure 1 shows the three approaches to reducing health inequalities and their comparative impact over time.

- Intervening to reduce risk of death in people with established disease –***eg improving quality and access to health and social care***. This has the greatest impact in the *short term*
- Intervening through lifestyle and behaviour change, such as stopping smoking, and weight management – ***prevention*** - to reduce mortality in the *medium term.*
- Intervening to modify the ***social determinants of health*** such as worklessness or poor housing – to impact on mortality in the *long term.*

These approaches derive from the former Health Inequalities National Support Team and have been used widely in national strategies. The next section demonstrates how local strategies and policies embed these three approaches to improve the life chances for everyone in LBBD.

Figure 1: Health Inequalities, Different Gestation Times for interventions



Adapted from: Health Inequalities National Support Team (2009)

2.2 Our key strategies

This section outlines key strategies for partners.

Joint Health and Wellbeing Strategy

The JHWS 2015-2018 was updated in August 2015. It set key outcomes:

- Improving life expectancy
- Reducing the gap in life expectancy between LBBD and London
- Improving health and social care outcomes through integration of health

Based on evidence of need from the JSNA 2014, partners priorities, value for money and achievability the JHWS outlined top priorities for improving health and wellbeing of all the people who live and work in the borough.

The JHWS sets priorities under the key themes of:

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

Social determinants of health - such as educational attainment and health and the built environment cut through these themes and there was a set of actions for supporting vulnerable and minority groups.

In line with the Marmot Review, the strategy also takes a life course approach covering the life stages of: pre birth and early years, primary school children, adolescence, maternity, early adulthood, established adults, older adults. The strategy is supported by a deliver plan.

The Corporate Plan and the Growth Commission Report

The council's corporate vision is: "one borough, one community, London's growth opportunity". The aim is to encourage civic pride, enable social responsibility and grow the borough. To this end they also commissioned an expert report the "Growth Commission". The Growth Commission Report: "No-one left behind": in pursuit of growth for the benefit of everyone recommends goals to improve health and life expectancy as well as social determinants. Through these ambitions the council is prioritising:

- **Social *determinants of health*** – such as protecting green and public open spaces, increasing educational attainment. These are central to the Growth Commission report of regeneration, new homes, new jobs, culture and heritage.
- **Prevention** e.g. behaviour change campaigns for obesity, smoking, substance misuse, teenage pregnancy and vaccinations.
- **Integration *and care*** – e.g. calling for integrated services for vulnerable children and young people.
- **Safeguarding** –The council has also recently refreshed its Corporate Plan that outlines more details of these commitments. The council is also developing a borough manifesto. It is also revising the Local Plan for the Borough.

Sustainability and Transformation Plan (STP)

The visions for the STP are:

- Improving the health and wellbeing outcome for NEL, ensuring ***sustainable health and social care services*** built around the needs of local people
- New models of care with better outcomes – focusing on ***prevention*** and out of hospital care.

Priorities are promotion of ***prevention and self-care*** and improving primary care and reforming acute services. Whilst not explicit in these visions: a number of priorities for the STP relate to inequalities and ***social determinants of health*** such as employment and improving the physical environment and housing.

Developing an integrated care model

Locally we are working across Barking and Dagenham, Havering and Redbridge to develop an approach to integrating and commissioning care for the area. Priorities for this model include: stronger communities ***(social determinants of health)***, investment in ***prevention*** and ***improved health and social care through integrated high quality care pathways*** and improved access and a locality delivery model of care.

3 Our people and their health and wellbeing. Key findings of the JSNA 2016

There are three parts to this section. 1) The first summarises the latest demographic information. 2) The second gives key messages about the key outcomes: healthy life expectancy and life expectancy. 3) Subsequent sections describe key messages under each stage of the life course.

3.1 Population growth and changes in our population from 2011 to 2030

Changes in the population 2001 to 2015

The population of the borough has increased by 21.9% between the 2001 Census and 2015 ONS mid-year estimates to 201,979.

In relation to age: the borough has the highest population percentage of children and young people aged 0 to 14 (at 26 %) in England and Wales. The number of over 65s has reduced over this time. Crucially, the number and proportion of our residents over 85 has increased.

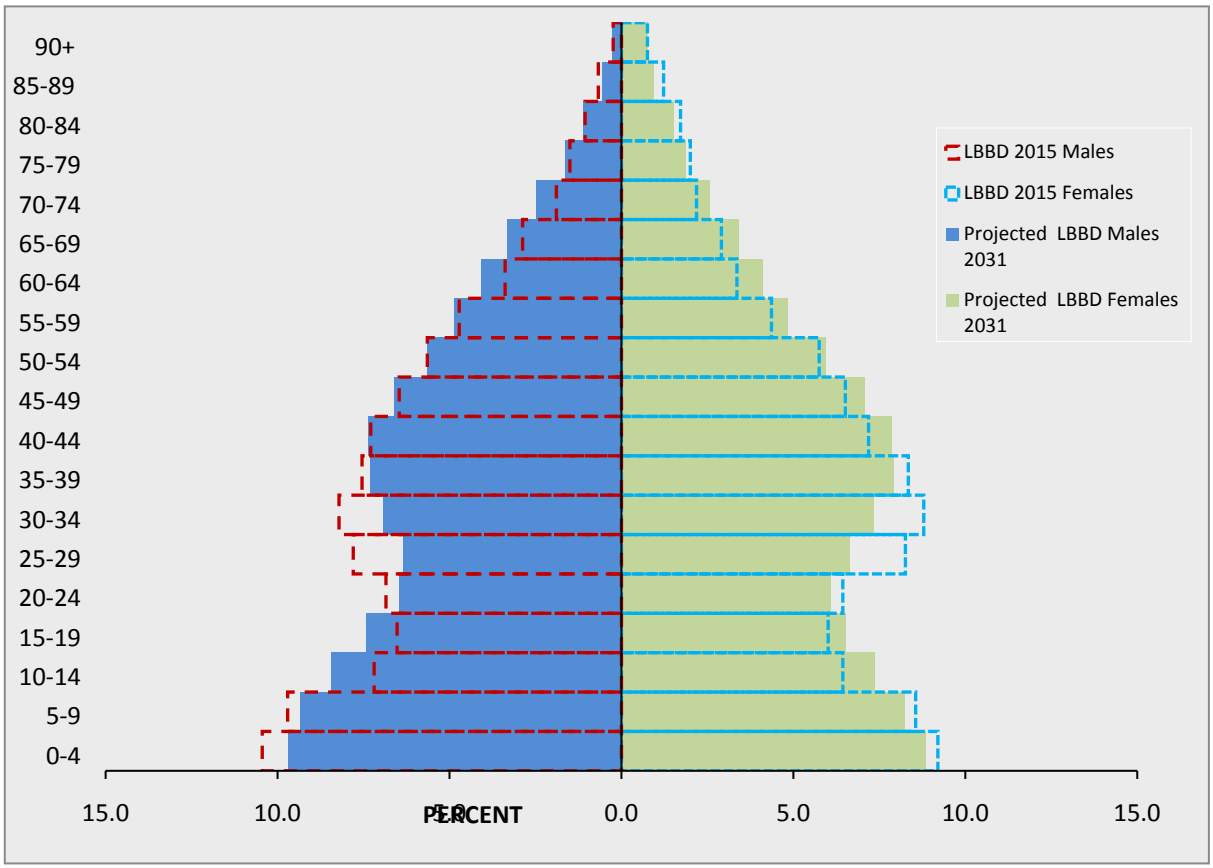
The ethnic composition of the borough has changed. There has been a large decrease in the white population from 80.9% in 2001 to 49.5% in 2011 and to 45.0% in 2015. In particular, the Black African population has risen from 4.4% in 2001 to 15.4% in 2011 and 16.2% in 2015. This is the second highest proportion of this population group within a local authority across England and Wales. The Bangladeshi population has rise from 0.4% (2011) to 4.8% of the population in 2015. There has also been a sharp rise in the number of eastern European residents. Estimates suggest that in 2015 45% are white British and 55% are from Black and Minority Ethnic Groups (BME).

Socio-economic changes over this time include: a rise in private renting, a reduction in people with no qualifications and an increase in lone parent households. LBBD now has the highest percentage of lone parent households (14.3% of households) in England. The relative deprivation of the borough has changed from a rank of 22nd to 12th (Index of Multiple Deprivation) in the country and 7th to 3rd in London.

Predicted changes in the population 2015 – 2030

Figure 2 shows the population pyramid for LBBD for males and females comparing 2015 with 2030. It includes assumptions for example in relation to fertility rates, death rates, inward and outward migration as well as information on housing developments in growth areas.

Figure 2 LBBD 2015 vs Projected LBBD 2031



Source: GLA Witan, 2016

- Barking and Dagenham in 2031 is projected to have fewer young children aged 0-9 years, and fewer young adults aged 25-34 years (reducing from 16.5% to 13.7% of the total population).
- The reduced number of children will be as a result of a significantly lower young adult population; an age group responsible for 59% of all births nationally.
- The proportion of older adults is also projected to increase, particularly females age 40-74 years and males aged 60-74 years.
- These changes are expected to occur due to the borough becoming less deprived, leading to a lower birth rate, and a higher proportion of older people

Predicted population size within the "growth areas"

The growth areas include a total of 28,084 new homes (the largest include13,865 Barking Riverside and surrounding areas, 4,568 in the South Dagenham area, 5,716 in Barking Town Centre). This equates (assuming 2.7 people per home) to 75,827 residents[4].

In Barking Riverside specifically, under the Healthy New Town programme, detailed modelling of population and health needs is being undertaken to inform the infrastructure plans for the development. The modelling suggests that the population will be younger, with a higher proportion BME than Barking and Dagenham as a

[4] Source: LBBD Planning

whole. This is based on assumptions based on information on those who have moved in to date and from other similar developments. However they must be treated with caution as multiple, as yet unquantifiable, factors may impact on the future demographics of this population.

Predicted health needs

Different national data sets and tools predict specific health needs. For example:

- People living with sight loss is expected to increase from 4,050 to 5,180 between 2015 and 20305
- Prevalence of cancer is expected to increase from about 3,500 to 5,500 or 7,000 (dependant on different assumptions about incidence and survival) between 2010 and 20306
- People with dementia over 65 is expected to increase from 1,502 in 2014 to 1,842 in 2030 7

3.2 Life expectancy and health life expectancy

- Both females and males in Barking and Dagenham live shorter than females and males live in London and England. Life expectancy in Barking and Dagenham (77.6 years for males and 82.1 for females, 2012-14) is lower than in any other London borough.
- There is a gap in life expectancy for females and males between LBBD and London and England. For females this was closing until 11/13 but unfortunately it has widened again as women's life expectancy in LBBD has fallen. For males, there has been a widening of the gap in life expectancy between London and LBBD.
- Healthy life expectancy (the years lived in good health) in Barking and Dagenham for males is 4 years and for females is approximately 9 years lower than the England average. This has a significant impact on the quality of life for residents it also has a significant impact on how residents manage their own health and use health services.
- With a healthy life expectancy of only 54.6 years and life expectancy of 82.1 years women in Barking and Dagenham live 27.5 years with chronic health issues before they die (2012-14).
- The most common causes of premature death (under 75 years old) in men, in descending order is: coronary heart disease (CHD), lung cancer and chronic obstructive pulmonary disease (COPD). For women, the top three causes are: lung cancer, CHD and breast cancer.

[5] Source: RNIB Sight Loss Data Tool version 3
[6] Source: PHE – LCI and MCS
[7] Source: Projecting Older People Population Information System (POPPI)

3.3 Pre-birth and early years

Early years lay a foundation for health and wellbeing for the rest of the life course. The Health and Wellbeing Board are working in partnership to provide children with the best start in life. The impacts of early years behaviours like breastfeeding and healthy weaning, exposure to cigarette smoke or domestic violence can impact children throughout their lives. In Barking and Dagenham, 37% of children live in poverty. This figure is equal to the London average but much higher than the England rate of 28%. This can have a huge impact on a child's start to life, and to future educational achievement and employment prospects. **JHWS priorities are shown in bold.**

Level of development

We want our children to start well and this means having a good level of development.

Our data:

- In 2015, 67.8% of our children achieved a good level of development, a 7.8% increase on 2014 results.
- Overall girls are doing much better than boys (76% compared to 60%).
- There are some groups of children that need extra focus, in particular White British children, with White British girls doing slightly worse than White British boys.
- Children who had attended at least 12 sessions at a Children Centre were more likely to achieve a good level of development than those who had not.

Our priorities and strategies:

- **Our children to start well – this means having a good level of development (social determinant of health).**
- **An integrated early years service from conception to age 5 (improvement and integration of services)**

Immunisations

Immunisation of children against preventable infectious diseases is not only essential to maintaining individual child health, but also the health of the family and children in the wider community.

Our data:

- Uptake of immunisation in our children has improved significantly and moved substantially closer to the local target of 90% uptake.
- Uptake still remains below the national target of 95% across all childhood immunisations.
- The gap for 5 year old immunisations in some cases is up to 10% lower than the national average

Our priorities and strategies:

- A priority within the Council's corporate indicators.
- Improvements are underway but we have not yet achieved the target, especially in 5 year olds.

- **Our children to be protected against diseases that we can prevent (improvement and integration of services)**

Dental health

Poor dental health in children will contribute to dental problems in later life through dental decay, gum disease and associated problems with pain and infection.

Our data:

- The dental health of our 3 year olds is much worse than in the rest of England.
- On average our children have 3.5 decayed, missing or filled teeth, well above the England average is 3.1 (2013 survey).
- Our 5 year olds have a higher level of decay than London and England with one in every three children having a decayed tooth.
- Our Asian children have particularly high rates of decay and untreated disease.

Our priorities and strategies:

- We are developing an oral health strategy to address this issue.
- **Our children to have regular check-ups and less dental decay (improvement and integration of services)**

Accident and emergency attendances and hospitalisation in 0-5 years

The leading causes of attendances at Accident and Emergency and hospitalisation amongst the under 5s include illnesses such as gastroenteritis and upper respiratory tract infections, along with injuries caused by accidents in the home. Around half of under 1 year olds visit an Accident and Emergency department, leading to 1 in 3 being admitted[8].

Our data:

- There were 758.3 A&E attendances for those aged under 5 in Barking and Dagenham in 2014/15 per 1,000 population. This is higher than the London average (681.9) and the national average (540.5). The figure for LBBD also represents an increase from the previous year's figure.
- In 2012-14, the infant mortality rate was 4.4 per 1,000 live births in the borough. This is higher than that seen nationally (4.0) and in London (3.6) for the same time period.

Our priorities and strategies:

- **An integrated early years service from conception to age 5 (improvement and integration of services).**

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8 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413133/2902452_Early_Years_Impact_5_V0_1W.pdf

3.4 Primary school children

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

Childhood obesity, healthy diet

We particularly want to protect our children against becoming overweight and obese. Childhood obesity is known to be linked to poorer health in later life particularly heart disease and diabetes.

Our data:

- Barking and Dagenham has the highest proportion of overweight and obese children in Reception class (27.5%) among all London local authorities. This has increased slightly (0.7%) compared to the previous year. (Source: NCMP 2014/15).
- The percentage of overweight or obese children in year 6 fell by 1.6%, and is the 7th highest rate among London local authorities.

Our priorities and strategies:

- Improving lifestyles and behaviours in children in relation to drugs, alcohol, obesity, physical activity and diet are prominent priorities within: the council corporate plan, JHWS and STP
- We have developed a Healthy Weight Strategy
- **Our children to be more active and eat healthier diets (prevention).**
- **More children are taking regular physical activity (prevention)**

Mental health

Child and adolescent mental health is in section 3.5 Adolescents: Emotional and mental health

3.5 Adolescence

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

Teenage pregnancy

Our data:

- We have the 2nd highest teenage pregnancy rate in London, this is higher than England average.
- Conception rates are falling: from 40.1 to 32.4 (pregnancies per 1,000 women aged 15-17) from 2013 and 2014 respectively.
- The borough's Teenage Pregnancy rate is declining at a faster rate than regionally and nationally.

Our priorities and strategies:

- **Empower adolescents to make informed choices about their sexual and emotional health (prevention).**

Educational attainment/NEETS (Not in Education, Employment or Training)

There is a strong link between NEETs and poor health outcomes.

Our data:

- There were 512 recorded NEETS in LBBD in 2016. There has been no change in these levels since 2013/14.
- Of Young people aged 18-24 in LBBD, 3.6% were claiming either Jobseekers Allowance or Universal Credit. This is much higher than London average and the average of any other borough in London (May 2016 data).

Our priorities and strategies:

- **To continue to improve the educational attainment of children and young people in our borough (social determinant of health).**

Smoking and drinking

Smoking results in short term harm such as impacting on respiratory function. Moreover, most young people who smoke regularly continue to smoke throughout adulthood. Drinking during childhood, particularly heavy drinking is associated with a range of problems including physical and mental health problems, alcohol-related accidents, violence, and anti- social behaviour.

Our data:

- We estimate that up to 27% of local young people between the ages of 11 and 19 (mainly in the older group) smoke regularly.

- A Young Peoples specific service, Subwize, engaged with 309 individuals, 264 were under the age of 18 (2015-16). Alcohol was stated as their main problem substance for 36% of these young people, the youngest of these being 11 years old.
- Most of the referrals were White British. Women and BME groups were under represented.
- Alcohol related hospital admissions for the under 18s in LBBD are lower than the London and national average.

Our priorities and strategies:

- We want to prevent our teenagers starting as well as support them in stopping.
- This is a priority in the STP and a Council key indicator.
- **Fewer adolescents to smoke and/or problematically use alcohol (prevention).**

Emotional and mental health

We want to empower our adolescent residents to make informed choices about their sexual and emotional health, including issues linked to preventing child sexual exploitation. Mental health problems in childhood and adolescence can have tragic circumstances.

Our data:

- There are 7,188 children and adolescents with diagnosable mental health problems.
- The most common conditions are emotional disorders, conduct disorders and hyperkinetic disorders.
- Vulnerable children (such as from homeless families or families affected by substance misuse and looked after children) are more likely to suffer mental ill health.

Our priorities and strategies:

- A key local and national policy priority is to ensure parity of esteem with physical health.
- We have recently undertaken a CAMHS needs assessment to further inform priorities.
- We have developed and agreed a Local Transformation Plan for Child and Adolescent mental health. This is due to be refreshed in October 2016.
- **More adolescents have developed coping and rebound skills to manage life stresses.**

3.6 Maternity

Early antenatal booking

Early antenatal booking is recommended to ensure that women do not miss out on interventions, monitoring or screening that might benefit their health and their babies. Socially disadvantaged groups are less likely to book by 12 weeks.

Our data:

- We have seen an improvement in booking before 12 weeks. 8 out of 10 women (2014 data) compared to 6 out of 10 women (2013) saw a midwife within 12 weeks.
- However data for England in early 2014 9 out of 10 women saw a midwife within 12 weeks.

Our priorities and strategies:

- **High quality care and support during pregnancy.**
- **The majority of women to take up the opportunity of antenatal screening**
- **More women in pregnancy from vulnerable groups to have dedicated support**.

Smoking

Our data:

- In the first quarter of 2015/16 around 9 in 100 women who gave birth in the borough were smokers. Although the percentage is reducing, it remains the highest level in London.

Our priorities and strategies:

- Fewer of our parents to expose their children to cigarette smoke during pregnancy.

Breastfeeding

Breast feeding has a number of benefits for mother and child including increasing immunity for the child and reducing risk of obesity in later life.

Our data:

- In recent years an increasing number of Barking and Dagenham mum's are choosing to breastfeed but mums in Barking and Dagenham are still less likely to breastfeed than mums in London.
- Barking and Dagenham has relatively low breastfeeding initiation rates (78%) compared with London and England (86.1% and 74.3% respectively).

Our priorities and strategies:

- Breast feeding rates are improving. We now want to target white British mums, mums from lower socio economic groups who are less likely to breast feed.
- **More infants are breast fed in the first months of life.**

3.7 Adulthood

3.7.1 Changing lifestyle behaviours.

Lifestyle and behaviour change is a key way to improve life expectancy that will have an impact in the medium term. To address health inequalities interventions must be universal but with an intensity according to the level of disadvantage in addition to targeted interventions for some specific vulnerable groups.
Targeting certain disadvantaged groups who have Changing lifestyle behaviours (Obesity, smoking, substance misuse, Teenage pregnancy) are key priorities of the plans of the council, STP, integrated model of care as well as JHWS.

Smoking

More than half of the inequality in life expectancy between social classes is now linked to higher smoking rates amongst poorer people. In our borough smoking has a significant impact on life *expectancy.*

Our data:

- The smoking prevalence in LBBD, whilst reduced, remains the highest in London (2013).
- Deaths from smoking in people over 35 years is also the highest in London (2011-13 data).
- 9 out of 10 deaths from lung cancer are attributable to smoking. This is the leading cause of premature death in women, and second highest cause in men.
- Hospital admissions attributable to smoking are much higher than London and England at 2,001 for LBBD compared to 1,608 and 1,688 per 100 000 population for London and England respectively.

Our priorities and strategies:

- This is a priority in the council corporate plan, priority for prevention in the STP and key to the integrated model of care.
- A Tobacco Control Strategy has been developed.
- **Fewer adults smoke/or problematically use alcohol (prevention).**

Weight and diet

After smoking, obesity is one of the most important risk factors to being healthy for our residents.

Our data:

- Over two third of adults in the borough are overweight (68.4%) compared to 58.4% in London and 64.6% in England (PHOF estimates 2012-2015).
- Also according to QOF 2014/15, 11.5% of adults in LBBD are obese; this is higher than London average of 7.3% and the national average of 9%.

Our priorities and strategies:

- **More adults have a healthy weight and have access to healthy food/produce (prevention)**
- Key strategies prioritise referral to healthy lifestyle programmes and health and the built environment.
- A Healthy Weight Strategy has been developed.

Physical activity

Our data:

- Only 15% of Barking and Dagenham's population in physical activity for at least 30 minutes participate 5 times per week with nearly 45% participating once per week.
- There is also low utilisation rates of our green spaces.

Our priorities and strategies:

- *There* is *a corporate priority to increase leisure centre attendance.*
- There is an STP priority for use of green spaces and the built environment.
- Healthy New Towns focus on developing green spaces.
- A Healthy Weight Strategy has been developed.
- **More adults to take regular physical activity including cycling and walking (prevention)**

3.7.2 Early intervention and prevention of long term conditions.

Cancer, heart disease and chronic obstructive airways diseases are the major causes of premature death in our residents. Early diagnosis and intervention for people with established disease and screening programmes improves quality of life and reduces mortality by identifying disease early. The NHS Health check programme is a key mandatory programme identifying diabetes, heart disease, high blood pressure and stroke to support early identification and appropriate interventions. Cancer screening programmes are key. These are priorities within our key strategies and performance indicators. For example: empowering our residents to manage their own condition is fundamental to the STP and the integrated model of care. NHS Health checks and cancer screening programmes are priority indicators for the council and the JHWS.

This section now summarises key data from the JSNA for long term conditions (cancer, cardiovascular diseases (including diabetes, heart disease and stroke).

Cancer

Our data:

- Cervical screening rates improved between 2012/13 and 2013/14 and then declined in 2014/15 by 1.6% compared to the previous year.
- Similarly Breast cancer screening rates increased slightly between 2012/13 and 2013/14 from 64.3% to 65.1% followed by a decline to 60.4%. This is lower than the level for England (72.2%).
- The rate of uptake for bowel screening in LBBD has gradually improved over the last few years, increasing from 35.1% in 2009/10 to 43.2% in 2014/15. However it is still much lower than the national target of 57.9% and is also low 7th lowest between all London boroughs.
- Cancer deaths are falling nationally but, unfortunately, in Barking and Dagenham it is continuing to rise.
- Lung cancer is the most common cause of death in our Barking and Dagenham residents with smoking causing 9 out of every 10 lung cancer deaths.
- The rate of premature death from lung cancer in Barking and Dagenham is higher than London and 50.3% higher than England.
- The one year survival rate for all cancers in B&D in 2013 (64.9%) was the second lowest in London after Newham, much lower than London rate of 70.9% and the England rate of 70.2%.

Our priorities and strategies:

- We want to increase screening uptake and early diagnosis of cancer. Key priorities for the JHWS and the STP are early diagnosis of cancer and improvement of cancer screening for breast, bowel and cervical cancer.
- **More adults to take up the offer of screening for cancers including breast, bowel and cervical.**
- **More adults with the early signs of chronic disease to be identified in primary care and start treatment and care.**

Diabetes

Diabetes is a major public health problem, with approximately 10% of the NHS budget spent on diabetes care. 90% of adults with diabetes have Type 2 or adult onset diabetes. Unhealthy diet, low physical activity and obesity are major contributors to Type 2 diabetes.

Our data:

- In 2015 there were 11,013 people aged 17 years or older who had a diabetes diagnosis. This is equivalent to 7.3% of this age group compared to 6.4% for England.
- This is a 4.0% rise on March 2014 data(10,629) although this is most likely due to increased detection.
- The rate of emergency diabetic admissions in known diabetics is higher than London and England.

Our priorities and strategies:

- We want to increase the number of people identified with pre diabetes and prevent them from developing diabetes. A key priority for the STP is diabetes prevention.
- We aim to focus on improving the quality of care and support for people living with diabetes as well as empowering our residents to manage their own condition.
- **Improve services for people living with long term conditions.**
- **More adults with the early signs of chronic disease are identified in primary care and start treatment and care.**

Stroke

Residents who do have strokes in Barking and Dagenham are likely to have severe strokes, and are more likely to die under 75 years of age.

Our data:

- The prevalence of stroke is 0.91% across Barking and Dagenham; significantly lower than the national rate of 1.73%.
- Stroke related emergency hospital admissions have increased in Barking and Dagenham between 2003/04 and 2014/15, whilst for the same period England saw a decline.
- Mortality rates for stroke in people aged 65-74 years old and for men of any age is higher than the London and England average.

Our priorities and strategies:

- NHS Health checks identify people with stroke risk factors to enable proper consideration of evidence-based lifestyle advice and treatments where indicated.
- The NHS Health check is a mandatory programme and a corporate priority for the council.
- It is a priority to ensure GP stroke registers are up to date and blood pressure monitored regularly.
- **Improve services for people living with long term conditions.**
- **More adults with the early signs of chronic disease are identified in primary care and start treatment and care.**

Respiratory diseases e.g. chronic pulmonary disease

Our data:

- Barking and Dagenham has the 3rd highest prevalence of COPD among the 32 London boroughs at 1.64% (2014/15 data).
- LBBD had the highest rate of hospital admissions for COPD (370 per 100,000 population) of all the boroughs in outer North East London. This rate is more than double the England average at 200 per 100,000 population (2011-12 data).
- Premature mortality rate from respiratory conditions was at 31.6 per 100,000; considerably higher than that of London and England (17.1 and 17.8 respectively) (2014/15 data).
- Currently, an estimated 47% of patients with diagnosed COPD continue to smoke.

Our priorities and strategies

- **Active case finding: around a half of all patients with COPD remain undiagnosed.**
- **Fewer adults smoke/or problematically use alcohol (prevention).**

3.7.3 Health and care system

The JHWS aims for more adults to have access to community based urgent care services in ways that suit their work/life balance and to avoid unplanned hospital care. For our residents the effective management of chronic conditions in primary care is important.

Our data:

- Barking and Dagenham CCG has the 3rd highest unplanned hospitalisation rate in London (1,054 per 100 thousand, or just over one admission per 100 residents in 2014/15), and is ranked 40th among 209 CCGs across England.
- The rate varies between wards, Heath (1,560) had the highest rate per 100 thousand population in 2014/15, while Chadwell Heath (826) and Mayesbrook (846) had the lowest rates.

Our priorities and strategies:

- Other key JHWS and council key performance indicators relating to the health and care system include: direct payments for social care, delayed transfer of care, unplanned hospitalisation, A and E attendances.
- **More adults with the early signs of chronic disease are identified in primary care and start treatment and care.**
- **Improve services for people living with long term conditions.**

Mental health

Severe and enduring mental health is in section 3.9 Vulnerable and minority groups

3.8 Older adult priorities

The health and wellbeing of this group is often characterised by an increasing dependency on support, as individuals' age and become frailer. Health deteriorates for many of our residents in older age. Older residents are more likely to fall or to have poor eye health. The impact of social isolation, poverty and the lifetime effects of health risk behaviours such as smoking, all contribute to an older person's health and wellbeing. There is no avoiding that old age is followed by death, and providing individuals support and dignity in dying is an important part of the health and social care agenda.

Health and care system

In the future there will be an increase in the numbers of people with diabetes, stroke, heart disease and arthritis needing care as well as larger increase in the number of residents with dementia needing care. The demand from those with moderate or severe need for social care is estimated to increase by 90%.

Our data:

- An analysis of resident's use of social care between 2008 and 2012 found that although demand for services fell in the period, Barking and Dagenham still has more service users than its comparator boroughs.
- There was a 17% fall in the number of older people using community based services. The use of residential and nursing care services remained stable.

Our priorities and strategies:

- Frail elderly adults to be supported to live independently.
- Key JHWS and council key performance indicators relating to the health and care system include: direct payments for social care, delayed transfer of care, unplanned hospitalisation, A and E attendances and older people's permanent admissions to residential homes.

Older people mental health

Older people (aged 65 years and over) may have additional needs and experience poor outcomes if those needs are not met.

Our data:

- Depression is almost twice more common in older women, than in older men in Barking and Dagenham.
- The number of cases of severe depression is projected to increase among residents aged 65-69 years. This will likely be a result of projected population growth in this age group over the coming years.

Our priorities and strategies:

- The JHWS aim is for mental health services for older people to have parity of esteem with physical health services.
- **Residents with dementia to be on a GP register and to have access to the services they need.**

Falls

Our data:

- In Barking and Dagenham every year our residents over 65 years old have around 7,000 falls.
- In 2014/15, 383 people aged over 65 suffered injuries due to falls, (1,656 per 100,000), this is lower than both the London rate of 2,253 and the national rate of 2,125 per 100,000 population aged over 65 years.
- Barking and Dagenham have around 9,400 falls made by residents aged over 65 years each year.
- Of those 9,400 around 4,060 will fall twice or more in a year. Additionally, according to Public Health England, 526 individuals attended A&E, many of these are preventable.

Our priorities and strategies:

- A JHWS priority is for fewer older adults injured through accidents in the home, particularly falls.

End of life care

Our data:

- Many more of our residents (56.3%) die in hospital than is the case for England as a whole (48.7%).
- Of deaths in other places a similar percentage die at home (22.7% Barking and Dagenham, 23% England) and fewer die in a care home (14.2% Barking and Dagenham compared with 20% England). It may be that our care homes are less well able to care for people who are dying and residents of care homes are more likely to go into hospital to die.

Our priorities and strategies:

- With active case finding and good disease management the majority of these deaths could be anticipated and the end of life adequately planned for.
- A JHWS priority is for adults who are terminally ill to die with dignity in a planned supported way.

Eye health

- Visual impairment is a common consequence of ageing. Nearly two thirds of visually impaired are women. People from BME communities are at greater risk of some leading causes of sight loss. Most people with severe visual impairment are over 65.

Our data:

- The estimated rate of common conditions leading to blindness or partial loss of sight is higher in LBBD than in London or England.
- The proportion of people registered as blind or partially sighted in LBBD is lower than London or England.

Our priorities and strategies:

- A scrutiny review of eye health was undertaken 2014-15
- An eye health strategy is being implemented 2016 -17.

3.9 Vulnerable and Minority Groups

Addressing of needs of vulnerable groups with poorer health outcomes is key to addressing health inequalities. Understanding these needs is an important aspect of the JSNA. This section summarises some of the information from the JSNA in relation to key vulnerable groups.

Looked after children

Our data:

- The trend in previous years shows increasing numbers of looked after children in the borough, however this has now stabilised at 455.
- Of the looked after children in care the percentage that received a health check increased from 93% in 2014/15 to 94% in 15/16. This is above national and London averages (88% and 90% respectively).
- Dental checks for all looked after children have increased from 80% to 85%, and medicals from 75% to 82%.
- Eye checks declined slightly by 1% to 76%.

Our priorities and strategies:

- Dental, eye and health checks for all children in care remain areas for improvement.
- Improving health outcomes for looked after children, care leavers and youth offenders is a JHWS priority.
- Child and adult safeguarding and child protection plans are also key priorities in the council KPIs and JHWS.

Children with special educational needs

Our data:

- The proportion of children identified with special educational needs is lower in Barking and Dagenham than nationally.
- There has been a downward trend in number of children with special educational needs (SEN) without statements.
- The numbers of children with severe disabilities is growing nationally.
- In Barking and Dagenham this means paying particular attention to our disadvantaged residents and our Asian and Black African communities because they have a higher prevalence of young disabled children.

Our priorities and strategies:

- The JHWS priority is for our children with special educational needs to have their needs met and demonstrate improved educational and health outcomes.

Domestic violence

Our data:

- Domestic violence affects our children and adults and is the leading cause of ill health for women aged 19-44 years.
- Barking and Dagenham has the highest reported rate of domestic abuse offences in London in 2015/16.
- Using year to date totals, there were 2,568 offences in 2015/16 which represents an increase of 5.4% compared with 2,436 offences in 2014/15.
-
- Domestic abuse is a factor that features in 62% of the borough's open social care cases.

Our priorities and strategies:

- The JHWS priority is for our children's and adults domestic violence services to meet the needs of residents.
- Domestic violence is also a priority performance indicator for the council.
- **Children to be protected against Child Sexual Exploitation.**

Severe and enduring mental health issues and employment

The JHWS aim is for people with mental health issues to be dealt with on an equal footing to people with physical health issues. We also aim for vulnerable residents to have access to employment opportunities.

Our data:

- There were just under one in a thousand (or 0.76%) of Barking and Dagenham residents registered by GPs as seriously mentally ill in 2013/14, with a slight decrease (-.08%) in 2014/15.
- The London wide level of serious mental illness in 2014/15 increased by 2.14% (to 1.07%), compared to the previous year. Registration of serious mental illness locally may be less than expected in view of levels in other London boroughs with similar levels of deprivation.
- Throughout 2014/15 3.7% of adults in LBBD, who receive secondary mental health services, were in paid employment, this is low compared London and England averages (6.7% and 6.8% respectively).
- In August 2015 the borough had 8,090 residents claiming Employment and Support Allowance (ESA) benefit with around 43% of these claiming on the basis of mental health or behavioural related disorders.

Our priorities and strategies:

- The A key priority for the JHWS is for mental health services and pathways to explicitly consider access for individuals from minorities, including sexual orientation where there is evidence of enhanced need. The STP, ACO, council and JHWS all set as a priority the aim for more of vulnerable adults to have employment opportunities.
- **More of vulnerable adults to have employment opportunities.**
- We are developing a mental health strategy

Fuel poverty and affordable housing for older and vulnerable adults

Barking and Dagenham has developed an integrated Affordable Warmth Strategy for 2015/20, to deliver a holistic plan to mitigate against excess winter deaths, retrofit and insulate homes, encourage reduced energy consumption and promote access to lower energy tariffs.

Our data:

- Fuel poverty has risen slightly in the last few years but at a lesser rate than our comparator boroughs.
- The percentage of households in fuel poverty in LBBD has risen from 9.9% of households to 10.6% 2011 and 2014 respectively, this is in-line with the London average rate. The Council's interventions have prevented the number of households in poverty from rising. Tackling fuel poverty is to be embedded within the corporate delivery of services.

Our priorities and strategies:

- More older adults and vulnerable individuals to live in high quality and more energy efficient homes, protected from weather extremes.
- To increase the number of vulnerable adults identified by the annual Warm Homes, Healthy People programme.

Homelessness

Barking and Dagenham is one of the less wealthy London Councils and has a significant issue with homelessness. Homelessness directly links to health as homeless individuals and families are likely to be more unhealthy than the general population.

Our data:

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

Our priorities and strategies:

- A JHWS priority is to provide independence for our residents and tackle homelessness.

4 Next Steps for JSNA 2016 and 2017

The 90 sections of the JSNA provide a comprehensive description by partners of the HWB board of the needs and assets of the borough. This information should inform the development of key strategies and priorities of the HWB board and its partners as recommended below. Limited feedback on JSNA 2015 was that it was utilised and well received. We propose that we undertake more customer feedback of the JSNA 2016 and review the content and format for the 2017 JSNA.

5 Impact of Care Act 2014

The Care Act stresses the need to integrate health and social care services at all levels and is prescriptive about what it expects in terms of the JSNA and the Joint Health and Wellbeing Strategy.

6 Mandatory Implications

6 .1 Joint Strategic Needs Assessment

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

6.2 Health and Wellbeing Strategy

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

6.3 Integration

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

6 .4 Financial Implications

(Completed by Katherine Heffernan, Group Manager, Service Finance)

This report provides an update on the Joint Strategic Needs Assessment for Barking and Dagenham and identifies a number of priorities and recommendations. There is no new funding available to meet these recommendations and all action taken will be funded from within existing resources (which may require some level of prioritisation.)

6 .5 Legal Implications

There are no legal implications. (Completed by: Chris Pickering, Principal Solicitor, Employment and litigation)

6 .6 Risk Management

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

6 .7 Non-mandatory implications

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

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HEALTH AND WELLBEING BOARD

27 September 2016

Title:	**Healthwatch Annual Report 2015-2016**
Report of the Healthwatch Board	
Open Report	**For Information only**
Wards Affected: ALL	**Key Decision:** No
Report Author: Marie Kearns, Contract Manager, Healthwatch Barking and Dagenham	**Contact Details:** Tel: 0208 526 8200 E-mail: mkearns@harmonyhousedagenham.org.uk
Sponsor: Frances Carroll Chair, Healthwatch, Barking and Dagenham.	

Summary:

This report is for members to review the work of Healthwatch Barking and Dagenham during 2015-2016.

This paper is a summary of the Annual Report of Healthwatch Barking and Dagenham. It outlines the work that has been undertaken by the Healthwatch team during the year and highlights our achievements and challenges. Above all it shows how we interact with the public, capture their opinions and reflect them back to commissioners of both Health and Social Care services.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

1. Consider the report, noting the impact that Healthwatch has had in the last year.

Reason(s)

To bring to the attention of the Board trends in public opinion with regard to health and social care services in Barking and Dagenham. To advise the Board of the impact Healthwatch has had throughout the year.

1 Introduction and Background

1.1 This is the third annual report of Healthwatch Barking and Dagenham. The report sets out the work findings, and recommendations of the team. During the year we have looked at a number of areas including Phlebotomy, Intensive Rehabilitation Service, St Francis Hospice and Access in BHRUT Hospitals.

1.2 We are especially pleased with the outcomes from the Phlebotomy Project. This piece of work was shortlisted for the Healthwatch England National Awards. On the night of the awards Healthwatch Barking and Dagenham was highly commended in the category of "the value we bring to the community".

1.3 All the work undertaken by the Healthwatch team is driven by public opinion or where we have been asked specifically to look at a service as was the case with the Urgent Care Project.

2 Our work

Enter and Views and Project work

2.1 In total we made 26 recommendations in our project reports and 23 were accepted. We completed 9 Enter and View visits. We have looked at both health and social care services.

2.2 The outcome from the Morris Ward Enter & View is one to be proud of. Here we highlighted the difficulties for a patient who, as part of his therapy, had joined a local football team. Due to the ward's shift patterns he was always late for training as he had to wait for a member of staff to escort him. This made difficulties for him with the manager and his team mates. After we brought it to the attention of the ward manager, staff were made available to ensure he was always on time: allowing him the full benefit of the training session.

2.3 Our Enter and View at Park View (a dementia focused care home) also had positive outcomes. The service provider accepted Healthwatch's recommendations and involved residents in tidying the garden and planting flowers. Residents have also been made aware of food choices and the menu has now changed. Furthermore the cleanliness in the unit has been addressed and is regularly monitored by the manager.

2.4 Our Phlebotomy project highlighted the issue of uneven patient distribution which causes a bottle neck in certain locations where the service is provided. This was in part caused by referrers only telling patients about the larger sites and there not being sufficient advertising as to where all the blood testing sites were located. There were two service providers North East London Foundation and Barking Havering Redbridge Hospital Trust (BHRUT).

2.5 BHRUT responded to our recommendations by improvements in marketing and information sharing, a priority system for those fasting, the possibility of service provision in the evening and weekends. They have also improved the patient experience by making guest Wi-Fi available in the waiting area. Likewise the service commissioner has agreed to address public concerns with the service provider.

2.6 We conducted an unannounced visit at Five Elms GP Practice in May 2015 following a trend of consistent negative feedback. An inspection of Five Elms was carried out by the CQC in April 2016, which resulted in the practice being placed in special measures. Further information on the CQC inspection can be found elsewhere on the agenda in the Health and Wellbeing Outcomes Framework Performance Report for Quarter 1 2016/17.

Networks and partnerships

2.7 This year we have worked with Havering and Redbridge Healthwatch on the Urgent Care Project. We worked jointly on some primary research to help Barking Havering Redbridge University Trust (BHRUT) and the 3 local Clinical Commissioning Groups (CCG) to better understand how local people use urgent and emergency care services. All three Healthwatchs spoke to over 1000 people about their views on urgent and emergency care. These views are now being taken into account in the development of the new care model.

2.8 Healthwatch Barking and Dagenham are regularly represented on;

- The Health and Wellbeing Board
- The Children and Maternity Sub Group
- The Learning Disability Partnership
- The Mental Health Sub Group
- The Safeguarding Adults Board
- The Health and Adult Services Select Committee
- The London Healthwatch Group and Healthwatch England

2.9 Healthwatch Barking and Dagenham assisted the local CCG with their public consultation on their commissioning priorities.

Signposting and information giving

2.10 We have assisted or sign posted individuals to a number of services. This year we helped 508 people with a variety of enquiries. The following breakdown describes some of the most common reasons why people contacted us:

- GP Services – 155 (32%)
- Local Hospital Services – 144 (28%)
- Advocacy Services – 57 (11%)
- Mental Health Services – 42 (8%)
- Integrated Health & Social Care Services – 30 (7%)
- Local Residential Care Homes – 26 (5%)
- General Enquiries – 54 (9%)

3 Mandatory Implications

Joint Strategic Needs Assessment

3.1 When developing our annual plan Healthwatch Barking and Dagenham have been mindful of the content and data of the Joint Strategic Needs Assessment (JSNA).

Health and Wellbeing Strategy

3.2 All the topics for the Healthwatch work plan fall within the four themes of the Health and Wellbeing Strategy.

Integration

3.3 Healthwatch Barking and Dagenham are particularly interested in helping to promote joint working between health and social care service. This is reflected in many of the topics chosen for the 2016-2017 workplan including Community Equipment

Financial Implications

3.4 Healthwatch Barking and Dagenham are commissioned by the Local Authority and is funded until March 2017.

(Implications completed by Marie Kearns, Contract Manager for Healthwatch Barking and Dagenham)

Legal implications

3.5 Under the Health and Social Care Act 2012 local Healthwatch organisations have the authority to, and do, undertake announced or unannounced "Enter and View" visits to both health and social care settings.

(Implications completed by: Marie Kearns, Contract Manager for Healthwatch Barking and Dagenham)

Risk Management

3.6 All those undertaking Enter and View visits who are authorised representatives have undertaken specific training and have a DSB clearance.

Patient/Service User Impact

3.7 The Healthwatch programme is designed to reflect the views of the users of health and social care services in Barking and Dagenham. The main annual report highlights the specific impact that the views of service users have had in each area.

4 Non-mandatory Implications

Safeguarding

4.1 All staff and volunteers of the Healthwatch team are given awareness training on Safeguarding issues. A Healthwatch representative sits on the Safeguarding Adults Board.

Customer Impact

4.2 The Healthwatch programme is designed to reflect the views of the users of health and social care services in Barking and Dagenham. The main annual report highlights the specific impact that the views of service users have had in each area.

Contractual Issues

4.3 Healthwatch Barking and Dagenham is commissioned by the Local Authority and is funded until March 2017.

Staffing issues

4.4 Healthwatch Barking and Dagenham have a team of 2 full time equivalent members of staff and 8 volunteers.

Public Background Papers Used in the Preparation of the Report:

None

List of Appendices:

Appendix A Healthwatch Barking and Dagenham Annual Report 2015/2016

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healthwatch
Barking and
Dagenham

Healthwatch Barking and Dagenham Annual Report 2015-2016

Contents

Chairs Message

Welcome to the third annual report of Healthwatch Barking and Dagenham.

This year has been a busy and successful year. I would like to take this opportunity to thank all our volunteers, staff and board members as this would not have been possible without them.

Frances Carroll

Throughout the year we have worked on a number of projects and undertaken 9 Enter and Views across health and social care: The majority of which have had a positive outcomes for service users.

We are especially pleased with the outcomes from the phlebotomy project. This piece of work was shortlisted for the Healthwatch awards. On the night of the awards Healthwatch Barking and Dagenham was highly commended in the category of "the value we bring to the community".

We are equally proud with the Enter & View undertaken at Morris ward, where patients from Barking and Dagenham were staying longer due to an embargo on housing, since the visit this was uplifted and patients were discharged.

There have been areas where we have had a real impact and areas where more work needs to be undertaken.

This year we have worked with Havering and Redbridge Healthwatch on the Urgent Care Project. We worked jointly on some primary research to help Barking Havering Redbridge University Trust (BHRUT) and the 3 local Clinical Commissioning Groups (CCG) to better understand how local people use urgent and emergency care services.

All three Healthwatchs spoke to over 1000 people about their views on urgent and emergency care. These views are now being taken into account in the development of the new care model.

The CCG asked Healthwatch to host the annual event on their commissioning priorities. The feedback from this event has contributed to the CCGs decisions on commissioning for the coming year.

Last year our internal review found we needed to engage more with young people. To do this we have attended the Bad Youth Forum and involved the young people in re designing our leaflet. We have also signed up to take on work experience students.

The introduction of the Accountable Care Organisation (ACO), a new way of structuring health and social care services, poses many questions about how this will work best for the local people. We have taken part in the voluntary sector workshops, which looked at the role the sector, will play in the ACO.

Throughout the year, we have set up opportunities to listen and take note of experiences from local people who have used services within the health and social care system. Through these events we have signposted those who needed support in accessing services. The local intelligence has also helped us challenge commissioners and service providers. Furthermore trends captured throughout the year have then used as evidence for our work plan and priorities set for the coming year.

I would like to take this opportunity to thank all the partners and local people who have worked with us in making our local Healthwatch successful and look forward to working with everyone in the coming years.

The year at a glance

We were highly commended for the “value we bring to the community” in the national Healthwatch awards.

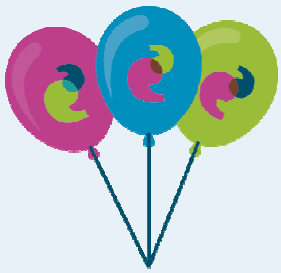
We’ve met hundreds of local people at our community events.

We have Enter & Viewed 9 local services.

We made 34 recommendations from our Enter & Views and 26 were accepted.

In total we made 26 recommendations in our reports, 23 were accepted.

We registered and taken on work experience students this year.



Who we are

We exist to make health and care services work for the people who use them.

Everything we say and do is informed by our connections to local people. Our sole focus is on understanding the needs, experiences and concerns of people of all ages who use services and to speak out on their behalf.

We are uniquely placed as a national network, with a local Healthwatch in every local authority area in England.

Our role is to ensure that local decision makers and health and care services put the experiences of people at the heart of their work.

We believe that asking people more about their experiences can identify issues that, if addressed, will make services better.

Our vision

We will continue to:

- Help you to shape and improve the services you use.
- Engage with people in your community & if you haven't met us yet, please get in touch!
- Be inclusive & we want people from every part of your community to join us.
- Tell you what's happening
- Use your feedback as evidence to build a true picture of your local services.

Our strategic priorities

- Champion the voice of the local community ensuring that we are inclusive and visible to all.
- Use evidence based feedback and make recommendations to service providers and commissioners.
- Continue engaging with vulnerable and disadvantaged groups
- Enable people to monitor and review the commissioning and provision of local care services relating to: the standard of provision; whether they could be improved and how they ought to be improved.
- Promote and support the involvement of people in the commissioning, provision and scrutiny of local care services (Health Care and Social Care).

Under the Health and Social Care Act 2012 Healthwatch Barking and Dagenham have the rights to:

- Have a seat on the Health and Wellbeing Board.
- “Enter & View” premises.
- Request information from providers and commissioners.
- Write reports containing the views of local people on health or social care services.
- Make recommendations and request a response.

Listening to people who use health and care services

Gathering experiences and understanding people's need

In order to gather the views of the community and identify local needs, we have taken the proactive role of making it easy for people to share their experiences of health and social care services.

Public events

Throughout the year we have held four public events.

These events are an opportunity for us to speak to a range of people from the community and understand their needs.

We are able to use this evidence to challenge service providers and commissioners and use the information to identify local priorities.

Associates and interested individuals

Healthwatch Associates are organisations or groups which are formed around their service users' needs on a particular area of health or social care. We currently have 25 Healthwatch Associates.

The relationship with the organisations enables Healthwatch to share and seek views of those accessing particular services. It also gives those community members who are not confident sharing their concerns, the opportunity to do so, through the Associates.

Enter and Views

Enter & View visits are carried out by trained Enter & View Representatives. The visits give a reflection of what the service looks like during the visit. Service users, family members and staff are spoken to.

These visits are crucial where individuals are unable to come out into the community to share their concerns.

We have undertaken 9 Enter & View visits this year.

Project work

There are certain projects we work on where we need to speak specifically to those who have used the service. Therefore we proactively go to where the service users are for example:

- For our urgent care project we attended the A&E department, GPs and Walk In Centres to find out what people know about urgent care in the local area.
- We worked with North East London Foundation Trust by sending out questionnaires on the Intensive Rehabilitation Service as our target audience was those using the service.
- Our volunteers and staff visited all venues where blood testing services are being provided to seek the views of those in the waiting area.

Other ways we have gathered experiences:

- Through our social media (see page 37).
- Hosting an event for the Clinical Comissoning Board (see page 39)
- We receive a number of phone calls throughout the year; this information is saved on our database. (see page 22 for a breakdown).

How we engaged with older people over the age of 65.

Public events give us the chance to speak to a wide range of people, recruit volunteers and help signpost people to the correct services. One event was specifically for older people. On the day people mainly spoke about general health and social services, no themes emerged from the day.

Most of the service users accessing the Intensive Rehabilitation Service were over 65. (Please see page 31 for more information on this project and the outcomes.

We also have an older person's representative on the Healthwatch Board, Barbara Sawyer.

How we engaged with Young people (under 21)

Last year a piece of work was undertaken to look at the areas we could improve on. According to the report our Healthwatch needed to involve young people more.

This year we have involved the BAD Youth Forum, (forum of young people) by seeking their views on how our leaflet could be made more attractive to a younger audience. We have designed a new leaflet incorporating the views of those young people.

A work experience student from year 10 has assisted with designing the new version.

To match with our branding a new bookmark has also been produced by the young work experience student!

Quote from our work experience student:

"Work experience at Healthwatch Barking and Dagenham was an excellent experience for me. The experience certainly opened my eyes and mind about health care in Barking and Dagenham and how it must be improved, to suit all types of disabled patients and able patients.

I have done a lot of projects at Healthwatch Barking and Dagenham, one of my favourite projects was the leaflet and bookmark project. I had to redesign the leaflet and bookmark for Healthwatch Barking and Dagenham, so it can be more eye-catching for people of all ages and abilities. I used publisher to make the leaflet and bookmark and I used a range of shapes, colours and fonts to express the point of Healthwatch Barking and Dagenham, and the work they do to improve health care."

How we engaged with people we believe to be disadvantaged, seldom heard or vulnerable.

There are a number of ways in which our Healthwatch have engaged with this group.

- We have spoken directly to parents who have children with Special Educational Needs by attending the Just Say Forum.
- We have undertaken an Enter & View on an Adult Mental Health Unit. (Please go to page 19 where there is a case study of this work).
- The residents of Park View Care Home have dementia, as this group of people are particularly vulnerable, it is important that their views are fully evaluated. Healthwatch representatives therefore spent some time observing resident and staff interaction and spoke to family members. (Please see page 14 for a summary and findings of the report).

How we engaged with people, who live outside our area, but use services within our area.

Take a look at the different ways we have incorporated the views of people who do not live in the borough but use the services.

- Barking Havering Redbridge Hospital Trust cover a number of areas, when we undertake Enter & View visits we speak to all the patients and the staff. Not all patients and staff live in Barking and Dagenham.
- We use Street life to consult with people who live in the neighbouring boroughs on local services we share
- During public events we encourage staff from other organisations to give their views. All staff do not live in the local area.
- Healthwatch have a database of interested individuals. These individuals receive up to date information relating to health and social care matters. A number of the individuals who have signed up do not live in the borough.
- We have 25 Associates registered. Associates are organisations representing a particular group of people. Individuals working in the organisations are not all from our borough.

What we've learnt from visiting services

What is Enter and View?

Enter & View is carried out under Section 221 of the Health and Social Care Act 2012. It allows Healthwatch to Enter & View certain health and social care services.

Authorised representatives observe and gather information through hearing the experiences of service users, their relatives /friends and staff to collect evidence of the quality and standard of the services being provided.

The information is then used to produce a report, which is shared with the service provider asking them for a response to any recommendations made.

We have completed 9 Enter and Views this year.

34 Recommendations made.

26 Recommendations accepted.

Enter & View Authorised Representatives

- Barbara Sawyer
- Val Shaw
- John Southall
- Frances Carroll
- Mary Parish
- Manisha Modhvadia
- Richard Vann
- Marie Kearns
- Roman Lakhera

Enter and View at Hanbury Court

We found service users were happy with the services being provided; there were no major issues that emerged at the time of the visit.

It did come to light that the lift/elevator in the home was not fully accessible for people with limited or no mobility. For this reason Healthwatch recommended that the service provider should consider looking at options where this could be made more accessible.

We did not receive a response from the service provider.

Park View

An unannounced Enter & View visit was undertaken after concerns were raised about the choice of food made available to residents.

Park View is a 24 hour nursing and dementia care home.

During the visit we found:

- The home was recommended by the residents and a family member.
- Oaks 2 garden area was not well-kept and the smell in the corridors was unpleasant.
- Some residents were unaware that there were food choices on offer.

Healthwatch made recommendations based on the findings.

The outcome from our visit has been positive; the service provider has involved residents in tidying the garden and planting flowers. Residents have also been made aware of food choices and the menu has now changed. Furthermore the cleanliness to the unit has been addressed and is regularly monitored by the manager.

3 recommendations were made and the service provider accepted all of these.

Gardiners Close

We received concerns about the lack of activities being provided to the residents. Due to the nature of the visit, Authorised Representatives decided to undertake an unannounced visit.

Gardiners Close is a supported living complex for those with learning disabilities.

We found:

- Some areas of the home were in need of renovating.
- Staff knew each resident very well including what they liked to eat.
- There was a need for activities to be more stimulating to the mind.

Our recommendations included renovating the home and more activities to be offered that would be intellectually stimulating for residents.

The area manager responded positively and informed Healthwatch that the team are looking at new activities for the residents.

The communal areas are due for redecoration in 2016/17.

2 recommendations were made and the service provider accepted both. As the redecoration is not due till 2016/2017 Healthwatch will ask for an update.

Fern Ward and Amber Wards Follow up Visits

Fern Ward

Medicine and Elderly Care Ward

On 8 October 2014 Barking and Dagenham Healthwatch carried out an Enter & View of Fern Ward, King George Hospital.

Some of the areas highlighted as needing improvements previously included:

- Information boards not being correctly updated.
- Catering staff not waiting for people who were in the toilet and not asking loudly enough if patients wanted a hot drink.
- People waiting too long when they used the call buzzer.

The trust responded positively, with an action plan to implement changes.

An unannounced follow-up visit was undertaken this year. Authorised representatives could clearly see that improvements were made in the areas previously highlighted. The changes seemed to be having a positive impact on patients on the ward. This was reflected in the feedback received from the patients.

6 recommendations had been made, and feedback from the follow up visit evidences that improvements have been made, having a positive impact on patients on the ward.

Amber A&B Wards

Trauma, Vascular Surgery and Orthopaedics Wards

Healthwatch undertook an Enter & View visit to Amber Wards A&B, Queens Hospital, on 20th March 2015. Taking into consideration the feedback from patients Healthwatch recommended;

- Better communication between ward staff and catering staff.
- Protocols to be in place to check finger nails of immobile patients in case of infection.
- More checks on patients who are bedridden to prevent pressure sores.

An unannounced follow up visit was undertaken on 22nd September 2015 to see if changes had been made to improve the patient experience.

Healthwatch found that improvements were made and actions implemented from the initial visit.

5 recommendations were made to the trust at the initial visit, during the follow up we found there to be significant changes put in place to ensure all recommendations were acted on.

Five Elms GP Practice

Healthwatch Barking and Dagenham identified a trend of consistent negative feedback from patients about this GP service. This included staff communication and waiting times for appointments.

An unannounced visit was carried out to better understand what was happening.

During the visit staff informed the Enter & View Representatives that the GP Practice had undergone significant changes since May 2015 and there were a number of changes to staff over a short of period time.

During the visit we found:

- Patients were happy with the way they were treated, although there was often a lack of empathy shown to them, during difficult times from receptionists.
- Information boards within the practice did not display information for patients.
- People also commented on the waiting area not being child friendly.
- We were also informed that there were issues with referrals being made to BHRUT outpatients. Patients had been referred back and the GP told there were no appointments available. This had a negative impact on the service being provided to patients.

Healthwatch recommended that:

- Consideration should be given to making the waiting area more children friendly.
- Patients should be treated in a professional manner when they attend the surgery.
- More information should be available to patients on the practice website and information boards.

7 recommendations were made to the practice. We received a response from the GP; however it was based on the services that they provide, rather than addressing the experiences of their patients and the recommendations made by Healthwatch.

Healthwatch visited the surgery on other business and observed that there was more information made available for patients on display boards.

Morris Ward

Healthwatch Barking and Dagenham carried out an announced Enter & View visit to Morris Ward; this was in response to relatives' concerns about a lack of activities being provided in the service and the length of time individuals were being detained on the ward.

Morris Ward is a forensic, low secure facility that is part of Sunflower Court – a Mental Health in-patient assessment complex. The service is provided by North East London Foundation Trust (NELFT).

We found that residents from Barking and Dagenham were being kept on the ward much longer than those from other boroughs, who were accessing the same service. The ward manager referred to a housing embargo in place in Barking and Dagenham. This emerged as a barrier to discharging patients back into the community, having been assessed as ready to take that step in their recovery.

We also found that some in-house procedures on the ward were barriers to progress for some patients taking part in activity related initiatives. It was identified that this was caused by a lack of staff being available at times when they were needed to support patients.

A patient that Healthwatch representatives spoke with said;

"I have been on Morris Ward for 2 years - the 'Coping through Football' programme run by the hospital has helped to transform the way I am and how I see things. I have been offered the chance to play for a semi-professional football club and this has helped me think about becoming a coach and getting my coaching badges. One area it could work better for me is that I am expected to be at training by a certain time and be ready to take part in sessions. This is a strict regime. The times coincide with the staff handover here on the ward and because I have to be escorted when I leave the unit, waiting for a member of staff to become available often makes me late by an hour."

In their response, the ward manager has said that since Health watch's visit, they have employed an additional member of staff to support individuals to participate fully in their activities. For this person, he was able to attend training sessions at the times he needed to.

Since the publication of our report, the housing embargo in Barking and Dagenham was lifted and the 4 individuals from the borough that we spoke with have been discharged back into the community. The issues raised from this has prompted local commissioners and providers of the service to look at new and innovative ways of making suitable housing accommodation available for patients from the borough who are ready to integrate back into the local community.

Both the recommendations were accepted by the trust. Our visit had a positive impact for the patients.

Enter and Views to the Children's Wards

Both visits were part of a wider programme of work which focused on the views of children and young people's experiences of using health services. These were announced visits.

Tropical Lagoon, Queens Hospital

Findings included:

- Clinical procedures were explained to children.
- Parents spoke of the temperature on certain areas of the ward being too cold.
- Food options were not suited to all children.
- Televisions were not in working order.
- Parents were unaware that they could ask for help, with bathing their children.

Recommendations and Outcomes

We recommended the trust to take a look at the temperature issue, ensure all TVs are in working order, make sure parents know if they can get help with bathing their children and consider more food options.

Since our visit:

The heating has been inspected and adjusted; the ward is now warm in all areas.

All televisions have been fixed and are in working order.

Actions have been put in place in order to implement other recommendations.

4 recommendations were made to the trust.

All the recommendations were accepted by Barking Havering Redbridge Hospital Trust.

Clover Ward, King George Hospital

Findings included:

- Whilst some children were happy with the choice and amount of food they received, others thought there were not enough food choices available for people from other cultures.
- The bathing facilities are adequate on the ward but parents were unsure what help was on offer if their child needed a bed bath.
- It was felt there should be more activities for older children.
- Parents commented on beds being uncomfortable.

Recommendations and Outcomes

- Recommendations included, more activities for older children, parents being aware of facilities available for their children, patients being made aware of the food choices and consideration for better sleeping facilities for parents.

Since our visit

The ward manager has collated a list of appropriate items to purchase for older children.

All staff informed at daily handover to ensure parents know they are aware of the bathing facilities. The information leaflet given to patients will also be updated to include this.

The ward manager has requested 13 beds to be purchased for Clover Ward for parents.

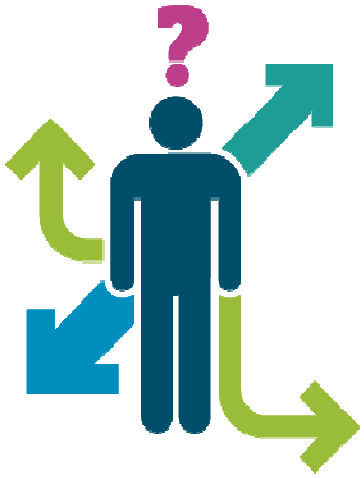
Actions have been put in place in order to implement other recommendations.

Healthwatch made 4 recommendations. All which BHRUT have accepted and have an action plan in place to implement.

Giving people advice and information

Helping people get what they need from local health and care service

It is the statutory duty of every Healthwatch to offer an information and signposting service to local people.



There are a number of ways in which people can make contact with us:

- Facebook
- Twitter
- By Post
- Through our website
- Telephone
- Face to face when we have stands across the borough.
- Streetlife
- Email

Website

Our website has a dedicated signposting section, where people can find details of organisations that are able to offer them advocacy support and details on how to make a complaint. We also promote new services that are related to health and well being under the news section.

Working with others

Healthwatch have a list of organisations that provide services within the borough. This list is used to signpost individuals when they make contact. It's a useful tool and is kept updated as and when there are new organisations that work with Barking and Dagenham residents.

Outreach sessions and public events

Whilst undertaking public events, we ensure staff and volunteers are aware of the different services available in the borough. A number of individuals approach Healthwatch to seek information about where to go for help.

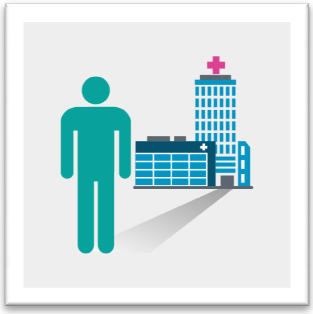
If our staff and volunteers do not have the correct details of an organisation that is able to assist the individual, then we see it as our duty to find out.

We have assisted or sign posted individuals to a number of services. This year we helped 508 people with a variety of enquiries. The following breakdown describes some of the most common reasons why people contacted us:

GP Services - 155 (32%)

The majority of issues raised by people were about not being able to get an appointment soon enough. A number of people said they went to A & E with the notion that they might be seen sooner. Other reasons included not being able to talk about more than 1 health issue at an appointment even though health issues might be linked in some way.

> **"The service me and my family get from the doctors has generally been good, but I have recently had to go back for separate outpatient appointments about the same thing when it could have all been dealt with at the same appointment - not good use of mine or the doctor's time"**



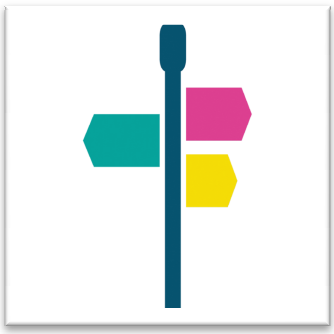
Local Hospital Services - 144 (28%)

The biggest factor that prompted local people to raise issues about the service was the delayed and extended waiting times for outpatient appointments. A number of people raised this as the source of most concern and frustration. Other common issues were the waiting time in A& E and the time it takes to have to sit and wait to have a blood test, especially at the Queens Hospital site.

> **'Waiting at the A & E department is still too long - they introduced a triage system to move you from one crowded waiting area to an even more crowded area and you still wait hours to be properly seen. The service was good when I eventually received it'**

Other Issues and Services -

Throughout the year Healthwatch was contacted about a variety of services and sources for advice;



Advocacy Services - 57 (11%)

Individuals looking for someone who can support and advise about rights and navigating complaints processes.

Mental Health Services - 42 (8%)

People asking for assistance with completing forms, changes to the way services were being provided and concerns about how to access other services for physical health needs.

Integrated Health & Social Care Services - 30 (7%)

Individuals got in touch to ask about The Community Treatment Team and Intensive Rehabilitation Services.

Local Residential Care Homes - 26 (5%)

People telephoned or emailed - mostly relatives and community volunteers - raising concerns about local care homes and the standards of care they were providing.

General Enquiries - 54 (9%)

Most people who contact for general reasons are often looking for information connected with other services and providers where there are out of date details. Also a number of people contact this Healthwatch first as the name can appear at the top of online search engines.

There were 40 people who contacted us and made complaints about services. The figures below show the percentage of complaints we received for each service.

- *GPs - 23 (58%)*
- *Local Hospitals - 5 (13%)*
- *Mental Health Services -4 (10%)*
- *Appointment Waiting Times -4 (10%)*
- *Social Care Services - 2 (5%)*
- *Dental Service - 1 (2%)*

Examples of how Advice & Signposting from Healthwatch Barking and Dagenham has assisted local people:

Miss M has contacted Healthwatch for advice previously - she has had ongoing concerns about how she and family members had been messed around by delays and changes to their out-patient appointments, without any way to resolve issues quickly with the local BHR Hospital Trust. Healthwatch was hosting an upcoming event - an opportunity for senior managers from the hospital trust to engage with local people about their services - and invited her along to take part and speak about her experiences. As a consequence of the contact made, she has been able to navigate to the most appropriate person to assist with appointment related issues.

Mr K came to Healthwatch after being referred by another local organisation. He had recently returned from holiday abroad with his family and on arrival home, his young son was taken ill. Rather than take him to hospital first, he sought immediate help from his GP practice and contacted them by phone to arrange an urgent appointment. He was told that if he wanted an appointment, there wasn't one available for a week or alternatively, he would have to go to A&E if he wanted to be seen straight away. Unaware that there was an out of hours urgent GP hub service, Healthwatch advised him to contact his GP practice again, explain in more detail about his son's symptoms and to ask for an urgent appointment slot at the hub.

Mr W contacted Healthwatch and came across as agitated and confused during the initial part of the telephone conversation. It quickly emerged that he had been waiting for a particular appointment at the Maudsley Hospital that had not yet occurred and as a consequence of which, he alluded to doing harm to himself. Although from another Healthwatch local authority area, concerned for the person's wellbeing, Healthwatch B&D contacted the local mental health access team; provided them with details and conveyed the conversation that had transpired. The practitioner confirmed they were aware of this gentleman and they would take the necessary action to contact him. They contacted Healthwatch B&D later to confirm they had been to see he was well.

How we have made a difference

Our reports and recommendations

26 recommendations, 23 accepted

Shortlisted for Healthwatch National Award for the work undertaken for the Phlebotomy Project.

On the night of the awards. Healthwatch Barking and Dagenham were highly commended for this piece of work.

St Francis Hospice Project: More promotion on culture and services is being provided.

Intensive Rehabilitation: management highlighted concerns to staff to ensure involvement of service users.

Complaints Project: Health & Well Being Board accepted recommendations made by Healthwatch.

Saint Francis Hospice

We were approached by St Francis Hospice to seek honest feedback about the services they offer. However, at the start of the project, we found that the majority of Barking and Dagenham residents spoken to had not heard of the hospice before. Therefore we looked at the reasons behind this too.

What we found:

- Those who had used the service were very happy with it.
- There was a need for the hospice to showcase the work they do with patients from different cultures.
- Healthwatch found that there is the need for more training for GPs on the palliative care pathways.

Recommendations and outcome

Healthwatch recommended examples are showcased more through social media networks and religious organisations to help eliminate some of the myth that the hospice is Christian based only. We also recommended that consideration should be given for CCGs to have training on palliative care pathways.

The Hospice welcomed Healthwatch's report and found it was very much in accordance with many of the issues they have identified when planning their five year strategy.

Medical Dressings Project

Concerns were raised to our advice and information service about the medical dressing's service. Healthwatch investigated the issue and our report found:

- 94% of patients said that their nurses spent enough time with them on each visit.
- Over 90% of patients said that communications with the services is good to excellent.
- 15% indicated they were not given a written care plan.
- Out of hours; the level of satisfaction was low, as some patients said they didn't get any response either to their call or any answer phone messages they left.
- Some people – 7 (21%) – said that when nurses have visited them, equipment and dressings were not available for when it was needed

Recommendations and outcome

Within our recommendations, we highlighted the need for out of hour's services to be responsive in a timely way and for adequate supplies of dressing items to be made available to prevent wasted visits with unnecessary risks to patients.

We received a response back from North East London Foundation Trust; however Healthwatch felt the response was based on the services that are provided rather than the actions that needed to be put in place in response to the experiences shared within the report.

Access to Out patients area for disabled people

Reason for the Healthwatch Inquiry

Healthwatch Barking and Dagenham, initially at the request of the Matron for Out-Patient Services at BHRUT, were asked to look into the experiences of some out-patients using the services at the local hospital trust sites. The focus of inquiry was access for disabled people with visual, hearing or mobility impairments.

This report highlights the experiences of service users and others who helped us to test areas of accessibility at the Queen's and King George's hospital sites.

Key findings

- Access through the front doors and other doors of each hospital was easy to navigate and was facilitated by a push button or sensor functioning automatic opener.
- In some areas at Queens Hospital, fixed seating didn't allow enough space for wheelchair users to occupy without blocking up the gangways.
- A hand held device for patients was introduced to enable staff to alert patients when it is their appointment time. The device vibrates and also emits a visual signal.
- The communication needs of a deaf patient were overlooked in a waiting area - their name for an appointment was called out from behind a wall.
- At both hospitals, despite indication by signage at reception areas, hearing loop systems were not in use or working.

Outcomes

The final report for this project is currently being worked on and will be published once the Trust has seen and commented on the findings.

Intensive Rehabilitation Service

Healthwatch undertook this project after concerns were raised from service users and families about the unmet needs of the service. For example if people wanted the service at home, will there be enough physiotherapists.

WE FOUND

- 91% would be happy to be treated at home again. This percentage indicates that the service is working well for those who receive it.
- 85% were happy with having treatment at home.
- 76% of the 33 who needed equipment to help with their recovery felt it was brought in a timely way.
- Individuals commented that on some occasions nursing staff either do not turn up or do not tell patients whether they will be coming in the morning or afternoon.

We made two recommendations to North East London Foundation Trust; one was to ensure that the patients are involved with their treatment and are able to talk about their goals to recovery. The second recommendation was for nurses to give either a morning or afternoon slot to service users, so they are not waiting all day.

North East London Foundation Trust accepted the first recommendation and all staff were reminded to ensure the joint goals are signed off by the patient.

In regards to the second recommendation the service provider felt patients may be confusing the IRS nurses with the district nurses. However they addressed the issue with their nurses.

Phlebotomy Services

This work was taken forward after receiving a large volume of concerns from the general public about accessing phlebotomy services within the borough.

The large amount of interest was a reflection of the concerns and frustrations the public had experienced when trying to access the phlebotomy service. The community felt strongly and were determined to have their say.

Our research showed that whilst the amount of access to blood testing sites might be sufficient, the way in which it was accessed was not evenly spread. The two local hospitals are bearing the brunt with patients waiting anything from two to four hours to have their tests. At the same time less well know sites are operating below their optimum capacity.

The issue of uneven patient distribution, causing a bottle neck in the service, was in part caused by referrers only telling patients about the larger sites and there not being sufficient advertising as to where all the blood testing sites were located.

We made recommendations to service providers, North East London NHS Foundation (NELFT) and Barking Havering and Redbridge University Hospital Trust (BHRUT).

Only BHRUT responded.

Their response included improvements in marketing and information sharing, a priority system for those fasting, the possibility of service provision in the evening and weekends and improving the patient experience whilst waiting by making guest Wi-Fi available in the waiting area.

Likewise the service commissioner has agreed to address public concerns with the service provider.

Healthwatch believe the research project will make a difference in developing better access for the community through the actions being implemented by commissioners and the service provider. The public will be better informed as to what options they have available and where they can go for their blood test.

5 recommendations were made

The CCG acknowledged all the recommendations.

BHRUT have responded with an action plan addressing all the recommendations.

WORK OF HEALTHWATCH BARKING AND DAGENHAM RECOGNISED IN NATIONAL AWARD

Healthwatch Barking and Dagenham were shortlisted for a national award that celebrates the difference local Healthwatch have made to health and social care in the past year.

Shortlisted from over 120 entries, Healthwatch Barking and Dagenham were shortlisted for its work on Phlebotomy services, where it brought the experience of local residents to the attention of Barking and Dagenham CCG and Barking Havering Redbridge Hospital Trust.

The trust has now taken steps to improve the experience of service users in response to our findings.

On the night of the awards Healthwatch Barking and Dagenham were highly commended for the work undertaken.

Respite Project

Last year feedback showed that we needed to engage more with young people.

As part of this year's work, we have spoken to young people receiving respite care services.

We received information from the professionals working with children and young people about how these individuals feel when receiving respite care. The views of the parents can differ from the person in respite care. This is also a group that is hard to reach.

Healthwatch undertook some primary research speaking to both parents and young people about respite care and how their views differ.

The themes emerging from parents are:

- Parents said the demand is high for certain activities.
- Parents felt that accessing hydrotherapy sessions for their children in the Borough is an issue and felt that this should be provided locally.
- Most parents of younger children commented that they make the decisions on behalf of their child, as to what activities they will attend.
- Some parents of older children said they speak to their children about where they would like to go.

Themes from younger people are:

- Young people said they enjoyed the activities they were attending.
- Some young people said as they had attended the activities whilst they were young. They have now settled in and therefore decided to continue accessing the activity.
- A few young people said their parents spoke to them about what respite care they would like.

A full report is currently been produced for this project.

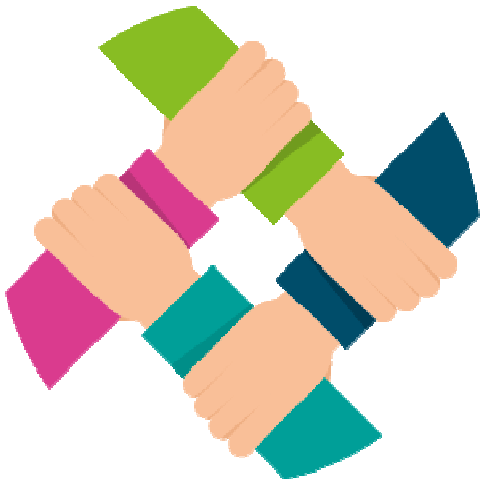
Other projects

There are a number of other projects we worked on this year including:

- Outpatients Appointments
- Access Project
- The Hub

We are currently finalising these reports and they will be published soon.

Working with other organisations



Healthwatch England

We have continued to attend the Healthwatch Network London meetings.

We also attended the National Awards Conference and were shortlisted for the work in improving access to Phlebotomy Services.

Clinical Commissioning Group

There are a number of ways in which we work with the CCG.

Patient Engagement Forum (PEF)

A Healthwatch Representative attends the Patient Engagement Forum on a regularly basis, to inform, update and seek views from patients.

Contract manager and CCG meetings

The Healthwatch Contracts manager and Chair meet with the CCGs lay representative and the Chief Operating Officer on a regular basis.

Responses to reports

We also asked the CCG for an official response to our Phlebotomy project.

Care Quality Commission (CQC)

Our working relationship has grown with the CQC this year. Our local representative attended the Healthwatch Board to give a briefing about how we can work together and the role of the CQC.

There has been no need to escalate reports for action.

We have not made recommendations to the Care Quality Commission and they did not undertake special reviews or investigations following our recommendations.

The CQC receive up to date reports that we publish for both our projects and Enter and Views.

CQC made contact with our Healthwatch to see if there was any evidence we could provide for their inspection on the North East London Foundation Trust (NELFT). NELFT covers both mental health and community health services in our borough. We submitted our reports which covered these two areas.

Health and Wellbeing Board

The Healthwatch Chair has a seat on the Health and Wellbeing Board. The Health and Wellbeing Board have four sub groups:

- Children and Maternity Sub-Group
- Learning Disabilities Partnership Board
- Integrated Care Sub-Group
- Mental Health Sub-Group

For each of the sub-groups a Healthwatch representative attends and contributes to discussions, ensuring the voice of the service users are heard and taken into account when decisions are made.

Complaints project

This piece of work was undertaken by Healthwatch Barking and Dagenham at the request of the Public Health Department of Barking and Dagenham. We were asked to compare and contrast the outcomes for complainants in a variety of organisations.

Healthwatch Barking and Dagenham have also conducted primary research amongst complainants from a variety of services.

Looking at the evidence our recommendations included

- That service providers make it a priority to engage with complainants at least once a year and the views and experiences of complainants contribute to any re-design of complaints procedures.
- Complainants should be advised of agencies or advocates who can help them with their complaint.
- Organisational annual complaints reports should be clearer about what their analysis is saying and what changes will be brought about as a result. This should be fed back to complainants who have contributed through highlighting the situation

The report was presented and accepted by the Health and Wellbeing Board. Organisations were requested to take action on the recommendations made.

London Borough of Barking and Dagenham (LBBD)

We have a seat on the Safeguarding Adults Board, which we attend on a regular basis.

Health and Adult Services Select Committee (HASSC)

Healthwatch attend the HASSC on a regular basis. The time is used to update members of outcomes from the projects completed and any raise areas of concern. The work is well received. Healthwatch also have an interest in the work the HASSC take forward and the topics being discussed at the meetings.

Accountable Care Organisations

Accountable Care Organisations will be a new way of structuring health and social care services. They were referenced by NHS England chief executive Simon Stevens in his Five Year Forward View (5YFV).

Health and social care partners across Barking and Dagenham, Havering and Redbridge will put forward a business case to the Government to allow the three boroughs, the three CCG, BHRUT and NELFT to work collaboratively to meet local needs.

A workshop took place in May 2016 to explore ways of working and discuss how the Voluntary Sector can support some of the key areas of focus that are emerging from the Accountable Care Organisation, in particular in the restrictions of primary care.

Healthwatch took part in the workshops to understand more about the ACO and also contribute to discussions of how Healthwatch can be involved and what we have to offer. It was an opportunity for the wider Voluntary Sector meet with the 3 CCGS and the local authorities and to better understand how an ACO would work and the role of the voluntary sector.

In summary the workshop identified:

- That there is a number of examples best practices across the Voluntary Sector but these need to better understand.
- There needs to be a single approach to commissioning of Voluntary Sector services, this should be streamlined, with a clear vision of the needs of the population to ensure that gaps are addressed and that there is no duplication. **Services need to be more consistent** so that confidence in them can be built.
- Everyone needs to work to a single vision and to address a commonly agreed and prioritised set of needs, being clear of our roles within the wider system. This will make best use of limited resources and support people in BHR to live longer, healthier, happier lives.

A follow up from the workshop for Healthwatchs was that Barking and Dagenham, Havering and Redbridge Healthwatch would meet with the ACO lead to discuss ways of working together and the role of Healthwatch during these initially stages. Two meetings have taken place.

Urgent Emergency Care

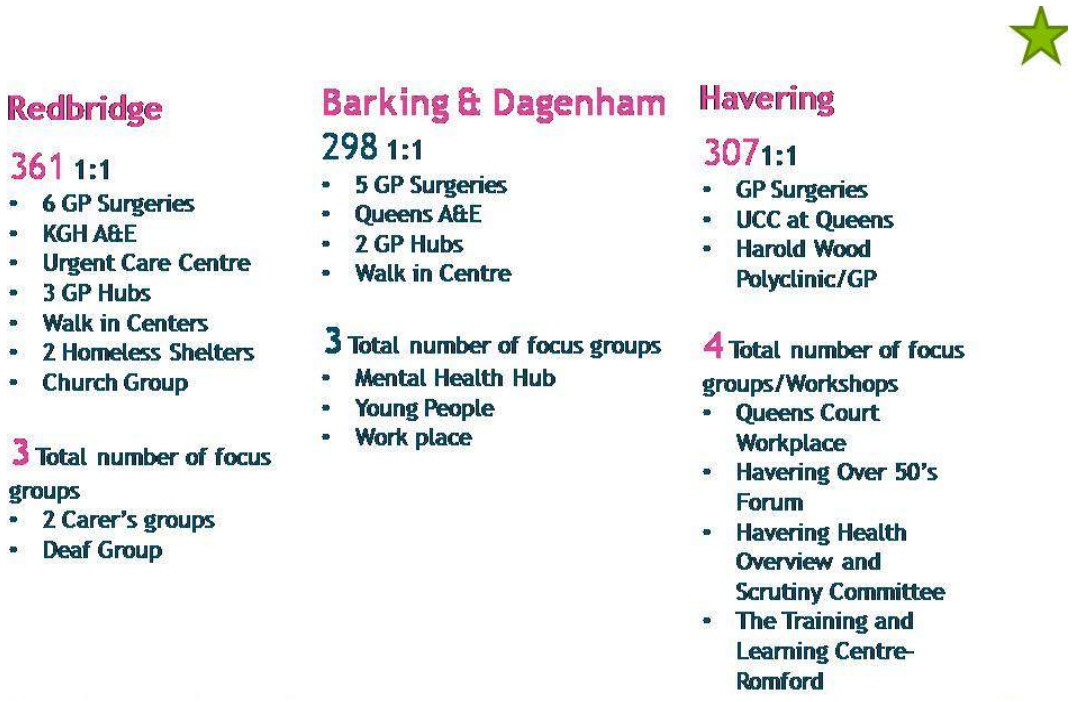
Barking Havering Redbridge System Resilience Group (SRG) drives improvement in urgent care across the BHR system. The SRG believes there is a need to do things differently as patients make increasing demands on already stretched services.

The research was being commissioned on behalf of the BHR Systems Resilience Group. The objective of the research was to gain a better insight into local people's understanding of what urgent and emergency care services are, what is available to them, and why they have chosen a specific service in the recent past.

The three Healthwatchs came together and successfully won the tender.

Each Healthwatch undertook engagement in their local boroughs and in total engaged with over 1000 people. This included one to one questionnaires and focus groups delivered to different groups.

At the same time the CCG contacted 3000 people and undertook telephone interviews.



Some of the key research findings from both pieces of work included:

Signposting and advice

- 39% of those who had visited A&E did not seek prior professional advice.
- Of those who sought advice from an NHS source, 87% said the advice was to go to A&E.
- A&E is seen as a reliable 24/7, same-day service for urgent care needs – long waits are not a deterrent.
- In comparison, people said they have to wait too long for a GP appointment.

How does this inform the co-designed model?

- To change behaviour, triage or streaming at the hospital/ED front door is needed to reinforce the signposting and advice given at first contact.
- Consistency is key. The same advice must be given regardless of the service or setting (NHS 111, GP practice reception, A&E)
- NHS 111 needs to be enhanced to provide patients with specialist clinical advice to help direct patients appropriately to other services and to provide people with greater assurance.
- Review capacity in primary care – to meet the demand from patients to see their GP (their first preference).

The three borough research has influenced the co design model of urgent care. It proved to be successful in making the voices of local people heard.

Involving local people in our work

Social Media and Communications

Healthwatch use social media via Facebook, Twitter, Streetlife and our website to share information and encourage participation about health and social care issues. This includes information on opportunities to get involved.

Twitter

784 Followers

139 Tweets

It's used to send out quick messages providing followers with links for more information.

We have used Twitter to seek and encourage involvement in a number of consultations and Twitter has proved to be successful once again.

Streetlife

Streetlife is a social network used to connect with local people and neighbouring boroughs. It's used to share news and views. Healthwatch have found this has been a great way to connect with people about local services.

60 Notices

2805 people accessing Streetlife

National and local health and social care news and events are uploaded on the website giving people the option of keeping up to date and get involved.

There is also a section on local services that individuals can access.

Communications

6 E-bulletins sent

50 Notices sent to Associate Groups

220 Subscribers

- Healthwatch Barking and Dagenham currently have 220 interested individuals and Associates.

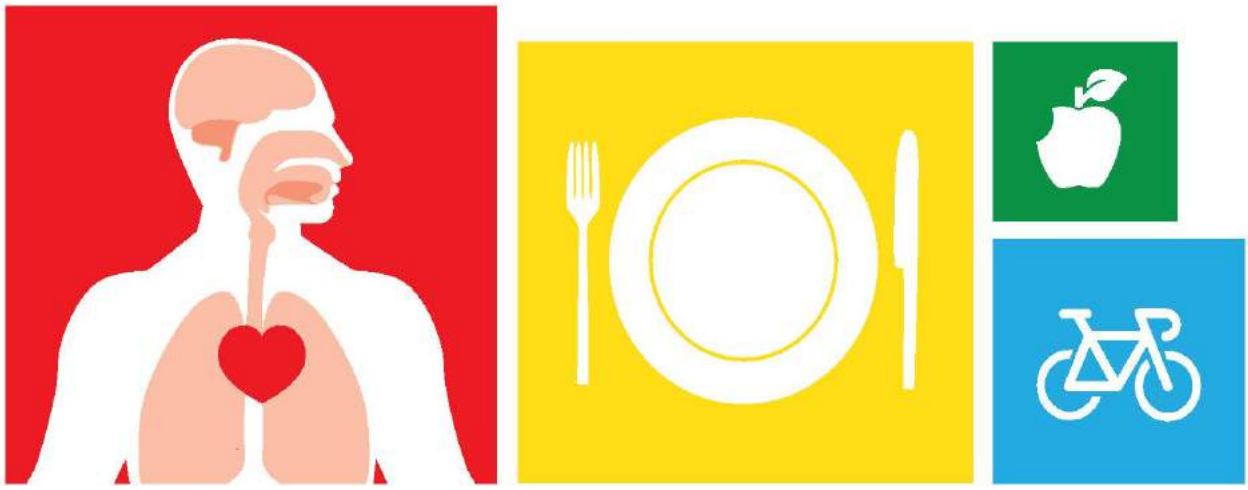
- Our E-Bulletin is published on a monthly basis; its main aim is to keep interested individuals and associates updated with local and national Healthwatch news and opportunities of involvement.

We also send out notices to inform and encourage people to get involved and have their say.
Examples of some notices sent:

- London Ambulance Service Consultation Report
- King George Hospital Elective Care Centre Briefing Document
- Barking Havering Redbridge Stroke Services Consultation
- Notice of Care Quality Commission Inspection of North East London Foundation Trust

Outreach and Engagement activities

Healthy Living Event



Healthwatch hosted an event to give local people a say on the Clinical Commissioning Group's plans for 2016/2017.

The event was informal, allowing people to learn about services that showcased the CCG's priorities for the coming year and tell the different services what they think. It was also an opportunity to seek views about CCG priorities and how the CCG can improve services offered in the borough.

The feedback contributed towards the commissioning priorities.

The main themes for the CCG to consider were:

- Services working together on linking mental and physical health needs.
- A better model of urgent care.
- Better advertisement of the GP Hub.
- More focus on young people's health for the duration of exams, for example what foods can give you energy and what can help you sleep better.
- The use of interactive methods and health education to improve lifestyles.

Response from the CCG

"The CCG were very pleased with the responses received to the event and the information given by local people to priorities and services. Many of the comments support our continued focus on improving our urgent and emergency care system, connecting physical and mental health together and focusing on preventing ill health. The event also helped us to understand where there is more to do - particularly in raising awareness of local services such as the GP hubs and IAPT"

Supporting our representative on the Health and Wellbeing Board to be effective.

The chair of Healthwatch Barking and Dagenham is our representative on the Health and Wellbeing Board (HWBB). The Chair attends the Board and the contract manager attends in a supporting role.

Staff support the Chair by providing local intelligence that has been collated through Healthwatchs statutory duties. This helps the chair to challenge the Health and Wellbeing Board when necessary.

The way we have involved volunteers in specific roles to help us carry out our statutory activities.

Enter & View

Many of our Enter & View Representatives are volunteers. Their role is to observe how local health and social care services are being provided at the time of the visit. Please refer to page 46 for more information about their role.

Board Members

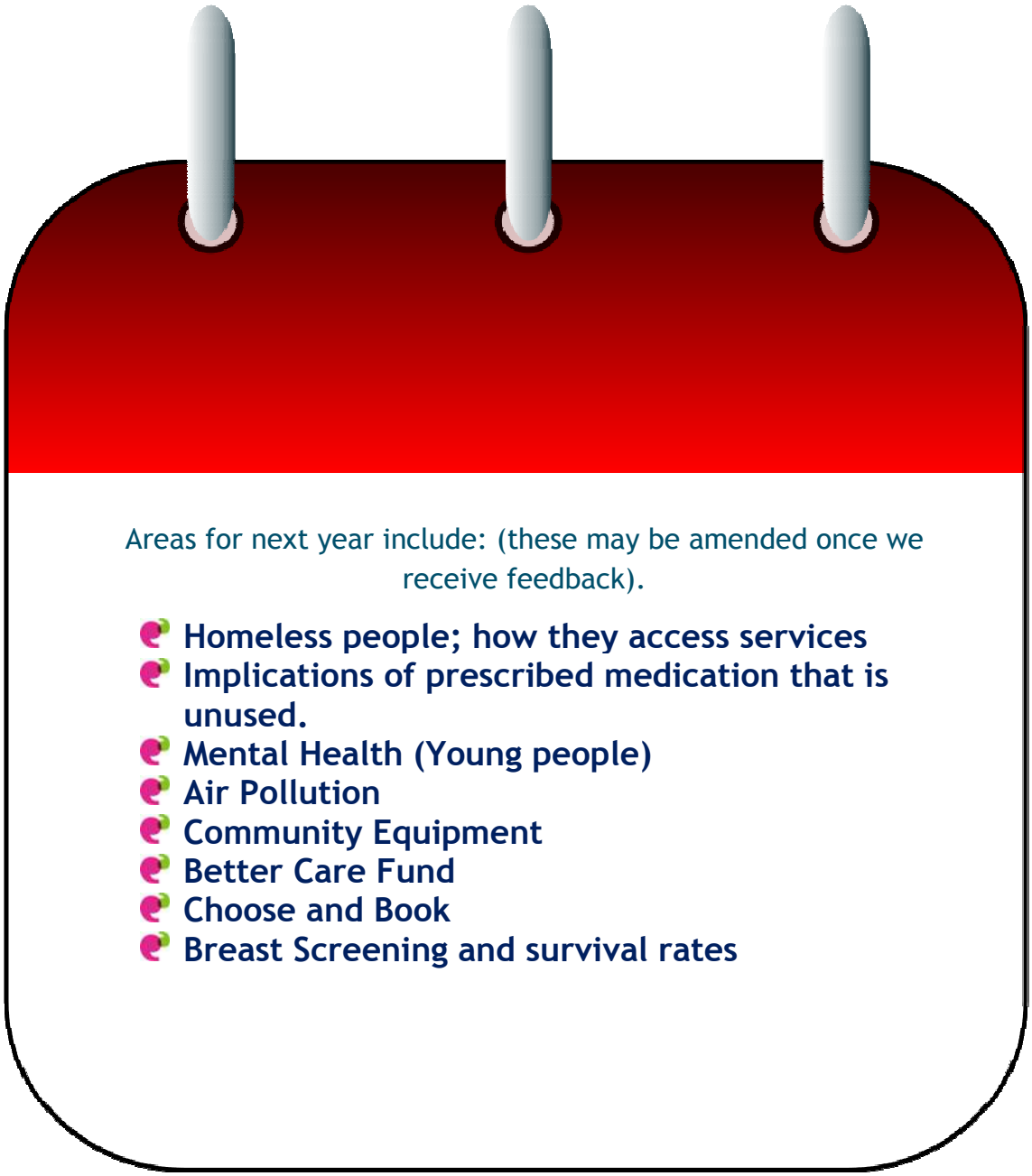
All our Executive Directors on the Board are volunteers. Please see page 44 for more information.

Our plans for next year

Future priorities

Every year Healthwatch Barking and Dagenham look into the feedback we have received from the local community in order to plan projects for the following year. We also invite the public, professionals and organisations to comment on the project areas that have been identified.

Once we have received feedback the final work plan is approved by the Board.



Areas for next year include: (these may be amended once we receive feedback).

- **Homeless people; how they access services**
- **Implications of prescribed medication that is unused.**
- **Mental Health (Young people)**
- **Air Pollution**
- **Community Equipment**
- **Better Care Fund**
- **Choose and Book**
- **Breast Screening and survival rates**

Our people

Decision making

Board and Team

Our Healthwatch is governed by our Executive Board. The Board are responsible for the strategic decisions of Healthwatch.

We have 8 seats on the Board which includes the Chair, 4 Executive Directors who are members of the public and 3 Associate members who represent local groups.

Each Director represents one of the areas:

- Health
- Social Care
- Children and Young People
- Older people

To ensure the Healthwatch activities are delivered in an open and transparent way, board meetings are open to the public; dates are published on the website, through the e-bulletin and the social networking sites. Furthermore all minutes are published on the website.

Staff undertake the role of ensuring the statutory functions of Healthwatch are carried out. Volunteers and Board members support the delivery of this.

Our Board Members

Frances Carroll
Chair

Barbara Sawyer
Executive Director

Harjinder Jutle
Executive Director

Lorraine Goldberg
Associate

Grace Kihu
Associate

We would like to take this opportunity to welcome some new board members: Val Shaw, John Southall and Ita O'Connor

Meet the staff

Marie Kearns

Contract Manager

Manisha Modhvadia

Healthwatch Officer

Richard Vann

Healthwatch Officer

Claire Gooch

Healthwatch Officer

Roman Lakhera

Healthwatch Officer

How we involve the public and volunteers in our governance and Healthwatch decision making.

Involving the Public and Volunteers in Enter & View

An Enter & View visit is undertaken:

- If we have received concerns from a family, carer or resident/service user about a particular social care or health service.
- If a visit is part of our wider work-plan, for example if we have specific work priority on children's services, we may undertake a visit to a children's ward.

All our Enter & View Representatives are volunteers. All Representatives are trained according to guidelines provided by Healthwatch England.

They are involved in planning the visit, undertaking the visit and ensuring recommendations are based on the findings.

Involving the Public and Volunteers on our Board

All our board members are volunteers. Please see page 44 for more information about the set up of the board.

All meetings are in the public domain, we promote all board meeting dates through social media and our outreach stands. All minutes are also available on our website.

Our Work Plan

Healthwatch is all about local voices being able to influence the delivery and design of services. We are here to ensure that local people's views are heard. As we are here for the people of Barking and Dagenham the areas of work we look at must come from them, or gaps in services highlighted by local publications such as the JSNA.

Every year we look at the intelligence we have and communicate with local stakeholders and the public about the areas of work we should focus on for the following year. From the comments received, a final work plan is produced.

Associates and Interested Members

We also have lay members who have registered their interest with Healthwatch. They give their opinions on the work-plan, consultations, receive e-bulletins and feedback to Healthwatch on health and social care services they have accessed. They also share Healthwatch information to groups and family members.

Have you heard of Healthwatch?

Everything that Healthwatch Barking & Dagenham does should bring the voice and influence of local people to the development and delivery of local services; putting local people at the heart of decision making processes.

Local people need to feel that their Healthwatch belongs to and reflects them and the local community.

We challenge services providers and commissioners to make improvements to better the experience of service users. However, how do we know if as a Healthwatch, we are doing our best and offering a good service to the people who use it or may use it in the future.

To find out how well we are doing as a Healthwatch in 2014-2015 we undertook a piece of work "Have you heard of Healthwatch"? We wanted to know:

- *If people have heard of us.*
- *How they heard of us.*
- *If they have used the service and what the outcome was for them.*
- *Any ideas on what Healthwatch could do to reach the local community.*

The findings highlighted some good areas of work and also identified where we needed to improve. The three areas were:

- *Work better and more often with young people.*
- *Make more people aware of Healthwatch*
- *Create an understanding amongst the community that Healthwatch do not deal with individual complaints but monitor trends.*

We used the findings from the report to help build on the areas that needed improvements:

To work more with young people:

- This year we have taken the step to engage more with young people.
- We signed up to take on young people from local schools, sixth forms and colleges for work experience.
- Our first student started in February 2016 for two weeks.

Make more people aware of Healthwatch

- We have continued to hold public events to promote and consult with the local community.

Create an understanding amongst the community that Healthwatch do not deal with individual complaints but monitor trends.

- Last year people were under the impression that Healthwatch are able to offer advocacy services. We have worked hard to inform people about what we can offer.

The involvement of young people has increased this year, to ensure this is consistent: Healthwatch will continue to:

- take on work experience students
- attend the BAD Youth Forum at least twice a year

Although all our reports are shared on our website, through our Associates and through various Boards, feedback shows that Healthwatch should showcase their work more broadly. To achieve this we will.

- advertise the service through the local paper
- have more stands at events taking place across the borough to engage, involve and share our findings with the local community and professionals. This will be a way of widening our audience.

Our finances

INCOME	£
Funding received from local authority to deliver local Healthwatch statutory activities	£125,000
Additional income	
Total income	£125,000
EXPENDITURE	
Operational costs	£12,800
Staffing costs	£81,150
Office costs	£31,050
Total expenditure	£125,0000
Balance brought forward	

Contact us

Get in touch

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Harmony House Dagenham
Dagenham
RM9 6XN

Phone number: 020 8526 8200

Email: Info@healthwatchbarkinganddagenham.co.uk

Website:www.healthwatchbarkinganddagenham.co.uk

Address of contractors

Harmony House Dagenham
Dagenham
RM9 6XN

We will be making this annual report publicly available by 30th June 2016 by publishing it on our website and circulating it to Healthwatch England, CQC, NHS England, Clinical Commissioning Group/s, Overview and Scrutiny Committee/s, and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us at the address above.

HEALTH AND WELLBEING BOARD

27 September 2016

Title: Healthy Weight Strategy 2016-2020

Report of the Public Health Team

Open Report	**For Decision**
Wards Affected: All wards in the borough	**Key Decision: Yes**
Report Author: Andy Knight, Commissioning Lead, Healthy Lifestyles Susan Lloyd. Consultant in Public Health	**Contact Details:** Tel: 020 8227 2799 sue.lloyd@lbbd.gov.uk

Sponsor:

Matthew Cole, Director of Public Health

Summary:

This report provides an overview of the Healthy Weight Strategy. The strategy sets out the plans and action over the next 4 years in tackling one of the biggest preventable health challenges the Borough faces.

The Healthy Weight Strategy vision is that the London Borough of Barking and Dagenham is a place where residents can make a change to enable them to achieve or maintain a healthy weight. The strategy will achieve this by addressing 4 ‘to do’s'.

1. Enable families and individuals to take responsibility for achieving and maintaining a healthy weight.
2. Make an active lifestyle and healthy eating the easier choice.
3. Address causes that put particular groups of families and individuals at a greater risk of obesity.
4. Ensure the built and natural environment support families and individuals to be more healthy and active.

Achievement of these 4 ‘to do’s' will involve action across the stages of life from childhood into adulthood, in line with the Health and Wellbeing Strategy.

Recommendation(s)

It is recommended that the Health and Wellbeing Board:

- Approve and endorse the Healthy Weight Strategy 2016-2020

Reason(s)

The Health and Wellbeing Strategy recognises the importance of achieving and maintaining a healthy weight. There is an increased need to tackle preventable diseases and in turn address the effect it has on residents overall health and opportunity to engage in the economic growth of the borough.

Due to the increased relevance and need to prevent ill health, evidence suggests achieving and maintaining a healthy weight is a key prevention priority. This strategy aims to set out the boroughs vision and actions to enable residents to achieve and maintain a healthy weight.

1. Background

1.1 The Health and Wellbeing Board has prioritised obesity as it's most important prevention priority.

1.2 Obesity is one of Barking and Dagenham's most significant and complex challenges, affecting the wellbeing of individuals and families.

1.3 Obesity also contributes to significant costs across health and social care.

1.4 On the guidance of the Health and Wellbeing Board and recommendation from the Health and Wellbeing Strategy a partnership Healthy Weight Strategy has been developed.

1.5 This strategy is the basis upon which the Borough is, and will be, taking action to achieve and maintain its ambition of a healthy weight for all residents.

1.6 The way people live their lives, the environment they live in, the food they have access to, and the physical activity they are able to do, all affect their ability to make a change and achieve a healthy weight.

1.7 From a health and social care perspective obesity is a risk factor for reduced mobility and for developing a range of diseases such as cancer, coronary heart disease, type 2 diabetes, and vascular dementia. All of which can significantly reduce healthy life expectancy.

1.8 In LBBD 27.5% of children in reception and 40.6% of year 6 children are overweight or obese[1].

1.9 The levels in the adult population are significantly worse as 63.5% of the adult population are classed as overweight or obese[2].

1.10 The strategy will inform commissioning intentions for the Borough's long term plans in tackling obesity. The strategy will also support the ambition to increase resilience and social responsibility to achieve and maintain a healthy weight.

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[1] 2014-15 data, National Child Weight Management programme.
[2] Active People Survey, Sport England. Excess weight in adults 2012.

2. The Vision

2.1 We want London Borough of Barking and Dagenham to be a place where residents can make a change to help enable them to achieve or maintain a healthy weight.

3. The Healthy Weight Strategy's Objectives

3.1 We are proposing four strategic objectives; achievement of these objectives will involve action across the stages of life from childhood into adulthood with a particular focus on whole families.

3.2 The strategy also makes best use of a range of existing, high quality local support, to help achieve healthy weight for all individuals and families at each life stage. The Healthy Weight Strategy aims to achieve this by:

- Enabling families and individuals to take responsibility for achieving and maintaining a healthy weight.
- Making an active lifestyle and healthy eating the easier choice.
- Addressing causes that put particular groups of families and individuals at a greater risk of obesity.
- Ensuring the built and natural environment support families and individuals to be more healthy and active.

4. Scale of the Challenge in London Borough of Barking and Dagenham

4.1 LBBD is one of the fastest growing local authority areas in the country, with high levels of migration and a growing number of the younger age profile.

4.2 Alongside the population growth there is an increasing shift in the ethnic makeup of the borough, with a growing proportion of the population from BME origin.

4.3 The Indices of Multiple Deprivation (IMD) data suggests that residents of LBBD are at an increased risk of excess weight gain and it is important that prevention efforts and service delivery are targeted where we can make the greatest impact.

4.4 Social marketing and behavioural study[3] datasets and analysis have identified these groups and areas as key targets for improved healthy weight outcomes;

- Children from all ethnic groups.
- Adults in semi-skilled occupations, skilled occupations and unemployed people.

[3] Behavioural Insight Study of Obesity in Barking and Dagenham, London South Bank University, 2012.

4.5 Tackling excess weight in this way will address health inequalities and focus on positive health outcomes across the life course.

4.6 According to the 2014/15 NCMP data for LBBD, 1 in 4 reception children and 1 in 3 year 6 children are overweight or obese.

4.7 NCMP measurements for 2014/15 indicate that the prevalence of children in reception year that are obese or overweight increased slightly from 26.8% in 2013/14 to 27.5% in 2014/15.

4.8 Conversely, the prevalence of overweight or obese children in year 6 fell from 42.2% in 2013/14 to 40.6% in 2014/15.

4.9 The NCMP data shows that in LBBD the following factors increase the risk of excess weight in children attending schools within the borough.

4.10 Ethnicity - LBBD has a high percentage of black or black British and Asian or Asian British children attending local schools. The national data suggested that these particular ethnic groups have a higher than average prevalence of excess weight.

4.11 IMD - According to the national data those children coming from a more deprived area have a higher prevalence of excess weight. The NCMP data clearly shows that there are a higher number of children with excess weight from the more deprived IMD deciles attending the schools borough.

4.12 The identification of these two risk factors positively correlating with excess weight prevalence suggests targeted work using these risk factors as a proxy could improve the statistics in LBBD.

5. Outcomes Focused Approach To Delivering The Healthy Weight Strategy

5.1 The key outcome from the implementation of this strategy is to enable more local people to achieve and maintain a healthy weight. This will be evidenced by an increase in the percentage of the Borough's population engaging in healthy weight activities.

5.2 To achieve healthy weight, a multifaceted community centred approach is recommended which involves as many partners, as wide and as varied as the complexity of the issue itself. Key values to ensure this becomes a reality are building resilience within the local communities and encouraging social responsibility.

5.3 Evidence suggests tackling obesity and gaining a positive impact will require many internal and external partners who will need to take action.

5.4 The use of community assets is a key and value for money approach to this strategy. Working with community and partner agencies would be beneficial to achieving the outcomes set out in the strategy.

5.5 Associated high level outcomes will be: a decrease in the percentage of LBBD residents who are physically inactive; improved mental well-being; increased

levels of perceived self-efficacy; and increased levels of social and community development.

5.6 The document details some key high level outcomes against each strategic objective; we expect these to be achieved through the delivery plan.

6. Priority Themes

6.1 The Healthy Weight Alliance recognises that no individual agency can overcome the challenges facing the borough and its residents; but by working together and building on resources and assets in our communities we can make collective changes.

6.2 The strategy has taken a life course approach, in line with the Joint Health and Wellbeing Strategy. Six life stages have been agreed.

- Theme 1 - Pre-birth and early years
- Theme 2 - Primary school (5 – 11 years)
- Theme 3 - Adolescence (12 – 18 years)
- Theme 4 - Adulthood (19 – 65 years)
- Theme 5 - Older people (66 years +)
- Theme 6 - Vulnerable groups

6.3 Each of these themes will address a set of key actions geared to enabling more people living in LBBD to achieve a healthy weight.

7. Performance Monitoring and Evaluation

7.1 The Healthy Weight Alliance group will steer the implementation and evaluation of the strategy and priority themes and actions.

7.2 Reporting arrangements will go to the Public Health Partnership Board, a subgroup of the Health and Wellbeing Board.

7.3 The strategy will be supported by a delivery action plan, which will set out how progress will be measured by the Healthy Weight Alliance group. These are intended to be reviewed every quarter.

8. Governance

8.1 The multi-agency Healthy Weight Alliance group will be responsible for ensuring that the delivery plans are in place to address the four key objectives in this strategy.

8.2 The alliance will also monitor progress towards locally agreed targets.

8.3 The Public Health Programmes Board will receive regular progress reports and key issues will be reported as appropriate.

9. Next Steps

9.1 The strategy will be used to set the strategic framework for addressing excess weight over the next 4 years.

9.2 A delivery plan has been written to accompany the health weight strategy and is available at http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MId=8816&Ver=4 entitled Draft Priority Themes and Delivery Plan.

10. Financial Implications

Implications completed by: Richard Tyler, Group Manager, Finance

There are no financial implications directly arising from this report.

11. Legal Implications

There are no direct legal implications arising from this report.

Implications completed by: Lindsey Marks Principal Solicitor Children's Safeguarding.

List of attachments:

Appendix 1: Barking and Dagenham Healthy Weight Strategy

Barking and Dagenham
Health and Wellbeing Board

Healthy Weight Strategy 2016-2020

#Let's Make a Change: A Healthy Weight Strategy for Barking and Dagenham

Contents

1. Foreword

Excess weight is one of the biggest health issues facing Barking and Dagenham residents – old and young. Over 50% of our population is overweight or obese. All the evidence shows that excess weight increases the risk of ill-health and reduced life expectancy.

I believe that residents can live healthily given the right environment.

This means that Barking and Dagenham must become a place where the healthy choice is the easy choice. It must be a place where eating healthily and being active is normal from the start, and families who are overweight or obese are supported to address their problems.

This is easy to say, but much harder to achieve.

So, this strategy is very welcome and very necessary. It sets out a series of principles, ideas and actions that will support residents to live healthy lives. This will help to focus and drive the work of all of the borough's social care and health partners and provides a way to evaluate and measure our progress through the Health and Wellbeing Board. Please take the time to read it.

Cllr M Worby

Chair, Health and Wellbeing Board

2. Introduction

What we are aiming to achieve?

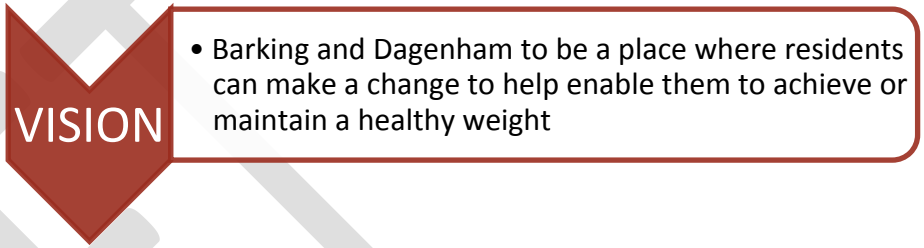
We want Barking and Dagenham to be a place where residents are supported to make changes, to enable them to get to or keep a healthy weight. We want to work with the whole community around improving health and keeping healthy and well.

We will do this by doing 4 things; doing these 4 things will need action across the stages of life from childhood into adulthood and will have a particular focus on individuals, whole families and communities.

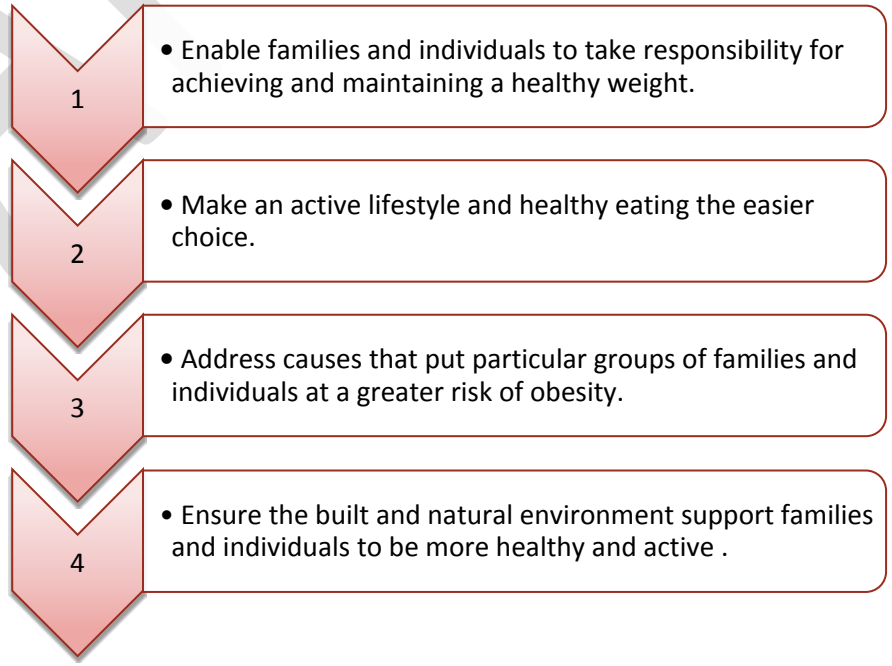
4 'to do's' to achieve a healthy weight

1. Enable families and individuals to take responsibility for achieving and maintaining a healthy weight.
2. Make an active lifestyle and healthy eating the easier choice.
3. Take action on the causes that put particular groups of families and individuals at a greater risk of obesity.
4. Make sure that the built and natural environment support families and individuals to be more healthy and active.

Vision



4 'to do's'



3. Background

Achieving and maintaining a healthy weight is a challenging outcome for residents in our borough where more than 50% of adults are either overweight or obese. Obesity can be prevented and; it costs taxpayers approximately £60.6 million a year to treat diseases related to overweight and obesity.

Carrying excess weight is a serious threat to general health and wellbeing, and can influence the development of more serious health conditions such as cancer, coronary heart disease, type 2 diabetes, vascular dementia and significantly reduces life expectancy. In Barking and Dagenham 27.5% of children in reception and 40.6% of year 6 children are overweight or obese[1]. Excess weight in the adult population is significantly worse with 68.4% of the adult population classed as overweight or obese[2].

This Healthy Weight Strategy draws insight from the intentions of the Health and Wellbeing Strategy 2015-18; which sets out a vision for 'improving the health and wellbeing of residents and reducing inequalities at every stage of people's lives by 2018'. This strategy seeks to support these forward thinking local policies by addressing one of the key health challenges the residents of Barking and Dagenham face. These policies support the drive to tackle excess weight amongst residents in our borough.

This strategy will take a whole systems approach, focusing on prevention. This approach is particularly important as there are shared values and aspirations across the Health and Wellbeing Board, to work together for the benefit of the residents. The Health and Wellbeing Strategy; the Childhood Obesity – A Plan for Action; the NHS England 5 Year Forward View, the North East London Sustainability and Transformation Plan and NHS Barking and Dagenham Clinical Commissioning Group's Five Year Strategy demonstrate that the main priority across the board is to ensure improved health and wellbeing for the residents of Barking and Dagenham.

A whole systems approach requires new partnerships, a series of interventions, ideas and principles to make initiatives more impactful. We will mobilise and activate communities around health and wellbeing, by providing a model and process for community engagement.

It is important that this strategy seeks to encourage people to take action to be healthy and to make good use of the local environment. We also want to reach out to all groups of people so that they feel part of what is happening, we will do this by integrating prevention initiatives with activity taken by primary care and other community partners[3].

Through this strategy, Barking and Dagenham will become a healthy place to live where the healthy choice is the easy choice. Healthy eating and physical activity are established from the start, and families who are overweight or obese are supported to address their weight problems.

[1] 2014-15 data, National Child Weight Management programme.
[2] Active People Survey, Sport England. Excess weight in adults 2012-14.
[3] Prevention- a local framework; *care and support for adults: London Borough of Barking and Dagenham,* 2015

4. Local context

Our community is one of the fastest growing local authority areas in the country, with high levels of migration and a growing number of the younger age profile. Alongside the population growth there is an increasing shift in the ethnic makeup of the residents. Unlike many London boroughs low income is more uniform across the borough with little to no pockets of deprivation in isolation. The Index of Multiple Deprivation data suggests that residents of our borough are at an increased risk of excess weight gain and it is important that prevention efforts and service delivery are targeted where we can make the greatest impact. Social marketing and behavioural study[4] datasets and analysis have identified these groups and areas as key targets for improved healthy weight outcomes;

- Children, all ethnic backgrounds.
- Adults in semi-skilled occupations, skilled occupations and people who are unemployed.
- Residents living in areas of high deprivation.
- Residents with physical disability.

Delivering services that target these groups specifically will aid in reducing excess weight and make a huge dent on the regularly reported statistics of our community and residents. Also tackling excess weight in this way will address health inequalities and focus on positive health outcomes across the life course.

Childhood obesity

According to the 2014/15 NCMP data for Barking and Dagenham, **1 in 4 reception children** and **1 in 3 year 6 children are overweight or obese**. This prevalence sets Barking and Dagenham as the 5th highest prevalence of excess weight in reception (26.6%) in London, above the London and National prevalence of 23% and 22.5% respectively. Barking and Dagenham also has the 3rd highest prevalence of excess weight in

year 6 (42.2%) in London, above the London and National prevalence of 37.6% and 33.5% respectively.

National Childhood Measurement Programme measurements for 2014/15 indicate that the prevalence of children in reception year that are obese or overweight increased slightly from 26.8% in 2013/14 to 27.5% in 2014/15. Conversely, the prevalence of overweight or obese children in year 6 fell from 42.2% in 2013/14 to 40.6% in 2014/15.

[4] Behavioural Insight Study of Obesity in Barking and Dagenham, London South Bank University, 2012.

The prevalence of excess weight in the borough for reception and year 6 children has remained relatively the same over the years with slight movements over the years. The excess weight prevalence remains above the National and Regional averages. The National Childhood Measurement Programme data shows that in Barking and Dagenham the following factors increase the risk of excess weight in children attending schools within our community.

- **Ethnicity** – Our borough has a high percentage of black or black British and Asian or Asian British children attending local schools. The national data suggested that these particular groups have a higher than average prevalence of excess weight.
- **Index of Multiple Deprivation** – According to the national data those children coming from a more deprived area have a higher prevalence of excess weight. The National Childhood Measurement data clearly shows that there are a higher number of children with excess weight less well off families attending the schools in Barking and Dagenham.

The identification of these two risk factors above positively correlating with excess weight prevalence suggests targeted work using these risk factors as a proxy could improve the statistics for residents.

How active is Barking and Dagenham?

- 46.4% of adults in Barking and Dagenham report to undertake 150 minutes of moderate intensity physical activity per week compared to the national average of 57%. However, 39.3% of adults do no sport or active recreation[5].
- The most popular physical activities for adults in the borough are swimming, going to the gym, football, running, and cycling.

Health inequalities in Barking and Dagenham

- The residents of Barking and Dagenham are not as healthy as they could be, compared to other parts of the country with healthy life expectancy for both men and women amongst the lowest in London.
- Healthy life expectancy at birth for men is 59.5yrs in Barking and Dagenham compared to 63.4yrs in England[6].
- Healthy life expectancy at birth for women is 54.6yrs in Barking and Dagenham compared to 64years in England[7].
- 117 deaths would be preventable by increasing physical activity levels amongst 40-79 year olds.

[5] Active people survey, percentage of adults classified as active and inactive, 2014.
[6] Public Health Outcomes Framework, 2012-14.
[7] Public Health Outcomes Framework, 2012-14

- The overall cost of inactivity per 100,000 people to Barking and Dagenham per year is over £23 million[8].

Population growth and pressures

- The population of our borough has increased by 12,383 between the 2011 Census and 2014 ONS mid-year estimates. This is a 6.7% increase. The borough's adult population is growing at a faster pace than in London and England. The growth rate in the borough's 18+ population is 5.2 per cent and has increased above the London rate (4%), between 2011 and 2014. Growth is also ahead of that for England.
- Our borough has the highest population percentage of children and young people aged 0 to 19 at 32.3% in England. Since 2011 the growth in the numbers of children aged 0-5 has slowed down and the population bulge has now moved to the 6-19 age groups.
- The over 65 population accounts for 10.4% of the overall population which is the 15th lowest in England. Whilst the elderly population has not grown dramatically, the number in the older ages is increasing, which could indicate higher care requirements.
- There has been a large decrease in the white population from 80.86% in 2001 to 49.46% in 2011.
- The Black African population has risen from 4.44% to 15.43%. This is the second highest proportion of this population group within a local authority across England and Wales. At the same time there has been a big rise in the Bangladeshi population from 673 to 7,701.
- In 2016 the BME population will make up 51% of the resident population. This is projected to keep on rising: by 2020, the BME population is estimated to have increased by 58%.
- Our borough still experiences high levels of deprivation ranking 7th most deprived in London and 22nd most deprived area nationally.
- Lone parent households with dependent children have seen a large increase with Barking and Dagenham now having the highest percentage of lone parent households in England and Wales at 14.3%. This is much higher than in other parts of London and England.
- There has been an increase in all religious groups in the borough, with the exception of Christian and Jewish groups. The number of Muslims has seen the most significant growth with the proportion rising from 4.36% to 13.37%.
- There are now significantly fewer people with no qualifications representing a 14.4% drop in numbers between 2001 and 2011.
- In 2011 49% of the working age population (16 to 65) were either employed (38%), self employed (9%) or full time students (2%)

[8] Turning the tide of inactivity; http://ukactive.com/downloads/managed/Turning_the_tide_of_inactivity.pdf 2014.

5.What will this strategy mean for the residents of Barking and Dagenham?

The key outcome from the implementation of this strategy is to enable more local people, including vulnerable people to achieve and maintain a healthy weight. This will be measured by an increase in the percentage of the residents engaging in healthy activities. Associated high level outcomes will be: a decrease in the percentage of residents who are physically inactive; improved mental well being; increased levels of perceived self-efficacy; and increased levels of social and community development.

Enable families and individuals to take responsibility for achieving and maintaining a healthy weight

Outcomes

- Families and individuals use knowledge about healthy food to make choices about what to buy and to cook.
- Families and individuals are physically active because they understand the importance of keeping activity.
- Families and individuals use locally available, and accessible, information to help them to change behaviour, improve diet and increase physical activity.
- Individuals want family members to be a healthy weight and understand that this can prevent weight linked diseases i.e. Type II diabetes, high blood pressure, heart disease, and joint pain.

Make an active lifestyle and healthy eating the easier choice

Outcomes

- Workers can make healthy food choices at their place of work.
- Children and young people can make healthy food choices at their schools by committing to the updated school food standards; and partake in school physical activity and sports.
- Residents can purchase healthy food including snacks in public and community facilities in the borough.
- Residents can purchase healthy food choices when shopping in the borough.

Address causes that put particular groups of families and individuals at a greater risk of obesity

Outcomes

- Residents in communities ‘at risk’ report improved knowledge, skills, access to healthy food and physical activity.
- Increased activity in localities where hard to reach groups are resident.

Ensure the built and natural environment support families and individuals to be more healthy and active

Outcomes

- Workers, children and young people actively use active travel planning.
- Families and individuals reporting using green space in the borough.
- Increased focus in using public spaces and town planning with sport and activity becoming a central theme, not a design afterthought.

6. What is a "Healthy Weight"?

All human bodies are built differently, therefore a **'healthy weight'** is defined as when an individual's body weight is appropriate for their height and benefits their health. Excess weight on the other hand arises when energy intake exceeds energy expenditure. **Simply put this means when a person eats and drinks too many calories which do not balance with the amount of physical activity, they develop excess weight.**

Excess weight for adults and children are categorised into 'overweight' and 'obese', and the unit measure is 'Body Mass Index (BMI)'.

Table 1: NICE BMI classification of overweight and obesity in adults

Classification	BMI Centile
Underweight	<18.5
Healthy weight	18.5 - 24.9
Overweight	25.0 - 29.9
Obese	30.0 - 39.9
Morbidly Obese	>40

Excess weight is calculated slightly differently for children and this is adjusted for a child's age and the sex of the child. The National Childhood Measurement Programme (NCMP) uses BMI reference charts to classify children which take into account children's weight and height for their age and sex. Children over the 85th centile are considered overweight and those over the 95th centile, obese (see table 2).

Table 2: UK National BMI percentile classification for a child*

Classification	BMI Centile
Underweight	≤2nd Centile
Healthy weight	2nd - 84.9th Centile
Overweight	85th – 94.9th Centile
Obese	≥95th Centile

**The thresholds given in Table 2 are those conventionally used for population monitoring and are not the same as those used in a clinical setting (where overweight is defined as a BMI greater than or equal to the 91st but below the 98th centile and obese is defined as a BMI greater than or equal to the 98th centile).*

We all live in communities and where and how we live, work and play impacts on both diet and physical activity. This strategy takes a whole systems approach to address these issues.

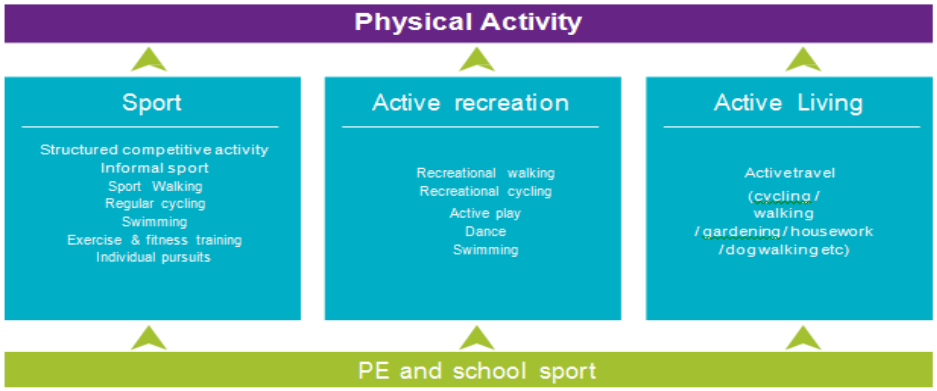
Physical Activity

Physical activity is a broad and inclusive term that includes: 'all forms of physical activity that contribute to physical fitness, mental well-being and social interaction. These include daily living, play, recreation, organised, casual or competitive sport and indigenous sports and games[9]. Physical activity is associated with health and academic benefits for children, such as improved academic performance, muscle and bone strength, health and fitness, improved quality of sleep and maintenance of a healthy weight[10].

Active Living is a way of life in which physical activity is valued and integrated into daily living, including using green space for gardening, walking or cycling to work, and DIY.

Active Recreation is generally unstructured activity that individuals freely pursue in their leisure time for a sense of enjoyment that also benefits their physical, social and emotional well being and includes using green space in the borough, exercise, dance, swimming for leisure, and aerobics.

Sport means 'all forms of physical activity which through casual or organised participation, aims at expressing or improving fitness and mental well-being, forming social relationships or obtaining results in competition at all levels' (Council of Europe's European Sports Charter, as adopted by Sport England).



[9] UN Inter-Agency Task Force on Sport for Development and Peace 2003
[10] Childhood Obesity – A Plan for Action, DH 2016

Healthy Eating

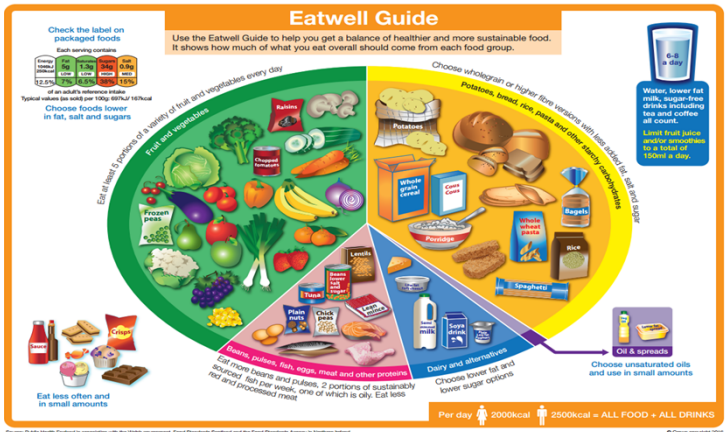
Healthy eating is defined as eating a wide range of foods to ensure that you are getting a balanced diet and that your body is receiving all the nutrients it needs[11].

The Eatwell Guide[12] shows the proportions of the main food groups that form a healthy, balanced diet, people are advised to:

- Eat at least 5 portions of a variety of fruit and vegetables every day
- Base meals on potatoes, bread, rice, pasta or other starchy carbohydrates; choosing wholegrain versions where possible
- Have some dairy or dairy alternatives (such as soya drinks); choosing lower fat and lower sugar options
- Eat some beans, pulses, fish, eggs, meat and other proteins (including 2 portions of fish every week, one of which should be oily)
- Choose unsaturated oils and spreads and eat in small amounts
- Drink 6-8 cups/glasses of fluid a day

If consuming foods and drinks high in fat, salt or sugar have these less often and in small amounts.

Eatwell Guide, PHE 2016



[11] http://www.nhs.uk/Livewell/Goodfood/Pages/eight-tips-healthy-eating.aspx
[12] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/510366/UPDATED_Eatwell-23MAR2016_England.pdf

7. The Importance of community engagement and frontline health services

Barking and Dagenham

It is important to support community led activity that helps people take responsibility for their own health. In future, this will involve working closely with all partners to mobilise and activate communities around health and wellbeing.

We want to help people to:

- Work together to use community assets and make good use of the local environment.
- Work together to reach everyone in our community.
- To work with council and health colleagues so that healthy weight is included where needed in new ways of delivering services.
- Make solutions sustainable.

Complex factors can lead to obesity; the problem will not be reversed by any single approach. A key action will be to mobilise and activate communities by providing a model and process for community engagement. Mobilise community assets and make better use of the local environment to engage the hard to reach populations.

Community

The community has a large role to play in developing a healthy weight environment for instance there is a need to improve the practical food skills and knowledge of children and families so they are empowered and motivated to make healthy food choices. Through building capacity in the community and workforce this can be achieved.

In addition schools, children centres, workplace and hospital set in the community provide a unique opportunity to influence the health of the pupils, workforce and the wider community that visit and use them. It is essential that they actively promote healthy eating, physical activity and active travel leading by example.

Frontline health services

Preventing families and individuals being overweight is important and it is also important that we have effective and tailored services for those people who are already overweight and obese so that they can lose weight and keep a healthy weight. Services therefore need to be channelled towards the overweight, tailored to individual needs and based around the family to prevent future obese generations.

We want to use the potential of front line health services in GP practices and pharmacies to support individuals to manage their weight. This will be through making sure that families and individuals who are ready to make a change are supported and where necessary referred to weight management services. Public health will work in partnership with GPs and pharmacists to strengthen the offer in frontline health services, including signposting to relevant training and offering a menu of supported and self-help interventions. .

Professionals such as GPs, practice nurses, pharmacists and health trainers have a large role to play in terms of early identification, brief interventions and referral into weight management services. Support will be given to implement evidenced based care pathways for pregnancy (pre, post and during), children and adults. There is a strong case for early identification and intervention to reduce the demand for surgery and life long care.

8. Benefits of residents maintaining a healthy weight

Maintaining a healthy weight is an extremely important part of good health and wellbeing. Excess weight is more than simply an individual's problem; rather it is a wider community problem.

Being overweight affects residents by making them more likely to develop medical conditions linked to excess weight, e.g. diabetes. Excess weight also contributes to increasing health care costs and decreasing productivity in the community and wider society.

Maintaining a healthy weight is not always easy. The key to success is making changes in daily eating and physical activity habits that can be maintained over one's lifetime. The community has a huge role to play in improving the health of its members by increasing healthy food and activity choices.

This strategy will contribute towards residents developing a positive attitude to a prevention approach. This is at the very heart of the Care Act 2014 which highlights that the most important element of supporting health and wellbeing, are actions and activities that help to develop prevention. In regards to healthy weight this means not waiting to respond when people reach an unhealthy weight, or individuals are at an increased risk for developing other health challenges.

This can be achieved by encouraging social responsibility; this relies on good community and individual resilience, supported by an effective infrastructure and access to a range of appropriate, high quality local services. This in turn will make a significant contribution towards achieving the boroughs policy objectives especially in areas such as social inclusion and regeneration.

Social inclusion

Access to healthy foods in schools and communities brings together individuals and families Community orchards are a good example of social cohesion in action.

Physical Activity, clearly brings people together and greatly contributes to breaking down social and cultural barriers, creating common ground, a sense of belonging, it fosters civic and social pride as well as achieving community cohesion, especially in diverse communities.

Participation in physical activity helps tackle isolation whilst improving people's purpose, self-esteem and confidence.

Increasing the use of good quality green space for all social groups is likely to improve health outcomes and reduce health inequalities. It can also bring other benefits such as greater community cohesion and reduced social isolation

Regeneration and growth

Barking Riverside has been awarded the status of a "Healthy New Town" – this means the council and its partners apply the latest health and social care research and practice in the planning and development of the built environment to create a healthy and resilient community. Residents of Barking Riverside are set to benefit from an initiative which will see developers and health practitioners work with the local authority to promote health and keep people independent.

The regeneration opportunity fosters more partnership working and collaboration opportunities. The development of sports facilities, like Abbey Leisure Centre, as well as transformational schemes in our parks and open spaces, such as at Barking park and Mayesbrook park, can play an important role in enhancing the image of the area as a place to live and do business in.

Lifelong learning

There is an increasing weight of evidence to demonstrate that maintaining a healthy weight has a positive impact on educational attainment especially in young people.

Physical activity also helps by giving both young and older people the opportunity to develop new skills, as well as the confidence and motivation to gain qualifications that can ultimately lead to employment and career development.

9. Equality and diversity

The intention of this strategy is to make maintaining a healthy weight achievable for all sections of the community. An Equality Impact Assessment has been carried out to inform this strategy, outlining how the needs of the borough's diverse communities have been taken into consideration in the development of the strategy and the actions proposed.

We know that certain groups, such as women and girls, older people, disabled people and people from lower socio-economic groups, are significantly less likely to be physically active or to lead healthy lifestyle.

A range of different factors are the reason for this under-representation and so it will be important to understand the breadth of causes in designing solutions to address this. For example, recent research on reasons for non-participation in sport by young people has highlighted not just obvious potential barriers, such as cost, but also issues such as the availability of the right kind of informal activities and emotional barriers around perceptions of safety and ownership of local leisure facilities and parks

It is also the case that under-representation may be a problem within more widely defined groups, for example, there may be specific barriers to participation for some lesbian, gay, bi-sexual or transgender people and some Black Asian and Minority Ethnic groups, which are not immediately apparent when looking at the overall participation levels for those groups as a whole.

It will be important that any actions to address under-representation is informed by insight and evidence of what already works locally as well as drawing on best practice nationally. The English Federation of Disability Sports have published *Talk to Me* principles which outline ten clear steps that can be followed to make activities more appealing to disabled people. We will look to adopt this for all our under-represented community groups. Another example of best practice would be the Disability Rights UK's *Get Yourself Active* project, which is led by and for disabled people, provides a template for disabled people's user led organisations (DPULOs) that can effectively lead the development of better physical activity and sporting opportunities for disabled people.

This strategy advocates targeted interventions to encourage and enable under-represented groups to lead healthy lifestyles.

10. Key strategies, plans and guidance

The priorities and actions set out in the strategy have been developed by a multidisciplinary group, with an interest in healthy weight.
There are a number of key national, regional and local strategies and policies that have both influenced and had an impact on the development of the strategy; these are set out in the table below;

Level	Key Strategies, Plans and Guidance	
National Policy and Strategy Documents	• Childhood Obesity – A Plan for Action, DH 2016 • Five Year Forward View, NHS England 2014 • Care Act 2014 • Towards an Active Nation, Sport England Strategy, 2016 • Working Together to Promote Active Travel: A briefing for local authorities, PHE 2016 • Everybody Active, Every day (PHE 2014) • PE and Sport Strategy for young people (PESSYP) (2009) • Sporting Future: a new strategy for an active nation (HM Government, 2015) • Turning the tide of inactivity – UKActive (2014) • Healthy Lives, Healthy People: A call to action on obesity in England (2011) • Marmott Review – Fair Society, Healthy Lives (2010) • Active Travel Strategy - Department for Transport & Department of Health (2010) • An update on the government's approach to tackling obesity (2012) • Eatwell Guide, PHE, 2016 • No health Without Mental Health, DH, 2011	• National Diet and Nutrition Survey: Headline Results from Years 1, 2 and 3 (combined) of the Rolling Programme 2008/09 – 2010/11 (2012) • Healthy lives, healthy people: Improving outcomes and supporting transparency (2012) • Healthy lives, healthy people: a call to action on obesity in England (2011) • UK physical activity guidelines (2011) • Changing Behaviour, Improving Outcomes: A new social marketing strategy for public health • The Independent School Food Plan (2013) • New Local Government Network report: Healthy Places - Councils leading on public health (2012) • NICE public health guidance: Obesity - working with local communities (2012) • NICE public health guidance: Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation (2012) • NICE Public health briefings for local government: physical activity and workplace health (2012), behaviour change and walking and cycling (2013)
Regional Policies, Strategies and Plans	• Sustainability and Transformation Plan, North East London, NHS England, 2016 (draft at time of writing) • Better Health for London – The report of the London Health Commission 2014 • Blueprint for a physically active sporting city (London Sport 2015) • Convergence – Strategic Regeneration Framework 2011 – 15 • GLA Guide – Better Environment, Better Health – LBBD (2013)	
Local Policies, Strategies and Practices	• Health and Well Being Strategy - Barking and Dagenham Partnership (2015) • Parks and green spaces strategy (2003) • Playing pitch strategy (2015) • Growth Strategy (2015) • Joint Strategic Needs Assessment (2015) • LBBD Mental Health Strategy Draft (2016) • Five Ways to Wellbeing	

11. Priority themes

The Healthy Weight Alliance recognises that no individual agency can overcome the challenges facing the borough and its residents; but by working together and building on resources and assets in our communities we can make collective changes. Our Health and Wellbeing Strategy outlines the assets that we are lucky enough to be able to drawn on in the borough.

We have taken a life course approach, in line with our Joint Health and Wellbeing Strategy to achieve our strategic objectives. Six life stages have been agreed.

- Pre-birth and early years
- Primary school (5 – 11 years)
- Adolescence (12 – 18 years)
- Adulthood (19 – 65 years)
- Older people (66 years +)
- Vulnerable groups

In addition to these life stages we recognise that we have vulnerable and minority members of our community who have special requirements, people from minority ethnic groups, people with mental health issues, people with learning disabilities, and people living with physical disability.

Theme 1

Pre-birth and early years

Key actions are:

1. We will increase the percentage of mothers booked in with Maternity Services by the 13th week of pregnancy.
2. We will support expectant mothers to achieve an appropriate weight gain during pregnancy.
3. We will increase the number of babies who are breastfed.
4. We will support parents and carers to establish a healthy lifestyle (diet and physical activity) for their children from a very early age.
5. We will support children and parents in settings and encourage healthy activity in the family.

Theme 2

Primary school (5 – 11 years)

Key actions are:

1. We will continue to support and deliver the National Childhood Measurement Programme.
2. When children and families are identified as needing support to achieve a healthy weight, we will enable them to access support.
3. We will work with schools to support them to achieve the provision and standards required to reflect local needs for example the 'Healthy Schools London' awards at primary school level.
4. We will promote access to a range of healthy food choices, lunch boxes and vending (this will be meet statutory requirements and School Food Plan guidance where applicable).
5. We will support children to develop skills and confidence in their physical ability and nutrition knowledge.
6. We will promote local community ownership and the family role in achieving and maintaining a healthy weight.

Theme 3

Adolescence (12 – 18 years)

Key actions are:

1. We will support a whole family and young person approach to promote healthy eating and physical activity.
2. When adolescents and families are identified as needing support to achieve a healthy weight we will enable them to access support.
3. We will work with schools to support them to achieve the provision and standards required to reflect local needs for example the 'Healthy Schools London' awards at secondary school level.
4. Promote access to a range of healthy food choices, lunch boxes and vending (this will be meet statutory requirements and School Food Plan guidance where applicable).
5. We will support adolescents to maintain and deepen their skills, knowledge and confidence in their physical ability and nutrition knowledge.

Theme 4

Adulthood (19 – 65 years)

Key actions are:

1. We will support national/local initiatives to measure the prevalence of overweight and obesity and any linked factors, e.g. diet and exercise in our local population.
2. We will increase the number of adults 40 years plus who have an NHS heath check.
3. When adults are identified as needing support to achieve a healthy weight we will enable them to access support.
4. We will support local community ownership, the family and individual roles in achieving and maintaining a healthy weight.
5. We will support work places, including partner work places, to promote healthy choices including diet and physical activity.

Theme 5

Older people (66 years +)

Key actions are:

1. We will encourage older adults to be physically active by accessing leisure services and recreational activities.
2. When older adults are identified as needing support to achieve a healthy weight we will enable them to access support.
3. We will maintain the number of activity programmes aimed at 60+ residents.

Theme 6

Groups needing additional support

(Minority ethnic groups, people with mental health issues, people with learning disabilities, and people living with physical disability)

Key actions are:

1. We will ensure that children with a learning disability under 5 years have an annual check and health plan.
2. We will increase the percentage of adults with a learning disability with annual health check and personal plan.
3. When vulnerable individuals are identified as needing support to achieve a healthy weight we will enable them to access support.
4. We will increase the number of vulnerable adults taking part in physical activity for example individuals with dementia.
5. We will improve health outcomes for looked after children, care leavers and youth offenders by 2018.
6. We will implement an 'inclusive and active' action plan to raise participation in sport and physical activity by disabled people.

12. Cross cutting themes

To make the healthy weight strategy a reality there are a two important cross-cutting themes, healthy environment and community engagement.

Theme 7
Healthy environment

Key actions are:

1. We will develop an environment that promotes physical activity as part of daily life, including active transport e.g. a sustainable transport network that makes walking and cycling the default form of travel around our communities.
2. We will incorporate Health Impact Assessments (HIAs) into all new and existing housing developments.
3. We will support the use and development of high quality green space and infrastructure.
4. We will improve access to healthy foods in the retail and catering environment through the use of planning tools and public transport links.
5. We will promote safe access to active travel.

Theme 8
Community engagement

Key actions are:

1. We will undertake an asset mapping exercise to define where community assets are in place.
2. We will develop a communications strategy to help residents to #makeachange and reduce the barriers to them getting healthy in the borough.
3. We will engage residents in regular conversations.

To support the healthy weight strategy and to make it a success there is a need for training and communications.

Theme 9
Training

Key actions are:

1. We will support health professionals to give clear, consistent, evidence-based advice around healthy weight (diet, physical activity, play etc.)
2. We will support wider staff to give brief advice around healthy weight (diet, physical activity, play etc.)
3. We will support health professionals to help identify individuals who are already overweight and offer them support to manage their weight and signpost them to services.
4. We will support and encourage key residents in the community to become champions of healthy weight.

HEALTH AND WELLBEING BOARD

27 September 2016

Title: Health and Wellbeing Outcomes Framework Performance Report – Q1 (2016/17)	
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: NO**
Report Author: Fiona Wright Chris Bush Tudor Williams	**Contact Details:**
Sponsor: Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham	

Summary:

Background

The quarter 1 performance report provides an update on health and wellbeing in Barking and Dagenham. It reviews performance for the quarter, highlighting areas that have improved, and areas that require improvement. The report is broken down into the following sub-headings:

1. Introduction
2. Key Performance Indicators
3. CQC inspections
4. Additional performance information and analysis requested by the Health and Wellbeing Board
5. Additional performance information and analysis from Systems Resilience Group
6. Mandatory implications
7. List of Appendices

Recommendation(s)

Members of the Board are recommended to:

- Review the overarching dashboard, and raise any questions with lead officers, lead agencies or the chairs of subgroups as Board members see fit.
- Note the detail provided on specific indicators, and to raise any questions on remedial actions or actions being taken to sustain good performance.
- Note the areas where new data is available and the implications of this data; specifically, children and young people accessing tier 3/4 Child and Adolescent Mental Health Services, annual health check of looked after children, chlamydia screening, smoking quitters, breast screening, the percentage of people receiving care and support in the home via a direct payment, delayed transfers of care and Care Quality Commission inspections.

Reason(s)

The dashboard indicators were chosen to represent the wide remit of the Board, whilst

remaining a manageable number of indicators. It is, therefore, important that Board members use this opportunity to review key areas of Board business and confirm that effective delivery of services and programmes is taking place. Subgroups are undertaking further monitoring across the wider range of indicators in the Health and Wellbeing Outcomes Framework. When areas of concern arise outside of the indicators ordinarily reported to the Board, these will be escalated as necessary.

1. Introduction

1.1 The Health & Wellbeing Board has a wide remit, and it is therefore important to ensure that the Board has an overview across this breadth of activity. The indicators included within this report show performance of the whole health and social care system, including the Barking and Dagenham Health and Wellbeing Strategy Outcomes Framework, the Systems Resilience Group's Urgent Care Dashboard, information on CQC inspections as well as performance information drawn from the reporting of partners on the Health and Wellbeing Board.

Structure of the report

1.2 The following report outlines the key performance indicators for the Health and Wellbeing performance framework. The indicators are broken down across the life course for Children, Adolescence, Adults, Older people and Across the life course. All indicators are RAG rated and any indicator that is RAG rated as red or has seen a significant change has additional commentary available in Appendix C.

Changes to reporting for 2016/17

1.3 This report has been updated in line with the corporate and portfolio performance reports.

2. Key Performance Indicators

2.1 The dashboard is based on key performance frameworks: Public Health Outcomes Framework, Adult Social Care Outcomes Framework, Health and Wellbeing Board Outcomes Framework and Better Care Fund

2.2 The dashboard matches the Health and Wellbeing Strategy and is structured by stages in the life course and is available at Appendix A. Where performance is rated as red or there has been a significant change in performance further analysis has been provided within the report.

Children

2.3 Key indicators for Children are:

Percentage of Uptake of Diphtheria, Tetanus and Pertussis (DTaP) RAG: **Amber.**

Percentage of Uptake of Measles, Mumps and Rubella (MMR2) Immunisation at 5 years old RAG: **Red**

Prevalence of children in reception year that are obese or overweight RAG: **Red.** There is currently no new data available for this indicator. New data is expected to be available in November 2016.

Prevalence of children in year 6 that are obese or overweight RAG: **Red.** There is currently no new data available for this indicator. New data is expected to be available in November 2016.

Number of children and young people accessing Tier 3/4 CAMHS services. RAG rating not Applicable

Annual health check Looked After Children RAG: **Red**

The number of children subject to Child Protection Plans RAG: **Green**

2.4 Where the indicators are RAG rated red or where there has been a significant shift in performance, further information and analysis is provided in Appendix C.

Adolescence

2.5 Key indicators for Adolescence are:

Under 18 conception rate (per 1000) and percentage change against 1998 baseline RAG: **Red**

Care leavers in education, employment or training (NEET) RAG: **Amber.**

2.6 Where the indicators are RAG rated red or where there has been a significant shift in performance, further information and analysis is provided in Appendix C.

Adults

2.7 Key indicators for Adults are:

Number of four week smoking quitters RAG: **Red**

Cervical Screening RAG: **Amber.** The is currently no new data available for this indicator. New data is expected to be available in November 2016.

Coverage of women aged 25 -64 years RAG: **Amber.** There is currently no new data available for this indicator. New data is expected to be available in November 2016.

Percentage of eligible population that received a health check in last five years RAG: **Red**

2.8 Where the indicators are RAG rated red or where there has been a significant shift in performance, further information and analysis is provided in Appendix C.

Older Adults

2.9 Key indicators for Older adults are:

Breast Screening - Coverage of women aged 53-70 years RAG: **Amber**. There is currently no new data available for this indicator. New data is expected to be available in November 2016.

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes RAG: **Amber.**

The outcome of short term services: sequel to service RAG: **Amber.**

Injuries due to falls for people aged 65 and over RAG: **Green**. There is currently no new data available for this indicator.

2.10 Where the indicators are RAG rated red or where there has been a significant shift in performance, further information and analysis is provided in Appendix C.

2.11 No indicators with RAG ratings red or significant shifts in performance

Across the Lifecourse

2.12 Key indicators for Across the lifecourse are:

The percentage of people receiving care and support in the home via a direct payment RAG: **Amber.**

Delayed transfers of care from hospital RAG **Amber.**

Emergency readmissions within 30 days of discharge from hospital RAG: **Green**. Data available from the BHRUT board performance papers show that for May 2016 the trust were performing at 6.12% (Year to Date) with 5.59% within the month. BHRUT are performing above the standard which is 14.54%. The BHRUT board performance report indicates that the trust have been consistently operating above the standard over the last year. **Please note that this data is for BHRUT and not Barking and Dagenham alone.**

A&E attendances < 4 hours from arrival to admission, transfer or discharge (type all) RAG: **Red**

Unplanned hospitalisation for chronic ambulatory care sensitive conditions RAG: **Red**. There is currently no new data available for this indicator.

The number of leisure centre visits RAG: **Green**

The number of children and adult referrals to healthy lifestyle programmes RAG **Green**

Number of turned around troubled families RAG: **Red** at the end of Quarter 1 however data from July changes the RAG rating of this indicator to **Green**.

2.13 Where the indicators are RAG rated red or where there has been a significant shift in performance, further information and analysis is provided in Appendix C.

3. CQC Inspections

3.1 Appendix B contains an overview of CQC inspection reports published during Q1 2016/17, including those relating to GP surgeries, social care providers, and all other healthcare providers in the borough, or those who provide services to our residents. Those providers where standards have fallen below expected levels, and either require improvement or have resulted in special measures being put in place, are listed below.

BHRUT

3.2 The CQC revisited the Trust in March 2015 and found that there were improvements in responsiveness to patient needs, however at times there were still significant delays in initial clinical assessment.

Barking and Dagenham CCG care quality commission action plan

The care quality commission (CQC) have so far inspected 13* GP practices in Barking and Dagenham. These inspections have taken place under the new inspection criteria that came in to affect in October 2014. An additional 3 practices were inspected under the old criteria (prior to October 2014) each were rated as 'all standards met'.

3.3 Of these nine have been rated as 'good', two as 'requires improvement' and two rated as 'inadequate' and placed in special measures.

Where a practice is rated as requires improvement, or inadequate, the practice is required to develop an improvement plan which is then monitored by the CQC. Where a practice is rated as inadequate the practice will be re-inspected by CQC within six months.

Heathway Medical Centre – in special measures

3.4 Heathway Medical Centre is in a purpose built building, shared with another GP practice, located in a residential area in Dagenham. The registered patient list is 3800. Concerns were raised by the CQC from the inspection on 26 May 2016, published on 1 September 2016. Specifically, concerns around patient safety, service efficiency and leadership. Care and responsiveness also required improvement.

The practice has been placed in special measures and will be inspected again within six months of its original inspection. If sufficient improvements have not been demonstrated by Heathway Medical Centre, then CQC can take enforcement actions that could ultimately lead to the cancellation or variation of the terms of their registration.

The CCG are supporting the practice to put into action a plan to improve all aspects of the service provided to residents. The action plan and report on changes made will be taken to the Primary Care Commissioning Board. Matthew Cole, Director of Public Health, is a member of this board.

Five Elms Medical Practice – in special measures

3.5 Five Elms Medical Practice is a single location practice providing GP primary care services to approximately 4,300 people living in the Dagenham. Concerns were raised by the CQC in the inspection on 5 April 2016, published on 25 August 2016. Specifically, concerns were raised around patient safety, service efficiency, care, responsiveness and leadership.

The practice has been placed in special measures and will be inspected again within six months of its original inspection. If sufficient improvements have not been demonstrated by Five Elms, then CQC can take enforcement actions that could ultimately lead to the cancellation or variation of the terms of their registration.

The CCG are supporting the practice to put into action a plan to improve all aspects of the service provided to residents. The action plan and report on changes made will be taken to the Primary Care Commissioning Board. Matthew Cole, Director of Public Health, is a member of this board.

The inspection reports are also presented to the Barking and Dagenham Primary Care Commissioning Committee - in some cases the practices are already being monitored by the CCG for contractual reasons. The committee will then review the report and where applicable take further action; for example issue a contract remedial/breach notice and the practice would be required to put a remedial plan in place.

How the CCG is supporting practices to address issues?

3.6 Practices are responsible for making the required improvements and ensuring they meet the CQC requirements. However, the CCG is working with practices to support them to deliver the high quality care that patients expect.

Across Barking and Dagenham, and our partner CCGs, Havering and Redbridge, we have reviewed the common themes that have come out of recent CQC reports on GP practices.

The common themes identified include:

- Safeguarding
- Chaperones
- Policies
- Pre-employment checks including DBS and references
- Health and safety
- Risk management
- Infection control
- Medicines management
- Mandatory training

To address these areas the CCGs has developed a plan to actively support practices to improve in key areas. This includes providing practices with best practice guidance, and information on training available, along with information on other recommended services and support, such as how to access DBS checks and language services.

The CCG is also in the process of reviewing practice training requirements and will set up some specific training sessions for practice staff and GPs particularly around:

- Managing risk and learning from mistakes
- Health and safety
- CPR
- Equality and diversity
- Informed consent
- Informed decision making
- Whistle blowing
- Fire safety

Governance

The CCG also has Practice Improvement Leads who work with practices around specific pieces of work. Most recently they have been pro-actively supporting practices complete the national diabetes audit and talking to practices about the dementia work programme.

The CCG is also in the process of establishing a Quality Improvement Board with the neighbouring CCGs in North East London – we will advise of further detail about the board in the autumn.

National support for practices

3.7 Recently, NHS England has issued guidance about the General Practice Resilience Programme (GPRP) that will operate to deliver the commitment set out in the General Practice Forward View to invest £40m nationally over the next four years to support struggling practices. The programme aims to deliver a menu of support that will help practices to become more sustainable and resilient, so better placed to tackle the challenges they face now and into the future, and securing continuing high quality care for patients.

In 2016/17 there is £2.6m available from this fund in London to be invested in support to help practices become more sustainable and resilient, with further money available per year thereafter until March 2020.

Working with NHS England the CCG is currently undertaking an assessment of practices to define where this support should be focused. The CCG will then need to develop a plan to ensure that practices in the borough are able to appropriately develop in order to be sustainable and resilient.

Sahara Parkside Care Home – Requires Improvement

3.8 Sahara Parkside is a 30 bedded residential home located in Barking. The home offers specialist accommodation, care and support for adults with learning disabilities, who may have other conditions, including sensory impairment, a physical disability or other complex needs.

The Care Quality Commission (CQC) inspection report which was published on 5 April 2016 found that four out of five of the areas (Safe, Responsive, Effective and Well-Led) required improvement. It was agreed that improvements were required in consideration of the risks posed to the current service users and a suspension on future admissions was agreed until the required improvements were made.

Between May and the end of June 2016, regular Quality Assurance Audits of the provider were undertaken by LBBD and an action plan was agreed with them. As a result of sustained and significant improvement in the provision of safe and effective services at Sahara Parkside, the suspension on placements was lifted in July 2016. LBBD Quality Assurance staff continue to monitor the provider regularly and this will only be reduced when no further concerns are identified going forward.

Alexander Court Care Centre – Requires Improvement

3.9 Alexander Court is an 80+ bed nursing home situated in Dagenham. Concerns were raised by CQC during their inspection which was published on 9 June 2016. This inspection rated Alexander Court as being good at caring and being responsive,

inadequate at maintaining a safe environment and a service that requires improvement in the areas of effectiveness and being well led. As a result of these concerns, a joint inspection was carried out by the local authority (Operational Social Care and Commissioning), the Clinical Commissioning Group (CCG) and Environmental Health. This led to the imposition of a formal suspension on placements to the care home.

A detailed action plan was agreed with the care home, who also provided supporting evidence of actions being met, and a further joint review was undertaken by the CCG and the local authority in August 2016. Following this it was determined that there had been sufficient significant improvement to lift the suspension of admissions at the care home.

Alexander Court will remain on a heightened level of inspection by both the CCG and LBBD over the next 6 months and the improvement plan will continued to be worked through, and maintained, by the care home.

Cloud House Care Home – Requires Improvement

3.10 The Cloud House CQC inspection report was published on 17 June 2016 and rated the service as Good for the 'Caring' category. However, CQC also rated it as requiring improvement in the areas of Safe (Medication audits in the home were not effective and the process for staff promotions was not clear), Effective (Staff completing their induction had not received sufficient training to ensure they had the skills required to perform their roles), Responsive (The service did not complete formal needs assessments before people moved into the home) and Well-led (the service did not record the lessons learnt from incidents that occurred).

Cloud House are part of the local authority's quality assurance monitoring process and their progress with improvements, as part of the CQC action plan, is being monitored.

4. Additional performance information and analysis requested by the Health and Wellbeing Board

4.1 The Health and Wellbeing Board has asked for regular reporting on BHRUT's Referral to Treatment performance. A series of slides providing an update on the position is attached at Appendix E. A letter from Dr Nadeem Moghal, Medical Director at BHRUT and member of the Health and Wellbeing Board, addressing issues raised by the Health and wellbeing board at previous meetings is attached at Appendix F.

5. Additional performance information and analysis from Systems Resilience Group

5.1 **Delayed Transfer of Care (DTOC)** – As of July 2016 BHRUT are not achieving less than the local standard of 20 DTOCs with 24 DTOC patients reported. This is a worsening position when comparing against June 2016 performance (20).

5.2 **Urgent Care Centre (UCC) 4 hour waits**

Queens Hospital – For July 2016 the UCC at Queens Hospital is not achieving the 99% standard for seeing patients within 4 hours. July 2016 performance is currently at 98.48%. This is a reduction on performance compared to the June 2016 position of 98.98%.

King George's Hospital (KGH) – For July 2016 the UCC at King George's Hospital is achieving the 99% standard for seeing patients within 4 hours. July 2016 performance is currently at 99.51%. This is a slight reduction on performance compared to the June 2016 position of 99.85%.

6. Mandatory implications

Joint Strategic Needs Assessment

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

Joint Health and Wellbeing Strategy

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

Integration

6.3 The indicators chosen include those which identify performance of the whole health and social care system, including in particular indicators selected from the Systems Resilience Group's dashboard.

Legal

Implications completed by: Christopher Pickering

6.4 There are no legal implications for the following reasons:

The report highlights how the various bodies have met specific targets such as the performance indicators: whether they have or have not been met in relation to the indicators for London and England. How the authority is measuring up against the National average.

Financial

Implications completed by: Katherine Heffernan

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

7. List of Appendices

Appendix A: Performance Dashboard

Appendix B: CQC inspection report for Adult Social Care

Appendix C: Performance summary reports

Appendix D: Urgent and Emergency Care Programme Dashboard

Appendix E: BHRUT RTT Update

Appendix F: Letter from Dr Moghal re RTT

APPENDIX A

Key

Appendix A: Indicators for HWBB - 2015/16 Q4

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

														BENCHMARKING			
Title	**2014/15**	**2015/16**				**2015/16**	**2016/17**				**2016/17**	**DoT**	**RAG Rating**	**England Average**	**London Average**	**HWBB No.**	**Reported to**
		Q1	**Q2**	**Q3**	**Q4**		**Q1**	**Q2**	**Q3**	**Q4**							
1 - Children																	
Percentage of Uptake of Diphtheria, Tetanus and Pertussis (DTaP) Immunisation at 5 years old	85.1%	84.4%	83.8%	84.0%	88.0%	..						↗	A	95.7%	91.9%	1	PHOF
Year end figures not yet published. Data is published each quarter but when the full year figures are published they adjust for errors in the quarterly data and comprise all the children immunised by the relevant birthday in the whole year. Q1 2016/17 data has not yet published																	
Percentage of Uptake of Measles, Mumps and Rubella (MMR2) Immunisation at 5 years old	82.7%	81.0%	81.2%	93.8%	78.6%	..						↘	R	88.2%	79.9%	2	PHOF
Year end figures not yet published. 2014/15 Q4 data not yet published.																	
Prevalence of children in reception year that are obese or overweight	27.5%					..						↗	R	21.9%	22.2%	3	PHOF
Prevalence of children in year 6 that are obese or overweight	40.6%					..						↘	R	33.2%	37.2%	4	PHOF
Number of children and young people accessing Tier 3/4 CAMHS services	1,217	585	490	526	539	1,114	530					→	NC			5	HWBB OF
Year end figure is the number of unique people accessing CAMHS over the course of the year.																	
Annual health check Looked After Children	91.8%	82.0%	72.0%	73.8%	94.2%	94.2%	80.1%					↘	R	88.0%	90.0%	6	HWBB OF
The number of children subject to Child Protection Plans		320	323	292	253	253	265					↗	G			7	HWBB OF
2 - Adolescence																	
Under 18 conception rate (per 1000) and percentage change against 1998 baseline.	29.3	32.1	..	..	..							↗	R	21.6	19.9	8	PHOF
Number of positive Chlamydia screening results	541	118	130	125	120	493	..					↘	R			9	HWBB OF
Care leavers in education, employment or training (NEET)		52.0%	43.3%	45.2%	50.2%	48.4%	50.0%	..	..	..	..	→	A	48.0%	53.0%	9	HWBB OF
3 - Adults																	
Number of four week smoking quitters	643	121	89	131	211	551	155	..	..	..	..	↘	R			10	HWBB OF
Please note that the most recent quarter is an incomplete figure and will be revised in the next HWBB report.																	
Cervical Screening - Coverage of women aged 25 -64 years	70.1%					..					..	↘	A	73.5%	68.4%	11	PHOF
Percentage of eligible women screened adequately within the previous 3.5 (25-49 year olds) or 5.5 (50-64 year olds) years on 31st March. 2015/16 data due to be published November 2016																	
Percentage of eligible population that received a health check in last five years	16.3%	2.5%	2.9%	3.2%	3.1%	11.7%	2.6%	..	..	..	..	↘	R	9.6%	11.6%	12	PHOF
Please note that annual figures, and London and England figures, are a cumulative figure accounting for all four previous quarters. Please note base eligible population changed from 2014/15 and 2015/16.																	

Key

Appendix A: Indicators for HWBB - 2015/16 Q4

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

Title	2014/15	2015/16				2015/16	2016/17				2016/17	DoT	RAG Rating	BENCHMARKING		HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4				England Average	London Average		
4 - Older Adults																	
Breast Screening - Coverage of women aged 53-70 years	64.3%					..					..	↘	A	75.4%	68.3%	13	HSCIC
Percentage of women whose last test was less than three years ago. 2015/16 data due to be released February 2017																	
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	936.58	188.24	401.91	625.35	910	910	223.7	..	..	..	..	↗	A	668.4	463.9	14	BCF/ASCOF
The outcome of short term services: sequel to service	55.0					77.5	59.8	..	..	..	..	↘	A	74.6	69.9	19	ASCOF
Injuries due to falls for people aged 65 and over	1656.0					..					..	↘	G	2125.0	2253.0	16	BCF/PHOF
Directly age-sex standarised rate per 100,000 poulation over 65 years.																	
5 - Across the Lifecourse																	
The percentage of people receiving care and support in the home via a direct payment	75.7%	76.6%	75.1%	74.3%	73.2%	74.8%	71.4%	..	..	..	..	↘	A	62.1%	67.4%	17	ASCOF
Delayed transfers of care from hospital	135.2	158.0	197.5	213.7	251.8	205.3	183.7					↘	A	401.66	N/A	18	ASCOF
Emergency readmissions within 30 days of discharge from hospital		..	..	..	..	8.99%	..	..	..			↘	G			19	NHSOF
Taken from BHRUT board papers - standard 14.5%																	
A&E attendances < 4 hours from arrival to admission, transfer or discharge (type all)	85.3%	93.4%	92.3%	86.5%	79.8%	88.0%	81.7%	,,	,,	,,	,,	↘	R	95.0%		20	SRG
Unplanned hospitalisation for chronic ambulatory care sensititve conditions	1,015.8					..						↘	R	807.4	723.3	21	NHSOF
2015/16 Q1 data due to be released September 2016.																	
The number of leisure centre visits	1,282,430	384,043	373,784	334,615	363,103	1,455,545	383,895	..	..	..	..	↗	G			22	Leisure
The number of children and adults referred to healthy lifestyle programmes		692	753	512	735	2,692	677	..	..	..	..	↘	G			23	Leisure
Number of turned around troubled families			23	25	127	175	100	..	..	..	..	↘	R			24	NHSOF

APPENDIX B

Appendix B - CQC Inspections in Barking and Dagenham, 2016/17 Q1

Provider Name	Provider Type	Location	Link to report	Report Date	Inspection Date	Rating	Comments / Summary
Outlook Care	Care Home	Outlook Care - Maplestead Road	http://www.cqc.org.uk/location/1-124583683	08/04/2016	18/02/2016	**Good**	
Bupa Care Homes	Care Home	Chaseview	http://www.cqc.org.uk/location/1-127503453	05/05/2016	09/02/2016	**Good**	
Abbeyfield East London Extra Care Society Ltd	Care Home	The Abbeyfield East London Extra Care Society Limited	http://www.cqc.org.uk/location/1-112951275	19/06/2016	30/06/2016	**Good**	
Chinite Resourcing Ltd	Care Home	Chinite Resourcing Ltd	http://www.cqc.org.uk/location/1-326243330	23/06/2016	20/04/2016	**Good**	
LB Barking and Dagenham	Care Home	Millicent Preston House	http://www.cqc.org.uk/location/1-454801572	24/06/2016	04/05/2016	**Good**	
Sahara Parkside Ltd	Care Home	Sahara Parkside	http://www.cqc.org.uk/location/1-164893164	05/04/2016	16-19/02/2016	**Requires Improvement**	CQC rated requirements after an inspection in February 2016 as: Safe: Requires Improvement - Risk assessments and measures to reduce the risk of behaviour that challenged the service lacked detail Effective: Requires Improvement - Staff had not received the specialist training Responsive: Requires Improvement - Records of care delivered lacked detail Well Led: Requires improvement - Quality assurance systems had lapsed Action: LBBD Quality Assurance increased monitoring, undertook intensive work with the provider and also carried out unannounced visits on the scheme. A suspension on placements has now been lifted following significant improvements. Monitoring will only be deescalated upon evidence of prolonged improvement.

Provider Name	Provider Type	Location	Link to report	Report Date	Inspection Date	Rating	Comments / Summary
Delrose House	Care Home	Cloud House	http://www.cqc.org.uk/location/1-320058309	07/06/2016	12&15/04/2016	**Requires Improvement**	CQC rated requirements after an inspection in April 2016 as: Safe: Requires Improvement - Ineffective audits of medicine Effective: Requires Improvement Responsive: Requires Improvement Well Led: Requires Improvement - The service did not record the lessons learnt from incidents that occurred. Action: Review is scheduled and an update can be provided at the next meeting.
Lifestyle Care Management Ltd	Care Home	Alexander Court Care Centre	http://www.cqc.org.uk/location/1-2258796361	09/06/2016	10/03/2016	**Requires Improvement**	CQC rated requirements after an inspection in April 2016 as: Safety: Requires Improvement - The kitchen was not clean and medicines were not always administered safely. Effective: Requires Improvement - People did not always have access to nutritious food and drinks Responsive: Requires Improvement Well Led: Requires Improvement - Effective systems were not in place to monitor the quality of the service. Action: LBBD Quality Assurance increased monitoring, undertook intensive work with the provider and also carried out unannounced visits on the scheme. A suspension on placements has now been lifted following significant improvements. Monitoring will only be deescalated upon evidence of prolonged improvement.
Heathway Medical Centre	GP Surgery	Broad Street Resource Centre	http://www.cqc.org.uk/sites/default/files/new_reports/AAAF5830.pdf	01/09/2016	26/05/2016	**Inadequate**	The practice has been placed in special measures and will be inspected again within six months of its original inspection. If sufficient improvements have not been demonstrated by Heathway Medical Centre, then CQC can take enforcement actions that could ultimately lead to the cancellation or variation of the terms of their registration. The CCG are supporting the practice to put into action a plan to improve all aspects of the service provided to residents. The action plan and report on changes made will be taken to the Primary Care Commissioning Board. Matthew Cole, Director of Public Health, is a member of this board.
Five Elms Medical PRactice	GP Surgery	Five Elms Road	http://www.cqc.org.uk/sites/default/files/new_reports/AAAF1574.pdf	25/08/2016	05/04/2015	**Inadequate**	The practice has been placed in special measures and will be inspected again within six months of its original inspection. If sufficient improvements have not been demonstrated by Five Elms, then CQC can take enforcement actions that could ultimately lead to the cancellation or variation of the terms of their registration. The CCG are supporting the practice to put into action a plan to improve all aspects of the service provided to residents. The action plan and report on changes made will be taken to the Primary Care Commissioning Board. Matthew Cole, Director of Public Health, is a member of this board. The inspection reports are also presented to the Barking and Dagenham Primary Care Commissioning Committee - in some cases the practices are already being monitored by the CCG for contractual reasons. The committee will then review the report and where applicable take further action; for example issue a contract remedial/breach notice and the practice would be required to put a remedial plan in place.

Provider Name	Provider Type	Location	Link to report	Report Date	Inspection Date	Rating	Comments / Summary
Dr BK Jaiswal's Practice	GP Surgery	Julia Engwell Health Centre	http://www.cqc.org.uk/location/1-582326413	19/04/2016	28/01/2016	**Good**	
Dr Asma Moghal	GP Surgery	Becontree Medical Centre	http://www.cqc.org.uk/location/1-487154104	26/05/2016	11/03/2016	**Requires improvement**	Inspection key findings: Staff understood and fulfilled their responsibilities to raise concerns, and to inform practice management about incidents and near misses. However, the records of these events were brief and learning outcomes were minimal. There was no evidence to show patients received an apology. Risks to patients were assessed and managed, with the exception of those relating to recruitment checks and infection control. Data showed patient outcomes were comparable to the national average. We saw no evidence of completed audits having been carried out and we saw no evidence that audits were driving improvements to patient outcomes. Improvement areas include: Ensuring; patients affected by significant events receive reasonable support, patient group directions (PGDs) are completed and up to date, a programme of quality improvement is in place, recruitment checks, Infection prevention and control audits are carried out and that there is a system in place to allow patients to feedback.
Dr DP Shah's Practice	GP Surgery	Parkview Medical Centre	http://www.cqc.org.uk/location/1-559775380	22/06/2016	18/04/2016	**Good**	
Dr Kalkat's Surgery	GP Surgery	Bastable Avenue	http://www.cqc.org.uk/location/1-551125553	18/07/2016	17/05/2016	**Good**	

Provider Name	Provider Type	Location	Link to report	Report Date	Inspection Date	Rating	Comments / Summary
Five Elms Medical Practice	GP Surgery	Five Elms Health Centre	http://www.cqc.org.uk/location/1-569174460	24/08/2016	05/04/2016	**Inadequate**	Inspection key findings: Patients were at risk of harm because systems and processes were not in place to keep them safe. When there were unintended or unexpected safety incidents, reviews and investigations were not thorough enough and lessons learned were not communicated widely. The practice had no clear leadership structure, insufficient leadership capacity. Improvement areas include: Take action to assess the risk of, prevent, detect and control the spread of infections. Take action to assess the risks associated with fire.Carry, risk assessments to be carried out regarding DBS checks. Ensure there is an effective system in place for the receipt and distribution of safety alerts to all staff. Ensure there are processes for identifying Improvements for clinical care. Ensure sustainable action in response to patient feedback relating to lack access to the service and appointment availability. Involvement in decisions and explanations of tests and/or treatments. Ensure that all staff receive training around confidentiality and information governance, providing chaperone duties, infection control, as well as access to professional development opportunities. Ensure pre-employment checks are in place.
Heathway Medical Centre	GP Surgery	Broad Street Resource Centre	http://www.cqc.org.uk/location/1-2687718289	31/08/2016	26/05/2016	**Inadequate**	Inspection key findings: recruitment checks on staff had not been undertaken, there were no records of infection control audits and patient notes were not stored securely. Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement. There was no evidence that the practice was comparing its performance to others; either locally or nationally. Improvement areas include: Establish systems for managing service risks, for example infection control. Ensure documents and processes used to govern activity are up to date. This includes safeguarding arrangements, and the use of patient specific directions when authorising clinical staff to administer vaccines. Ensure there is a programme to meet the learning and development needs of staff. Ensure recruitment arrangements include pre-employment checks for. Ensure quality improvement activity, including clinical audits. Ensure systems are in place to seek and act on feedback.

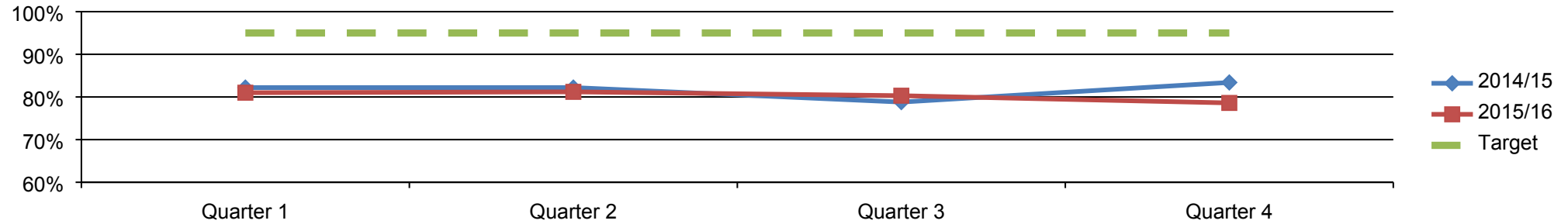
Provider Name	Provider Type	Location	Link to report	Report Date	Inspection Date	Rating	Comments / Summary
Dr Hamilton-Smith And Partners	GP Surgery	Chadwell Heath Health Centre, Ashton Gardens	http://www.cqc.org.uk/location/1-609934909	04/09/2016	05/05/2016 & 16/06/2016	**Requires improvement**	Inspection key findings: There was an open and transparent approach to safety and a system in place for reporting significant events. However, when things went wrong reviews and investigations were not always recorded. Risks to patients were not adequately assessed and managed. Areas of concern included recruitment and staff training. Staff assessed patients' needs and delivered care in line with current evidence based guidance. Clinical staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment. There were gaps in mandatory training and staff appraisals. The practice scored poorly on access to appointments. Improvements were made to the quality of care as a result of feedback. The practice had a number of policies and procedures to govern activity, that were outdated. The practice had good facilities and was well equipped to treat patients and meet their needs. Improvement areas include: The areas where the provider must make improvements are: Review the mandatory training requirements for staff. Ensure recruitment arrangements include all necessary pre-employment checks. Implement a programme of continuous quality improvement including audits to show
Dr KM Al-Kaisy Practice	GP Surgery	Urswick Medical Centre	http://www.cqc.org.uk/location/1-529661202	05/09/2016	17/05/2016	**Requires improvement**	Inspection key findings: Non-clinical staff had not received training on safeguarding children or vulnerable adults relevant to their role. Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks and fire safety. Verbal complaints were not always recorded. Although some audits had been carried out, there was no evidence that audits were driving improvements. The practice had a number of policies and procedures to govern activity, however not all policies were being followed. Data showed patient outcomes were comparable to the national average. Patients said they were treated with compassion, dignity and respect. Improvement areas include: Ensure recruitment arrangements include all necessary employment checks for all staff. Ensure there are systems in place to monitor and manage risk to patient and staff safety, including fire safety. Ensure that there are systems in place to manage staff training for their roles so that staff have the skills and knowledge to deliver effective care.

Provider Name	Provider Type	Location	Link to report	Report Date	Inspection Date	Rating	Comments / Summary
Abbey Dental Practice	Dentist	2 Arboretum Place	http://www.cqc.org.uk/location/1-362363499	19/05/2016	30/06/2015	**No action required**	
Barking Dental Practice	Dentist	25-27 London Road	http://www.cqc.org.uk/location/1-1460180397	19/05/2016	21/01/2016	**No action required**	
Rose Lane Dental Surgery	Dentist	129 Rose Lane	http://www.cqc.org.uk/location/1-1413667912	02/08/2016	15/02/2016	**No action required**	
Prompt Healthcare Staffing Limited	Community Services	Barking Enterprise Centre	http://www.cqc.org.uk/location/1-1002254715	12/04/2016	04/03/2016	**Inspected but not rated**	

Appendix C: Performance summary reports

Portfolio Performance Indicators			Meeting date: September 2016, Data: March 2016
Indicator 2: Percentage uptake of MMR (measles, mumps and rubella) vaccination (2 doses) at 5 years old			Source: NHS England
Definition	Percentage of children given two doses of MMR vaccination.	**How this indicator works**	MMR 2 vaccination is given at 3 years and 4 months to 5 years. Reported by COVER based on RIO/Child Health Record.
What good looks like	Quarterly achievement rates to be above the set target of 95% immunisation coverage.	**Why this indicator is important**	Measles, mumps and rubella are highly infectious, common conditions that can have serious, potentially fatal, complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby and can lead to miscarriage.
History with this indicator	2011/12: 82.8%, 2012/13: 85.5%, 2013/14: 82.3%, 2014/15: 82.7%	**Any issues to consider**	This data is only available on a quarterly basis. Figures are usually published by PHE 12 weeks after the end of the quarter. Quarter Q1 data is due to be released around mid-September.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15		82.2%			82.2%			78.8%			83.4%	
2015/16		81.0%			81.2%			80.3%			78.6%	



Performance Overview	Poor performance is seen across the whole of London with this indicator, and the borough's performance exceeds the London average but is below the national average for England. Low immunisation coverage is a risk to unimmunised children who are at risk of infection from the vaccine preventable diseases against which they are not protected.	**Further Performance comments**	Ensure Barking and Dagenham GP Practices have access to I.T. support for generating immunisation reports. Children who persistently miss immunisation appointments followed up to ensure they are up to date with immunisations. Identifying what works in the best performing practices and share. Practice visits are being carried out to allow work with poor performing practices in troubleshooting the barriers to increasing uptake. Encourage GP practices to remove ghost patients.
RAG Rating			
Benchmarking	In quarter 4 2015/16 Barking and Dagenham's MMR2 rate (78.6%) was similar to the London rate (80.4%)		

Indicator 2: Percentage uptake of MMR (measles, mumps and rubella) vaccination (2 doses) at 5 years old

1. **Key information** (concise summary / main messages)

This indicator reports of eligible children who have received two doses of MMR vaccine on or after their 1st birthday and at any time up to their 5th birthday.

The indicator is currently reported on a quarterly basis, however monthly reporting will be explored in future reports.

In Quarter 4 2015/16 78.6% of 5 year olds within Barking and Dagenham received a second dose of the MMR vaccination. This is a slight reduction (-1.7 percentage points) from the previous quarter and 1.8 percentage points lower than the London rate for quarter 4.

This indication is RAG rated as **Red**.

2. **What does this mean** (brief contextual analysis)

MMR is the combined vaccine that protects against measles, mumps and rubella. Measles, mumps and rubella are highly infectious, common conditions that can have serious complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby and can lead to miscarriage.

3. **What is the impact** (risks and opportunities / assessment of implications)

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

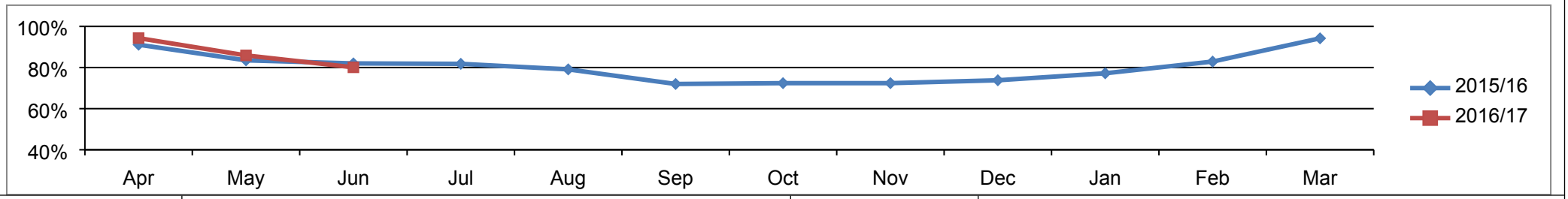
4. **What actions are required / being taken** (changes / decisions required)

This indicator is led by NHS England

Portfolio Performance Indicators	Meeting date: September 2016, Data: June 2016
Indicator 6: Looked after children with an up to date health check	Source: Children's Services

Definition	The % of looked after children in care for one year or more who have had an annual health assessment and dental check in the last 12 months.	**How this indicator works**	This indicator measures the number proportion of children looked after who have had their annual health assessment and had their teeth checked by a dentist. The health check includes dental and medicals checks and is an average of those 2 checks. It is reported as a percentage.
What good looks like	For the number and percentage of looked after children in care for a year or more with an up to date annual health check to be high and above the target as at end of March 2016/17.	**Why this indicator is important**	The data allows us to make performance comparisons with other areas and provides a broad overview of how well the borough is performing in terms of LAC health checks. This is an Ofsted area of inspection as part of our duty to improve outcomes for LAC and is a key HWBB priority area.
History with this indicator	2012/13: 71% 2013/14: 95% 2014/15: 93% 2015/16: 94%		

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	91.1%	83.5%	82.0%	81.8%	79.1%	72%	72.4%	72.4%	73.8%	77.2%	82.9%	94.2%
2016/17	94.3%	85.9%	80.1%									



Performance Overview **RAG Rating**	In Q1 2016/17, the percentage of looked after children in care for a year or more with an up to date health assessment decreased to 80% compared to 86% as at end of May 2015/16. Q1 performance is slightly lower than Q1 2015 (80% compared to 82% respectively) and although below benchmark data, we predict that we will reach our target of over 90% by end of year as reported each year since 2013/14.	**Further Performance comments**	A review of LAC medicals out of time is routinely undertaken and fluctuations in performance are due to a number of factors (see report). Performance on health and health checks are included in performance dashboards for each team across social care and this performance area is receiving close monitoring to prevent a decline throughout the year.
Benchmarking	Performance on LAC annual health checks has exceeded all benchmark data for the last 3 year and remains above national (88%), similar areas (91%) and London (90%) in 2015/16.		

Indicator 6: Looked After Children with up to date health checks

1. **Key information** (concise summary / main messages)

This indicator reports on the percentage of looked after children who have been in care for one year or more that have an up to date annual health check (includes an average of medical and dental checks).

In Q1 2016/17, the percentage of looked after children in care for a year or more with an up to date health check slightly decreased to 80% compared to 94% as at end of 2015/16. Although we are below benchmark data, we predict to reach our target of over 90% by end of year as reported each year since 2013/14.

This indicator is RAG rated as **Red.**

2. **What does this mean** (brief contextual analysis)

As at the end Q1, 259 (87%) out of 298 looked after children (in care for one year or more) had an up to date dental check and 220 (74%) had an up to date medical (an average of 80%). This means that 39 looked after children did not have an up to date dental check and 78 have not got an up to date medical according to ICS. A review on those cases is underway to assess why.

3. **What is the impact** (risks and opportunities / assessment of implications)

The risk is that activity will not increase compared to what is required to meet target, but it is relatively early in the year and health checks for looked after children exceed 90% each year above benchmark data. Both social care and health colleagues have sufficient time to close the trajectory gap.

4. **What actions are required / being taken** (changes / decisions required)

A review of LAC medicals out of time is routinely undertaken and fluctuations in performance are due to:

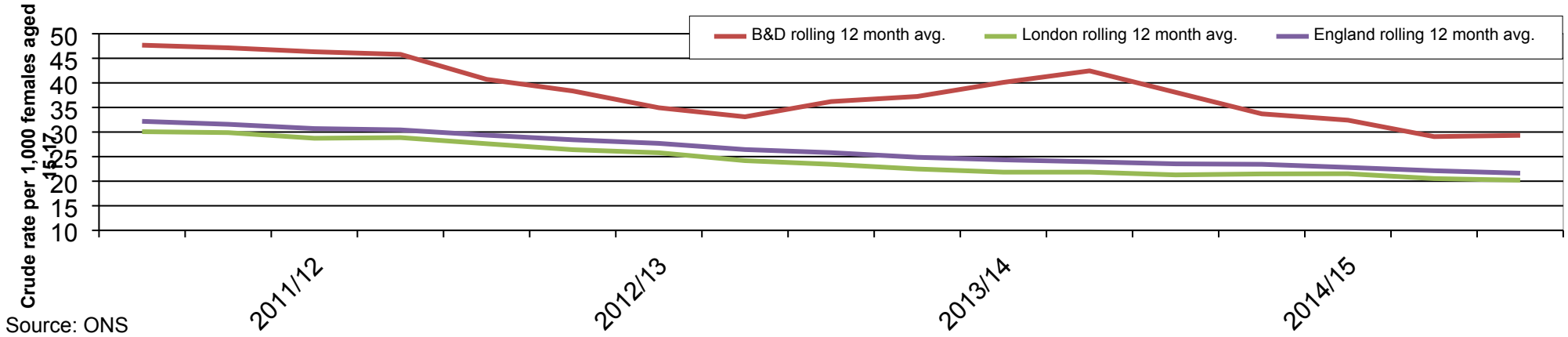
- Changes and increases in the looked after children numbers places pressure on social care and health agencies.
- The relevant paperwork is usually sent to health at least two months before the due date and health agencies carry out the medical and quality assure each medical. There is sometimes a delay in Health completing the medicals and returning the forms to social care.
- Also, contributing to delay is the fact that social workers are not completing the required forms in a timely fashion to pass to Health, despite Health Business Support Officer chasing them regularly.

Performance on health and health checks are included in performance dashboards for each team across social care and this performance area is receiving close monitoring to prevent a decline throughout the year.

Portfolio Performance Indicators Indicator 8: Under 18 conception rate (per 1,000)			Meeting date: September 2016, Data: June 2016 Source: ONS
Definition	Conceptions in women aged under 18 per 1,000 females aged 15-17.	**How this indicator works**	This indicator is reported annually by the Office for National Statistics and refers to pregnancy rate among women aged below 18.
What good looks like	For the number of under 18 conceptions to be as low as possible, with the gap to regional and national averages narrowing.	**Why this indicator is important**	Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children.
History with this indicator	2009: 54.7 per 1,000 women aged 15-17 years 2010: 54.9 per 1,000 women aged 15-17 years	**Any issues to consider**	Data for this indicator is based upon births and abortion data and is therefore released around 1 year after the end of the period.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
2014/15	31.0	20.5	37.1	28.6
2015/16	32.1			

Under 18 Conceptions 2011/12 Q1 - 2015/16 Q1



Source: ONS

Performance Overview **RAG Rating**	The rate of under 18 conceptions is showing a generally decreasing trend over the last 4 years, with the quarterly-rolling annual average falling from 47.7 at the start of 2011/12 to 29.3 in 2014/15 Q1.	**Further Performance comments**	Barking and Dagenham remains above the national and London averages (21.6 and 20.2 per 1,000 respectively), who both saw a continued decline in their conception rate.
Benchmarking	Barking and Dagenham's rate is above the national and regional averages, with Barking & Dagenham currently having the third highest average rate over the last 12 months (July 2014 to June 2015).		

Indicator 8: Under 18 conceptions, rate per 1,000

1. **Key information** (concise summary / main messages)

The rate of under 18 conceptions has been decreasing over the last four years from 47.7 per 1,000 in Quarter 1 2011/12 to 29.3 per 1,000 in Quarter 1 2014/15.

According to quarterly data there has been an increase on rate from 28.6 in Quarter 4 2014/15 to 32.1 in Quarter 1 2015/16.

Analysis of under 18 conceptions data from 1998 to 2015/16 shows that the quarterly data has a seasonal fluctuation. The increase in conception rate in the latest quarterly data is expected with regards to the seasonality.

Looking at the rolling 12 month period the latest data has increased the conception rate by 0.2.

This indicator is RAG rated as **Red.**

Percentage change from 1998 base line

As of 2014/15 the annual under conception rate for Barking and Dagenham has decreased by 40.6% since the 1998 base line. This is below the London and England decreases of 57.9% and 51.1% respectively.

2. **What does this mean** (brief contextual analysis)

Although the borough's rate continues to remain above the England and London rates, since Quarter 1 2011/12 to Quarter 1 2015/16 the gap has reduced by 50.3% and 48.1% respectively.

3. **What is the impact** (risks and opportunities / assessment of implications)

Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children.

4. **What actions are required / being taken** (changes / decisions required)

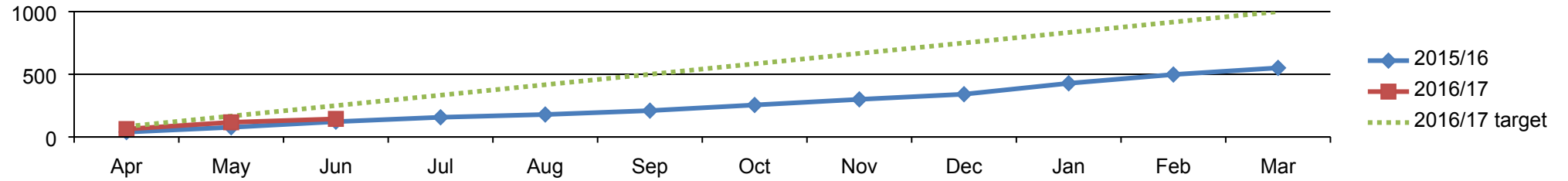
The C-Card distribution scheme, which supplies teenagers with condoms, has seen improved performance and is now reaching higher numbers of teenagers. Subwize has also retrained staff in the scheme and satellite working with the borough's young people has started.

An audit on safeguarding and teenage pregnancy is taking place and due to be presented at the next integrated sexual health board meeting, which will help guide further improvements to the reduction in teenage pregnancies.

Portfolio Performance Indicators	Meeting date: September 2016, Data: June 2016
Indicator 10: Number of smoking quitters aged 16 and over through cessation service	Source: Quit Manager

Definition	The number of smokers setting an agreed quit date and, when assessed at four weeks, self-reporting as not having smoked in the previous two weeks.	**How this indicator works**	A client is counted as a 'self-reported 4-week quitter' when assessed 4 weeks after the designated quit date, if they declare that they have not smoked, even a single puff of a cigarette, in the past two weeks.
What good looks like	For the number of quitters to be as high as possible and to be above the target line.	**Why this indicator is important**	The data allows us to make performance comparisons with other areas and provides a broad overview of how well the borough is performing in terms of four week smoking quitters.
History with this indicator	2012/13: 1,480 quitters, 2013/14: 1,174 quitters, 2014/15: 635 quitters, 2015/16: 551 quitters	**Any issues to consider**	Due to the nature of the indicator, the quit must be confirmed at least 4 weeks after the quit date. This means that the May data will likely increase upon refresh next month.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	39	38	45	35	22	31	45	45	41	87	70	53
2016/17	63	54	27									



Performance Overview	Between April and June 2016/17 there have been 144 quitters. This is 57.6% against the revised target of 1,000 quitters at this point in the year. At the end of June 2015/16 there had been 122 quitters which equated to 16.3% against the previous target of 3,000 quitters. This demonstrates an improvement on last year's figures although the indicator is still RAG rated as Red.	**Further Performance comments**	All Primary Care Providers have been contacted to advise about their individual targets. Primary Care Providers will be sent a league table of achievement on alternate months as a reminder of what they have delivered and what the gap to target is. Non-Providing practices will be encouraged to refer to named pharmacies within their local vicinity. The Tier 3 team will contribute support for areas of highest prevalence. The Tier 3 team will assign a proportion of their capacity to commence prevention work in schools and youth services.
RAG Rating			
Benchmarking	Between April and December 2015 there were 512 quitters in Havering and 472 quitters in Redbridge.		

Indicator 10: Number of smoking quitters aged 16 and over through cessation service

1. **Key information** (concise summary / main messages)

The service needs to deliver **83** quits a month to stay on trajectory for meeting the target. Quarter 1 has delivered **144** quits which is slightly up on 15/16 figures, but still behind trajectory (which is **249** quits).

This indication is RAG rated as **Red**.

2. **What does this mean** (brief contextual analysis)

We are behind by **105** quitters compared to last month when we were **62** quitters behind.

3. **What is the impact** (risks and opportunities / assessment of implications)

The risk is that activity will not increase compared to what is required to meet target, though it is still relatively early in the year and a common pattern with stop smoking services.

4. **What actions are required / being taken** (changes / decisions required)

All Primary Care Providers have been contacted to advise about their individual targets.

Primary Care Providers are being sent a league table of achievement on alternate months as a reminder of what they have delivered and what the gap to target is.

PH will review the worse performing practices and contact will be made to ascertain what actions they are taking to improve their performance.

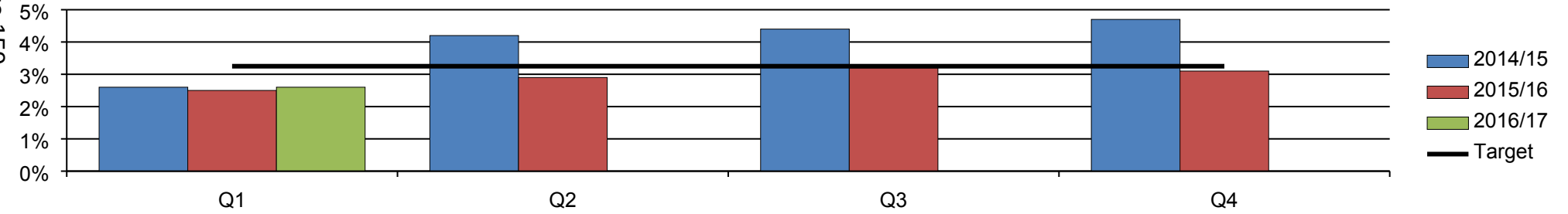
Non-Providing practices have been contacted via a letter to encourage sign-posting to pharmacies.

An electronic template is being developed that will enable practices to refer direct to lifestyle support, including the stop smoking team.

Portfolio Performance Indicators	Meeting date: September 2016, Data: June 2016
Indicator 12: Those aged 40-74 who receive Health Check	Source: Department of Health

Definition	Percentage of the eligible population (those between the ages of 40 and 74, who have not already been diagnosed with heart disease, stroke, diabetes, kidney disease and certain types of dementia) receiving an NHS Health Check in the relevant time period.	**How this indicator works**	**Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions is invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and afterwards given support and advice to help them reduce or manage that risk.** The national targets are 20% of eligible population should be offered a health check and 75% of those offered should receive a check.
What good looks like	For the received percentage to be as high as possible and to be above target.	**Why this indicator is important**	The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, and kidney disease.
History with this indicator	2012/13: 10.0%, 2013/14: 11.4% received 2014/15: 16.3%, 2015/16: 11.7% received	**Any issues to consider**	There is sometimes a delay between the intervention taking place and reflecting in the Health Analytics data. This means that the May data will likely increase upon refresh next month.

	Q1	Q2	Q3	Q4
2015/16	2.5%	2.9%	3.2%	3.1%
2016/17	2.6			



Performance Overview **RAG Rating**	The service needs to deliver 518 health checks a month in order to stay on trajectory for meeting the target. April to June has delivered an average of 378 health checks per month. This means that the monthly target has not been met.	**Further Performance comments**	All Primary Care Providers have been contacted to advise about their individual targets. Primary Care Providers will be sent a league table of achievement on alternate months as a reminder of what they have delivered and what the gap to target is. Non-Providing practices will be encouraged to refer to named pharmacies within their local vicinity. Poorly performing practices will be visited and supported to address any problems they have.
Benchmarking	In 2015/16 11.7% of the eligible population of Barking and Dagenham received an NHS health check. This is above the Havering and Redbridge rates of 6.9% and 10.7% respectively.		

Indicator 12: Those aged 40-74 who receive NHS Health Checks

1. **Key information** (concise summary / main messages)

The service needs to deliver **518 health checks** a month to stay on trajectory for meeting the target. April to June delivered **1154** checks against a trajectory of **1554**.

Health check data is recorded via the GP systems and accessed via Health Analytics. There is sometimes a delay between the intervention taking place and reflecting in the Health Analytics data.

Please note that the May data is provisional and will likely increase upon refresh next month.

This indication is RAG rated as **Red.**

2. **What does this mean** (brief contextual analysis)

As at end of June, we are **420** checks behind trajectory, compared to end of May when we were **321** checks behind trajectory and still slightly down for the same period in 2015/6.

3. **What is the impact** (risks and opportunities / assessment of implications)

The risk is that activity will not increase compared to what is required to meet target, but it is still relatively early in the year and Providers have sufficient time to close the trajectory gap.

4. **What actions are required / being taken** (changes / decisions required)

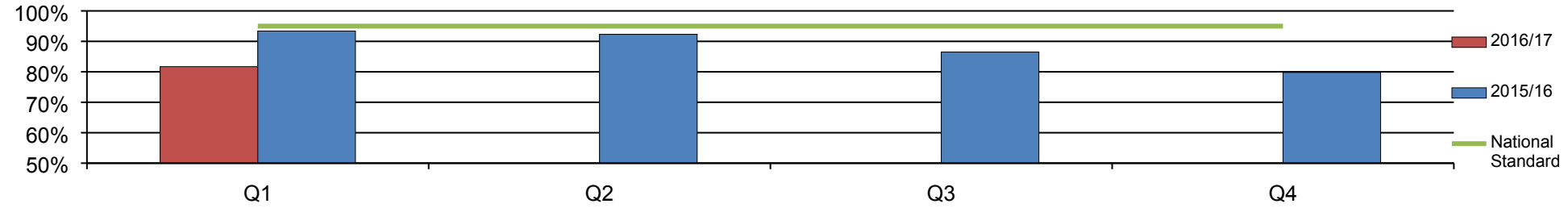
All Primary Care Providers have been contacted to advise about their individual targets.

Primary Care Providers are being sent a league table of achievement on alternate months as a reminder of what they have delivered and what the gap to target is.

PH will review poorly performing practices and make contact in order to establish plans of action to address recovery.

Health and Social Care Performance Indicators				Meeting date: September 2016, Data: June 2016
Indicator 20: A&E attendances < 4 hours from arrival to admission, transfer or discharge (type all)				Source: Systems Resilience Group
Definition	The percentage of individuals who are waiting less than 4 hours in A&E between arrival and admission, transfer or discharge		**How this indicator works**	This indicator reports the percentage of A&E attendances where the patient spends four hours or less in A&E from arrival to transfer, admission or discharge. This is a measure against the national waiting time standard, for which the target is 95%.
What good looks like	The National Standard for this indicator is 95%		**Why this indicator is important**	The maximum four-hour wait in A&E remains a key NHS commitment and is a standard contractual requirement for all NHS hospitals.
History with this indicator	2015/16: 88% 2014/15: 85.3% 2013/14: 89% 2012/13: 84.1%			

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
2015/16	93.4%	92.3%	86.5%	79.8%
2016/17	81.7%			



Performance Overview **RAG Rating**	The percentage of patients being seen within 4 hours of arriving at A&E has dropped from 93.4% in quarter 1 2015/16 by 11.7 percentage points to 81.7% in quarter 1 2016/17. The National Standard for this measure is 95%	**Further Performance comments**	BHRUT have set a recovery plan in place which includes a recovery trajectory aims to have the indicator meeting national standards by 2017. This trajectory incorporates gradual increases in performance per quarter.
Benchmarking			

Indicator 20: A&E attendances < 4 hours from arrival to admission, transfer or discharge (type all)

1. **Key information** (concise summary / main messages)

This indicator reports the percentage of A&E attendances where the patient spends four hours or less in A&E from arrival to transfer, admission or discharge. This is a measure against the national waiting time standard, for which the target is 95%.

The July 2016 provisional data (data reported directly from the Trust) shows performance at 85%. The Trust is therefore achieving against the improvement trajectory of 84% for July but is not achieving against the National standard of 95% for this indicator. July's performance is an improvement on June's performance (82.43%).

This indication is RAG rated as **Red.**

2. **What does this mean (brief contextual analysis)**

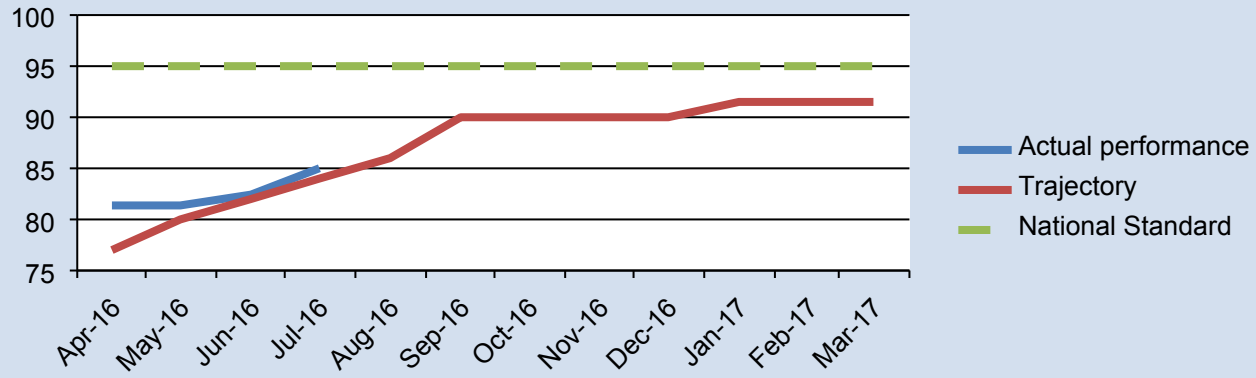
The maximum four-hour wait in A&E remains a key NHS commitment and is a standard contractual requirement for all NHS hospitals.

3. **What is the impact** (risks and opportunities / assessment of implications)

4. **What actions are required / being taken** (changes / decisions required)

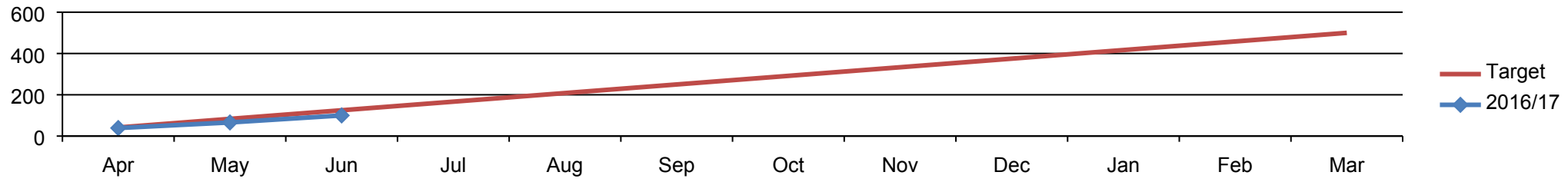
BHRUT have set a recovery plan in place which includes a recovery trajectory aims to have the indicator meeting national standards by 2017.

This trajectory incorporates gradual increases in performance per quarter. The follow chart displays the latest data against the recovery trajectory from April 2016 to March 2017.



Health and Social Care Performance Indicators Indicator 24: Number of 'turned around' troubled families												Meeting date: September 2016, Data: June 2016 Source: Children's Services
Definition	Number of families 'turned around' meeting all outcome targets and showing 'significant and sustained improvement'						**How this indicator works**	This indicates the number of families 'turned around' meeting all outcome targets, showing 'significant and sustained improvement' (rolling figure including TF2 claims approved internally and submitted to DCLG for payment.				
What good looks like	2,470 families to be 'turned round' by March 2020. A local target of 500 claims within 2016/17 has been set						**Why this indicator is important**	TF2 is a payment by results programme. Successful family interventions mean significant reduction in costs to the Local Authority (LA) and its partners. The LA target for TF is to "turn around" 500 families in16/17.				
History with this indicator												

	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2015/16	-	-	-	-	-	23	0	22	3	90	14	23
2016/17	39	27	34									



Performance Overview **RAG Rating**	At the end of June 2016/17, we had identified 1,555 families that meet the TF2 criteria and submitted 275 claims to DCLG (June 2016/17), 100 of which were during 2016/17. The next claim window closes on September 9th by which point we estimate a total cumulative claim figure of 450. We have an indicative target of 14 claims per week to meet the claim target of 500 claims per year. July's data is available for this indicator and shows that performance for this indicator has improved and is RAG rated as **Green** for July 2016/17.	**Further Performance comments**	Families that are successfully turned around are saving the LA substantially. Cost benefit analysis of TF carried out by DCLG shows that every £1 the LA spends on TF saves £2 on LA budgets. A DCLG spot check on claims/process undertaken in June 2015 produced very positive comments. The throughput of claims will inevitably be uneven as evidence such as school attendance, health and housing. data is often only available at set times of the year
Benchmarking	No benchmark data available. DCLG no longer produces league tables.		

Indicator 24: Number of turned around troubled families

1. **Key information** (concise summary / main messages)

This indicator reports on the number of families turnaround based on claims submitted and approved by the Local Authority (LA) data team and finance and auditing approval process. Once approved, claims are submitted to DCLG for payment.

TF2 is a Payment by Results programme set out by DCLG. Successful family interventions mean significant reduction in costs to the Local Authority (LA) and its partners. The LA target for TF2 is to "turn around" 500 families in16/17. DCLG are encouraging front loading the programme to enable successful outcomes in 2020. LBBD are committed to turn around 2,470 families by March 2020.

As at the end of June 2016/17, we have identified 1,555 families that meet the TF2 criteria. Since the TF2 programme commenced (September 2015), we have submitted in total 275 claims to DCLG (175 between September 2015 to March 2016 and 100 as of Quarter 1 2016/17. The next claim window closes on September 9th by which point we estimate a total cumulative claim figure of 450. Of this figure around 10% of these families have found employment. We have an indicative target of 14 claims per week to meet the claim target of 500 claims per year.

A target of 500 turned around families has been set by end of year 2016/17 and at the end of quarter 1 have made 100 claims against a year to date target of 125. Benchmark data is not available to date.

This indicator is RAG rated as **Red** at the end of Quarter 1 however data from July changes the RAG rating of this indicator to **Green**.

2. **What does this mean** (brief contextual analysis)

LBBD are doing well compared to other London LAs but success is measured anecdotally. It is very difficult to gauge success as DCLG are not releasing data on other LA performance. TF2 is a significant potential funding stream providing that we are able to succeed in the outcomes for families.

3. **What is the impact** (risks and opportunities / assessment of implications)

The impact of TF is in its very early stages but families that are successfully turned around are potentially saving the LA in costs. Cost benefit analysis of TF is showing that for every £1 the LA spends on TF is saving £2 on LA budgets.

Risks: DCLG outcome targets are unachievable leading to a loss in funding.

Opportunities: Families are receiving early intervention services are not being assessed by CS and therefore saving money and officer time.

4. **What actions are required / being taken** (changes / decisions required)

TF project board meet monthly to monitor the success of the programme. Currently looking into working with schools to assist identification and direct work with families.

No current decisions needed, DCLG spot check on claims/process undertaken in June 2015 currently awaiting feedback from DCLG, but informal feedback was very positive.

APPENDIX D

URGENT & EMERGENCY CARE PROGRAMME DASHBOARD

Sector	Freq	Provider	KPI		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Annual
Outcomes	Monthly	BHRUT/PELC	A&E 4 Hour Wait (BHRUT)	Actual	81.37%	81.37%	82.43%	85.01%									
				Trajectory	77.00%	80.00%	82.00%	84.00%	86.00%	90.00%	90.00%	90.00%	90.00%	91.50%	91.50%	91.50%	87%
				National Standard	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
				Queens	77.39%	78.19%	77.78%	81.34%									
				KGH	87.33%	86.23%	89.62%	90.73%									
		BHRUT	4hour - Type 1	BHRUT	78.27%	78.43%	79.49%	82.63%									
				Queens	76.43%	77.32%	76.74%	80.57%									
				KGH	82.06%	80.71%	85.24%	86.99%									
	Monthly		A&E to admission Conversion Ratio	BHRUT	15.37%	14.23%	14.90%	14.43%									
				Queens	17.62%	16.42%	16.75%	16.36%									
				KGH	12.01%	10.85%	12.05%	11.43%									
	Monthly		DTOC	Actual	25	14	20	24									
				target	20	20	20	20	20	20	20	20	20	20	20	20	<20
	Monthly		UCC Utilisation	Total Trust (inc Pelc)	23.77%	25.47%	23.07%	26.08%									
				Standard	45%	45%	45%	45%	45%	45%	45%	45%	45%	45%	45%	45%	>45%
				KGH	30.39%	28.97%	29.94%	29.87%									
				Queens	19.34%	23.19%	18.63%	23.65%									

Sector	Freq	Provider	KPI		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Annual
Demand		BHRUT	A&E Attendances by Site - All attendances, all commissioners	**Total Trust (inc KGH UCC)**	**22,036**	**24,144**	**22,793**	**24,471**	-	-	-	-	-	-	-	-	
				Total UCC	5,238	6,149	5,258	6,382									
	Daily			**Queens (All Types)**	**13,197**	**14,642**	**13,845**	**14,902**									
				Queens (Types 1&2)	10,645	11,246	11,266	11,378									
	Weekly			UCC - Queens	2,552	3,396	2,579	3,524									
	Daily			**KGH (All Types)**	**8,839**	**9,502**	**8,948**	**9,569**									
				KGH (Type 1)	6,153	6,749	6,269	6,711									
	Daily			UCC - Pelc	2,686	2,753	2,679	2,858									
	Monthly	LAS	Number of ambulance conveyances	Queens	3,097	3,171	2,922	2,895									
				KGH	1,132	1,148	1,104	1,105									
	Monthly	NHS111	NHS 111 Referral Destination - Recommended to attend Primary Care	NHS 111	57.79%	58.15%	57.61%	56.80%									
			NHS 111 Referral Destination - Ambulance Dispatches	NHS 111	9.76%	10.31%	11.05%	11.18%									
			NHS 111 Referral Destination - Recommended to attend A&E	NHS 111	9.73%	9.49%	9.94%	10.84%									
Demand		BHRUT	% of attenders that were self referred to A&E	BHRUT	80.81%	82.11%	82.34%	83.65%									
		BHRUT	A&E Attendances - BHR CCGs at All Providers (Operating Plan EM6)	Actuals	24,091	27,674	25,853										
				Trajectory (All prov)	26,230	26,363	26,667	26,803	26,055	26,667	26,800	26,667	26,603	26,363	24,657	27,673	317,548
			A&E Attendances - BHR CCGs at BHRUT (excl. attendances KGH UCC) (Operating Plan EM6)	Actuals	16,294	18,672	17,508										
				Trajectory	17,070	17,639	17,070	17,639	17,639	17,070	17,639	17,070	17,639	17,639	15,932	17,639	207,680
	Monthly	BHRUT	Non Elective Admisisons - BHR CCGs at All Providers (Operating Plan EM 5)	Actuals	6,503	6,926	7,051										
				Trajectory (All prov)	6,997	7,096	7,076	7,175	7,057	7,076	7,175	7,076	7,135	7,096	6,561	7,332	84,851
	Monthly		Non Elective Admissions - BHR CCGs at BHRUT (Operating Plan EM 5)	Actuals	4,801	4,994	5,131										
				Trajectory (BHR)	5,336	5,514	5,336	5,514	5,514	5,336	5,514	5,336	5,514	5,514	4,980	5,514	64,921

Sector	Freq	Provider	KPI		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Annual
	Weekly	CTT/ LAS	LAS/CCT number of conveyances avoided		52	72	75	89									

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URGENT & EMERGENCY CARE PROGRAMME DASHBOARD

Sector	Freq	Provider	KPI		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Annual
Out of Hospital	Monthly		Walk In Centres -activity	Haroldwood poly clinic, Loxford WIC, South	8,547	8,918	8,346										
	Monthly	BHRUT	UCC 4 Hour Waits	Queens	98.67%	99.29%	98.98%	98.48%									
		PELC		KGH	99.40%	99.78%	99.85%	99.51%									
				Standard	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%
	Monthly	BHRUT	UCC Target Activity	Queens	87.5	99.8	91.4	101.8									
				Standard	>100	>100	>100	>100	>100	>100	>100	>100	>100	>100	>100	>100	>100
	Monthly	Prime Minister's Challenge Fund - Access Hubs (All BHR CCGs)	Total no. of Patients Seen (Actual)		4,701	6,398	4,299	5,094									
			% of appointments utilised		88.66%	92.04%	83.90%	90.98%									
Integrated Urgent Care				10 National standards published May 2016 - implementation requires discussion/agreement with provider													

Sector	Freq	Provider	KPI		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Annual
Front Door	Weekly	BHRUT	Majors Lite Performance - seen within 4hours	Queens	71.24%	70.53%	72.07%	76.51%									
				Standard	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
	Weekly		Majors Lite Average Daily Activity	Queens	108.8	118.1	119.7	121.7									
				Standard	85	85	85	85	85	85	85	85	85	85	85	85	85
	Weekly	NHS 111	% calls answered within 60 seconds	NHS 111	95.02%	98.07%	98.68%	96.69%									
			LONDON - % calls answered within 60 seconds		91.50%	95.30%	95.70%	95.40%									
	Weekly	CTT	Referrals received vs plan	Community Hub	711	799	661										
				Acute Hub	301	371	309										
	Weekly		Referrals from LAS		62	76	77										
	Weekly		Barking & Dagenham	Community Hub	165	213	202										
				Acute Hub	59	76	89										
	Weekly		Havering	Community Hub	352	389	306										
				Acute Hub	190	243	178										
	Weekly		Redbridge	Community Hub	185	192	148										
				Acute Hub	28	25	20										
	Weekly	BHRUT	UCC 4 Hour Waits	Queens	98.67%	99.29%	98.98%	98.48%									
		PELC		KGH	99.40%	99.78%	99.85%	99.51%									
				Standard	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%
		BHRUT	UCC Target Activity	Queens	87.5	99.8	91.4	101.8									
				Standard	>100	>100	>100	>100	>100	>100	>100	>100	>100	>100	>100	>100	>100
	Weekly	BHRUT/ Pelc	Ambulance Handovers Within 15mins	Queens	32.80%	33.33%	32.84%	34.27%									
				KGH	31.13%	27.89%	30.00%	27.48%									
				London	41.51%	44.07%	44.96%	45.01%									
			Ambulance Handovers Within 30mins	Queens	84.12%	87.06%	84.30%	82.72%									
				KGH	88.87%	87.15%	87.08%	88.19%									
				London	90.83%	92.20%	91.81%	89.78%									
			Time to Assessment (number of minutes 95th percentile of patients waited from arrival to initial assessment)	KGH	26	29	28	30									
			Time to Assessment (number of minutes 95th percentile of patients waited from arrival to initial assessment)	Queens	144	121	128	143									
			Time to Treatment (median number of minutes patients waited from arrival to treatment)	KGH	88	87	88	94									
			Time to Treatment (median number of minutes patients waited from arrival to treatment)	Queens	79	79	81	75									

URGENT & EMERGENCY CARE PROGRAMME DASHBOARD

			Patients waiting > 4 hrs from decision to admit to admission	BHRUT	69	81											
			12 hour trolley waits	BHRUT	1	2	0	1									
				Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
		NELFT	Enhanced Psychiatric Liaison Scheme - Beds Saved	NELFT	17	6	18	17									
				Target	20	20	20	20	20	20	20	20	20	20	20	20	20
	Weekly		End of Life Scheme - Beds Saved	BHRUT	7	9	9	8									
				Target	6	6	6	6	6	6	6	6	6	6	6	6	6
			Frail Older Persons Advice & Liaison service Scheme - Beds Saved	BHRUT	37	33	15	14									
				Target	15	15	15	15	15	15	15	15	15	15	15	15	15

Sector	Freq	Provider	KPI		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Annual
In Hospital (decision to admit)	Weekly	BHRUT	MRU same day discharge/Demand	Queens	11.13%	10.58%	11.48%	11.40%									30%
				Target	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	
	Weekly		ERU <48hr Discharge/Demand	Queens	8.05%	10.66%	10.40%	10.10%									30%
				Target	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	
	Weekly		CAU same day discharge/Demand	KGH	10.13%	10.30%	14.75%	14.30%									30%
				Target	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	

Sector	Freq	Provider	KPI		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Annual
In Hospital Capacity/ Pressure	Monthly		Bed Occupancy (% beds occupied)	Queens	90.16%	92.10%	93.23%	88.71%									
				KGH	83.87%	74.55%	81.36%	77.06%									
				Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	<90%

Sector	Freq	Provider	KPI		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Annual
Hospital back Door	Weekly	IRS	IRS New Referrals		177	185	147										
	Weekly		IRS % Stepdown from Acute Beds		79.10%	68.11%	80.27%										
	Weekly		IRS New Referrals	B&D CCG	42	37	27										
				Havering CCG	70	81	68										
				Redbridge CCG	64	67	52										
	Weekly		IRS % Stepdown from Acute Beds	B&D CCG	76.19%	70.27%	77.78%										
				Havering CCG	82.86%	60.49%	86.76%										
				Redbridge CCG	78.13%	76.12%	73.08%										

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APPENDIX E

18 WEEK REFERRAL TO TREATMENT (RTT)

Piers Young
Deputy Chief Operating Officer
BHRUT

Louise Mitchell
Chief Operating Officer
CCG

EXECUTIVE SUMMARY

- Since we identified the RTT issue we have made good progress has been made to reduce the number of patients waiting longer than NHS Constitutional standards for their treatment on both our admitted and non-admitted waiting lists, and we have completed a major validation exercise

- There is a very significant challenge to return to meeting the RTT standards in a sustainable manner. This will involve carrying out around 5k operations and 93k outpatient appointments over an 18 month period

- Even with material demand management, outsourcing and additional recruitment, the size of the programme means this work will take until 2017 to clear (detailed demand and capacity work to be carried out to confirm timeline)

STRATEGIC CONTEXT

NHS Constitution

- Patients' legal right to start non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral

CQC Quality Report 2 July 2015

- Improve the service planning and capacity of outpatients by continuing to reduce the 18 week non-admitted backlog of patients
- Ensure no patients waiting for an appointment are coming to harm whilst they are delayed
- Reduce the did not attend, hospital cancellation and hospital changes rates
- Improve the 31 day cancer wait target

GOVERNANCE – MANAGEMENT AND ASSURANCE

Management	• Weekly RTT Programme Board - reporting to Trust Executive Committee • Access board – reporting to programme board - chaired by Deputy Chief Operating Officer
Assurance	• Weekly RTT Programme Board • Monthly review by Trust Board • Weekly NHSE/NHSI Assurance Group – chaired by NHSE • Monthly meeting with NHSI- chaired by NHSI • System Resilience Group – multi-stakeholder membership – chaired by CCG

RTT UPDATE

- **Trajectory for patients who have waited a long time:** We have developed a trajectory for treating all patients who have waited a long time by 30 September 2016. The RTT Recovery Programme continues to be well ahead of this planned trajectory

- The number of patients who have waited a long time has reduced by 67% since 3 April 2016. Work continues to focus on speeding up treatment for this patient cohort

- **Clinical Harm Review:** A key element of our RTT Recovery Plan is the Clinical Harm Programme. The programme is designed to ensure risk to patients waiting longer than NHS Constitutional standards for their treatment is appropriately and effectively managed

  - Phase 1 focused on patients on the admitted pathway. We carried out a clinical review process where we assessed >900 patients. No moderate or severe harm was identified
  - Phase 2 of the clinical harm review process focused on patients who had waited a long time on the non-admitted pathway; we reviewed >800 patients
  - We are also up to date with the reviews of those patients who have waited a long time since the clinical harm review programme started 2 May 2016
  - A total of 3,402 clinical harm reviews have been completed, to date we have found no harm to these patients

OUR RECOVERY AND IMPROVEMENT PLAN

- Our RTT Recovery and Improvement Plan is a large and complex programme, which contains a number of workstreams including:

1. Theatres productivity
2. Outsourcing
3. Validation
4. RTT administration
5. Demand and capacity
6. Demand management
7. Clinical Harm Review

- The plan aims to deliver key constitutional standards, the alignment of elective demand and capacity, and improved data quality sustainably

RTT UPDATE

- **Theatre Productivity:** We have initiated a Theatre Productivity Programme to increase the number of operations for our patients on the admitted pathway. There is dedicated programme support and we profile an increase in admitted treatments (operations performed) of up to a maximum of 780 operations to 30 September 2016

- **Outsourcing:** We have developed relationships with independent providers who can assist in referral to treatment for suitable cohorts of patients on the admitted and non-admitted pathway (including diagnostic services)

- We inform our patients that they will remain NHS patients and treatment is free of charge to them before we refer them to an independent provider

- **Validation:**Following extensive validation and improvements in data quality the waiting list stands at approximately 46,900. We have taken steps to assure we can return to reporting for our RTT performance. Reporting would resume for October 2016 and will be publically reported circa 6 weeks later in December 2016

RTT Admin: We are reviewing the admin roles for booking and managing patient pathways

- This includes the development and management of clear processes and defining the roles and responsibilities of our staff in delivering the RTT standard

Demand and Capacity: We have developed detailed demand and capacity plans for the specialities

- These models will allow services and staff to quantify weekly capacity gaps and for future planning purposes identify what are sustainable waiting lists capable of delivering the RTT standards

Demand Management: A phased demand management programme has commenced which includes a series of schemes rolled out by the CCG that cover:

- Referral redirection
- Pathway redesign
- Referral Management

Communications: A system-wide communications strategy has been developed which sets out a joint communication and engagement approach between commissioners and service providers in relation to improving waiting times for elective care for Barking, Havering and Redbridge residents

- **Communication objectives**:
  - Help drive improvement through effective communication and engagement with teams involved in elective care
  - Provide consistent, timely and honest information to patients to help manage their expectations around waiting and any impact that waiting a long time has had on them
  - Provide coordinated, timely and consistent information to key stakeholders around RTT and our recovery plan
  - Demonstrate our strategy for recovery is clear, realistic and making progress
  - Minimise reputational risk
  - Engage in two way communications with GPs, identify issues and reduce patient calls to GPs

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APPENDIX F

Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

Councillor Maureen Worby
London Borough of Barking and Dagenham

Sent by email:
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Date: 16 September 2016

Dear Councillor Worby,

Following on from our discussions at the Barking and Dagenham Health and Wellbeing Board on 26 July, around our current Referral to Treatment (RTT) performance, please find our responses to the points raised below.

1. **Noted that the number of people waiting for their appointment had now been reviewed and BHRUT confirmed that this now stood at 54,000 patients;**

   The number of patients on our waiting list is reducing and as at 8 September 2016 the total number of patients waiting for treatment is 46,885.

2. **Noted that BHRUT had not yet recommenced reporting its RTT performance to NHS England;**

   We will start reporting again in December 2016. The data will be based on our October 2016 waiting list information.

3. **Requested BHRUT to provide an update on patients' RTT waiting times to every Board meeting until the NHS Constitution standard, which gives patients a legal right to start non-emergency NHS consultant-led treatment within a maximum of 18 weeks following a GP referral, was achieved and embedded at BHRUT.**

   We can confirm that we will provide an update on waiting times at every Board meeting until we achieve the NHS Constitution standard.

4. **Suggested that consultation with the Council would have been helpful in drafting the communications with the patients waiting for appointments. Particular concern was raised in regards to the lack of understanding by patients that alternative treatment provided outside of**

5. **Queens and King George hospitals would still be paid for via the NHS and that there would be no charge to patients for accessing these services at private facilities**

We take this point on board. We currently inform patients that we are looking to provide their treatment with a private provider to ensure they do not wait unnecessarily and assure that they will remain a BHRUT/NHS patient.

We also outline the services are free of charge and there is no charge to them. A standard script is used by staff to consistently communicate this message to patients.

5. **Reminded BHRUT that the Board was still awaiting details of:**

(a) The numbers of patients in each specialist area and how many of those patients were Barking and Dagenham residents.

Please note: The Board also now requires details of the current number of LBBD residents that were included in the outstanding 54,000.

Our total waiting list size has reduced to 46,885 patients as of 8 September 2016 of which 12,494 (26.7%) patients are Barking and Dagenham residents.

In Appendix A you can view the number of B&D residents on our waiting list by specialty.

(b) Evidence to substantiate the previous anecdotal claim by BHRUT that patients were prepared to wait longer to be seen within BHRUT rather than being treated by other providers

Please note: The Board now also requires details of the number of LBBD residents that have already been referred to independent / private providers or non BHRUT hospitals.

Our data indicates that approximately 34.4% of patients declined to be treated by an alternative provider. We are unable to split this data by borough.

The number of patients that we have referred to a private/independent provider for surgery and have been treated up to 8 September 2016 is 175.

The number of patients we have referred to, and have appointments with, a private/independent provider for an outpatient appointment is 48.

6. **Reminded BHRUT of the previous request made by the Board for them not use the term 'waiters' in their future reports and that 'patients' or 'people' was more appropriate;**

We have noted the Board's request and in future all our reports will refer to patients or people.

If you have any further questions about this information please do not hesitate to contact me.

Yours sincerely

Dr Nadeem Moghal
Medical Director

APPENDIX A – BARKING AND DAGENHAM PATIENTS WAITING BY SPECIALTY

Specialty	Total Number of Patients Awaiting Surgery	Total Number of Patients Awaiting an Outpatient Appointment	Grand Total
Anti-Coagulation		29	**29**
Audiology		18	**18**
Breast Surgery	20	65	**85**
Cardiology	3	952	**955**
Clinical Haematology		81	**81**
Clinical Neuro-physiology		61	**61**
Clinical Oncology		35	**35**
Colorectal Surgery		2	**2**
Dermatology	24	827	**851**
Diabetic Medicine		27	**27**
Endocrinology		230	**230**
ENT	237	1114	**1351**
Gastroenterology	2	853	**855**
General Medicine	2	74	**76**
General Surgery	83	741	**824**
Geriatric Medicine		31	**31**
Gynaecological Oncology	14	65	**79**
Gynaecology	89	583	**672**
Hepatology		97	**97**
Maxillo-Facial Surgery	85	486	**571**
Medical Microbiology		5	**5**
Medical Oncology		2	**2**
Neonatology		28	**28**
Nephrology		127	**127**
Neurology	6	714	**720**
Neurosurgery	13	183	**196**
Ophthalmology	71	840	**911**
Oral & Maxillo Facial Surgery		8	**8**
Orthodontics		3	**3**
Paediatric Cardiology		37	**37**
Paediatric Clinical Haematology		3	**3**
Paediatric Diabetic Medicine		1	**1**
Paediatric Endocrinology		2	**2**
Paediatric Medical Oncology		6	**6**
Paediatric Nephrology		7	**7**
Paediatrics		334	**334**
Pain Management	164	371	**535**
Respiratory Medicine	2	292	**294**
Rheumatology	2	292	**294**
Trauma & Orthopaedics	198	882	**1080**
Urology	115	665	**780**
Vascular Surgery	31	160	**191**
Grand Total	**1161**	**11333**	**12494**

HEALTH AND WELLBEING BOARD

27 September 2016

Title:	**Update on North East London Sustainability and Transformation Plan (NEL STP) for Barking and Dagenham Health and Wellbeing Board**

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: Helena Pugh Local Authority Engagement Lead, NEL STP, Tower Hamlets, CCG	**Contact Details:** NEL STP office: Tel: 020 3816 3813 E-mail: nel.stp@towerhamletsccg.nhs.uk

Sponsor:

Conor Burke, Accountable Officer, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

Summary:

This report provides a further update to the Board on the development of the north east London Sustainability and Transformation Plan (NEL STP).

A draft 'checkpoint' STP was submitted to NHS England on 30 June 2016; it formed the basis of a local conversation with NHS England on 14 July. A public facing summary of progress to date is included in Appendix A.

The STP Board is establishing a working group of senior representatives from partner organisations to develop the STP governance. This includes Local Authority representation.

We expect to hold public events across north east London over the coming months, so we can discuss it with local people enabling us to gather feedback, test our ideas and strengthen our STP.

Further work is continuing to develop the plan in more detail; the next iteration of the plan will be submitted to NHS England in October. Additional updates will be presented to the Board as they become available.

For Barking & Dagenham, Havering and Redbridge, it remains the case that the detail of the local contribution to the Sustainability and Transformation Plan for north east London has been developed through the established programme to draft a business case for an Accountable Care Organisation.

Recommendation(s)

The Barking and Dagenham Health and Wellbeing Board is recommended to note the:

- summary of progress to date in Appendix A
- proposed approach to developing governance arrangements for the STP

Reason(s)

The NEL STP Board is developing a plan as stipulated by the NHS England guidance. The plan will reflect the work that has been initiated as part of the local devolution bid approved in December 2015, and which is being taken forward through the local programme to develop a business case for an Accountable Care Organisation.

1 Introduction and Background

1.1 In December 2015 NHS England planning guidance required health and care systems across the country to work together to develop sustainability and transformation plans (STPs). An STP is a new planning framework for NHS services which is intended to be a local blueprint for delivering the ambitions NHS bodies have for a transformed health service, which is set out in a document called Five Year Forward View (5YFV). England has been divided into 44 areas (known as footprints); Barking and Dagenham is part of the north east London footprint. Further background information about STPs was presented on 26 July to the Board.

1.2 The NEL STP describes how locally we will meet the 'triple challenge' set out in the NHS Five Year Forward View, to:

- meet the health and wellbeing needs of our population
- improve and maintain the consistency and quality of care for our population
- close the financial gap

1.3 The STP builds on existing local transformation programmes and supports their implementation. These are:

- Barking and Dagenham, Havering and Redbridge: devolution pilot (accountable care organisation)
- City and Hackney: Hackney devolution in part
- Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme
- The improvement programmes of our local hospitals, which aim to support Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust out of special measures

1.4 For Barking & Dagenham, the work to develop the detail underpinning the STP is being taken forward jointly with Havering and Redbridge through the work to develop the business case for an Accountable Care Organisation[1]. The issues that any ACO would need to address in order to achieve improved outcomes from health and social care, in the context of a financially sustainable health economy, will be reflected in the contributions from Barking & Dagenham, Havering and Redbridge to the NEL STP.

1.5 Additional NHS England guidance issued on 19 May, stated that the draft STP to be submitted on 30 June would be seen as a 'checkpoint'. The submission formed the basis of a local conversation with NHS England on 14 July.

1.6 Formal feedback on the submission was received at the end of August; it asked that the next draft of our STP, due to be submitted to NHS England on 21 October:

- Clearly articulates the impact the STP proposals would have on the quality of care

- Provides more detail, with clear and realistic actions, timelines, benefits (financial and non-financial outcomes), resources and owners
- Includes plans for primary care and wider community services that reflect the General Practice Forward View
- Contains robust financial plans that detail the financial impact and affordability of what is proposed
- Sets out plans for engagement with local communities, clinicians and staff

2 Proposal and issues

2.1 Appendix 1 provides a summary of progress to date: Better health and care: developing a sustainability and transformation plan for north east London; it is also available at: http://www.nelstp.org.uk/downloads/Publications/NEL-STP-summary-2016.pdf

Governance and leadership arrangements

2.2 The STP Board has agreed to take an inclusive and engaging approach to developing the governance arrangements required, recognising the need to ensure all partners are thoroughly engaged in the process and the governance implications across the system are understood and aligned to the existing organisational governance and regulatory regime. The STP Board is establishing a working group of senior representatives from partner organisations to develop the STP governance. This includes Local Authority representation. The group is chaired by Marie Gabriel, Chair, East London NHS Foundation Trust. The group aims to have a proposal for the governance arrangements developed for testing and implementation in October. This initial set of arrangements will operate in shadow and be reviewed in January 2017 to check its effectiveness, with the aim of full implementation rom April 2017. Best practice and exert advice will be sought to support the development of the governance. It is also anticipated that NHSE will release guidance at the end of September 2016.

Transformation planning

2.3 Since the submission on 30th June discussions have been held to agree how we will work together to carry out the more detailed transformation planning that is required for the next submission in October. This process began with a series of workshops in July in each of the following areas in the NEL STP footprint: Barking & Dagenham, Havering and Redbridge; City & Hackney; and Waltham Forest, Newham and Tower Hamlets. Following these meetings the NEL Clinical Senate met and ratified a proposal to progress a range of transformation initiatives at three delivery levels (locally led / locally led with NEL coordination / NEL led with local delivery).

2.4 To implement this model 10 core workstreams have been established with SROs and Delivery Leads identified. Each workstream is developing their own governance and working group arrangements to support the process with more detailed planning ahead of the next submission in October, engaging with local lead across the system.

The workstreams are:

- Prevention (locally led with NEL coordination)
- Local Integration plans (locally led)
- Primary Care (locally led with NEL coordination)
- Planned Care (NEL led with local delivery)
- Maternity (NEL led with local delivery)
- Cancer (NEL led with local delivery)
- Unscheduled Care (NEL led with local delivery)
- Mental Health (locally led with NEL coordination)
- Medicines Optimisation (locally led with NEL coordination)
- Learning Disabilities (locally led with NEL coordination)

2.5 As an example, a workshop was held with CCG and Local Authority representatives on 23 August to discuss the priority prevention programmes where joint working across NEL may enable greater benefits than are achievable through local working alone. This resulted in the recommendation to coordinate our efforts across NEL in three priority areas initially:

- Smoking cessation and tobacco control
- National Diabetes Prevention Programme rollout
- Workplace health

2.6 Nominations are being sought to take part in working groups to further progress our plans in these areas, once they are confirmed by Directors of Public Health.

Next steps

2.7 Further work is underway to produce **a detailed plan** to be submitted to NHS England in October.

2.8 To help us with the process of **developing and implementing our STP** we have engaged the Local Government Association (LGA) to provide the following support:

- Stage one: individual HWB or cluster workshops to explore self-assessment for readiness for the journey of integration - with the use of a toolkit launched at the recent LGA conference and being piloted until early October
- Stage two: NEL strategic leadership workshop to consolidate outputs from individual HWB / cluster workshops and to explore potential strategies and ways to strengthen the role of local authorities.

3 Mandatory Implications

Joint Strategic Needs Assessment

3.1 A public health profile for north east London (March 2016) is being used to help us understand the health and wellbeing, care and quality and the financial challenges locally and identify priorities for inclusion in the NEL STP. Details were presented to the last HWB.

3.2 The public health profile for north east London identifies common themes that are also identified with the Barking and Dagenham JSNA, as outlined below:

- According to the updated Index of Multiple Deprivation (2010), Barking and Dagenham continues to be in the bottom 7% of most deprived boroughs. In a population weighted ranking the borough is 8th worst in England.
- In Barking and Dagenham there is predicted to be an increase in population from 203,060 to 223,185 between 2015 and 2020, an increase of 9.9%. The 2011 Census found that the population of children aged 0-4 years had grown by 49% in the previous ten years, the highest growth for this age group in England and Wales. In 2013 the numbers of children under 5 years made up 10% of the population and between the ages of 0-19 made up 32% of the population.
- By the end of March 2014, 10,797 people had been detected with diabetes in Barking and Dagenham, a 6.7% rise on the March 2013 figure (10,260) and a 28.6% rise on the March 2010 figure (8,349). The prevalence of diagnosed diabetes in the borough is 7.3%, higher than the England average of 6.2%. It is estimated that 16% of the total number of people predicted to have diabetes are currently undetected.
- Barking and Dagenham has a significantly higher prevalence of overweight and obese adults when compared with London and is similar to that of England. In 2013/14 Barking and Dagenham had the ninth highest proportion of overweight and obese children in Reception class (26.8%) and the third highest proportion in Year 6 (42.2%) in England. Provisional measurements for 2014/15 indicate that the prevalence of children in reception year that are obese or overweight increased by 1%, while the prevalence of overweight or obese children in year 6 fell by 1.9%,
- Cancer contributes significantly to the health inequalities gap. There are 352 cancer deaths per 100,000 people each year in LBBD, the second highest rate between all London CCGs after Tower Hamlet. This is over 21% higher than the England average of 290 death per 100,000 population. The one year survival rate for all cancers in 2012 was 64%, the lowest in London at 69.7% and 69.3% for England.

Health and Wellbeing Strategy

3.3 The NEL STP links well with the Barking and Dagenham Health and Wellbeing Strategy 2015-18 which identifies three important stages of life: starting well, living well and aging well. Many of the emerging themes of the STP are covered in B&D HWBB strategy including prevention; care and support; and improvement and integration.

Integration

3.4 The STP will act as an ‘umbrella’ plan for change: holding underneath it a number of different specific local plans to address certain challenges. It will build on existing local transformation programmes and support their implementation. These include the Barking and Dagenham, Havering and Redbridge: devolution pilot (accountable care organisation).

Financial Implications

Completed by: Helena Pugh, Local Authority Engagement Lead, NEL STP

3.5 The NEL STP will include activities to address current financial challenges across the health and social care economy. The ambition is to ensure that all NHS

organisations are able to achieve financial balance by the end of the five year period of the plan.

Legal Implications

Completed by: Helena Pugh, Local Authority Engagement Lead, NEL STP

3.6 The NEL STP Board is developing a plan as stipulated by the NHS England guidance.

Risk Management

3.7 Risk management arrangements are being put in place by the north east London STP Board as part of planning for the STP; the board will be considering any risks on an on-going basis, will nominate officers responsible for identifying and carrying out mitigating actions.

Patient / Service User Impact

3.8 The involvement of patients, staff and communities is crucial to the development of the STP. We want it to be based on the needs of local patients and communities and command the support of clinicians, staff and wider partners. Where possible, we will build on existing relationships, particularly through health and wellbeing boards and patient panels and forums.

3.9 We are meeting with local public and voluntary stakeholders to discuss the plan. We held a successful meeting where partners, lay members and voluntary groups considered the challenges and opportunities of the STP. We have developed a website, http://www.nelstp.org.uk which shares some key points, links and background information about the STP and draws attention to the newly developed summary plan. We are also seeking to work with the voluntary sector to commission local organisations to engage with local people.

Publically available information associated with this report

- NHS Five Year Forward View https://www.england.nhs.uk/ourwork/futurenhs/
- Guidance on submission of Sustainability and Transformation Plans https://www.england.nhs.uk/wp-content/uploads/2016/05/stp-submission-guidance-june.pdf

List of Appendices

Appendix A: Better health and care: developing a sustainability and transformation plan for north east London (A summary of progress to date), Summer 2016

This is attached as Appendix A but can also be viewed at http://www.nelstp.org.uk/downloads/Publications/NEL-STP-summary-2016.pdf

Better health and care: developing a sustainability and transformation plan for north east London

A summary of progress to date

Draft, subject to change

Summer 2016

Everyone living in north east London should live independent and healthier lives, and for this to happen, the health service needs to improve and change. In order to achieve this, the NHS and councils are working to develop a Sustainability and Transformation Plan (STP) for north east London.

This plan will turn the ambitions of the NHS Five Year Forward View into reality.

Our vision is to:

- Measurably improve health and wellbeing outcomes for the people of north east London and ensure sustainable health and social care services, built around the needs of local people
- Develop new ways of working to achieve better outcomes for all, focused on the prevention of ill health and out of hospital care
- Work in partnership to plan, commission (buy), contract and deliver services efficiently and safely.

Five Year Forward View

The NHS Five Year Forward View is a strategy for the NHS in England. It sets out the gaps in health and social care, describing how the quality of NHS care can be variable, preventable illness is widespread, and health inequalities deep-rooted. People's needs are changing, new treatment options are emerging, and there are challenges in areas such as mental health, cancer and support for frail older patients. Pressure on NHS services continue to increase.

The NHS Five Year Forward View sets out solutions for the future based around new models of care (changing the way care is delivered) and highlighting the importance of public health and ill-health prevention, joining-up services across health and social care, empowering patients and communities, strengthening primary care and making further efficiencies in the health service.

Working together to achieve change

Clinical commissioning groups, local authorities and NHS provider trusts (hospitals, community services and mental health services) are working together to drive genuine and sustainable change, putting the patient and their experience at the heart of quality improvement and achieving improved health outcomes in the longer term by developing the STP for north east London. This involves 20 organisations:

Clinical commissioning groups (GP-led groups responsible for planning and buying NHS services): Barking and Dagenham, City and Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest.

Local authorities: Barking and Dagenham, City of London Corporation, Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest.

Providers: Barking, Havering and Redbridge University Hospitals NHS Trust, Barts Health NHS Trust, East London NHS Foundation Trust, Homerton University Hospital NHS Foundation Trust, NELFT NHS Foundation Trust.

We are also working with colleagues from NHS England, NHS Improvement, Health Education England and UCL Partners.

The STP is under development and nothing has been finalised. This document is a summary of progress to date and what we think the STP for north east London should address and include. We expect to have a completed STP in the autumn.

Why we need a Sustainability and Transformation Plan

Our challenges in north east London:

- Our population is projected to grow at the fastest rate in London with an 18% growth over 15 years (345,000 more people, the equivalent of a large borough).
- There are high rates of people being admitted to hospital with conditions that could be cared for in the community.
- A&E use is increasing in most boroughs.
- There are highly deprived areas, with many residents challenged by poor physical and mental health which is linked to factors such as low incomes, poor housing and high rates of smoking.
- There are generally high rates of physically inactive adults, which can lead to diabetes, dementia and obesity, all of which are more common in people living in poverty.
- People are living longer, meaning that they require more care and support later in life, and conditions linked to ageing such as dementia are becoming more common.
- We have higher than average rates of childhood obesity and below average immunisation rates.
- Two of our three hospital trusts are in special measures, meaning there are concerns about the quality of care they provide.
- More people than average find it hard to get an appointment with their GP.
- There is a national shortage of GPs, and many local GPs are nearing retirement age.
- The money we spend on health and care will increase significantly over the next few years but the money available to us will not.

Working together to address these challenges will give us the best opportunity to make sure health and care services in north east London are sustainable by 2021.

Sustainability: using resources to meet the needs of people today without reducing the ability of future generations to meet their own needs.

Solving our challenges

Our top three ambitions are:

1 **Promoting prevention and self-care** – to reduce the burden on health care services, we want to encourage more people to look after themselves and their health so that they stay well.

2 **Improving primary care** – to meet the rising demand placed on our primary care services, we will transform primary care by working together and using multi-disciplinary teams comprised of community, social care and healthcare professionals.

3 **Reforming hospital services** – most of our hospital care does not currently meet the required standards. We will change this by reforming hospital care through redesigning patient pathways and working together more closely.

The STP will act as an **'umbrella' plan for change**, underneath it are a number of local plans such as:

Hackney: devolution pilot, bringing health and social care providers together to deliver an integrated, effective and financially sustainable system that covers the whole range of wellbeing. To find out more: **www.cityandhackneyccg.nhs.uk**

Barking and Dagenham, Havering and Redbridge (BHR): as a devolution pilot BHR is exploring bringing health and social care services together to deliver better outcomes for residents, including the option of a single local accountable care organisation. To find out more:**www.bhrpartnership.org.uk**

Newham, Tower Hamlets and Waltham Forest: a partnership between Newham, Tower Hamlets and Waltham Forest CCGs and Barts Health NHS Trust, involving multiple other organisations and stakeholders. It aims to deliver safe, sustainable, high-quality services to improve the local health and social care economy in east London – in line with the challenges of the NHS Five Year Forward View and the established case for change. **www.transformingservices.org.uk**

In north east London there are also two 'vanguard' programmes, aimed at supporting improvement and integration of services. Each vanguard site has freedoms and flexibilities which they would otherwise not have in order to deliver innovation at pace and share their learning. These are:

Urgent and emergency care vanguard

Local GPs, hospitals, community services and councils are working across Barking and Dagenham, Havering and Redbridge to transform urgent and emergency care services. This is happening by changing the way people access urgent care locally, creating a simplified, streamlined urgent care system that delivers intelligent, responsive urgent care for local people.

For more information:
www.bhrpartnership.org.uk

New models of care vanguard

In Tower Hamlets local health and care partners are developing new ways of working to provide integrated and person-centred care to local people, including looking at how to transform the way care is provided to adults with complex needs and children and young people. With a focus on prevention and being able to access high quality services, the vanguard will improve physical, social, emotional and cognitive development and improve life-long health and wellbeing.

For more information:
www.towerhamletsccg.nhs.uk

Our approach

Promote prevention and personal and psychological wellbeing in all we do

- Workplace
- Housing
- Self-service care

- Leisure
- Education
- Employment

- Self-care
- Peer-led services
- Voluntary sector services
- Home-based support
- Mental health services
- Children's services
- Social care services
- Opticians/dentists/pharmacies
- GPs
- Integrated multi-disciplinary teams
- Support from volunteers

Promote independence and enable access to care closer to home

- Maternity
- Acute physical and mental care
- Emergency care
- Specialised services

Ensure accessible, high quality acute services for people who need it

We have identified six priorities to focus on across north east London:

1 Make sure we have the right health and care services in the right place to care for our growing population

Our growing population is putting pressure on our health and social care services. Rather than building another hospital, we need to focus on preventing illness, improving primary care (GP) services and making sure there are beds in our hospitals for those who truly need them. We can make this happen by:

- Changing the way people use health services by focusing on in prevention and self-care, equipping and empowering everyone to help themselves where possible.
- Making sure our urgent and emergency care system directs people to the right place first time, with proactive, easy to access primary care at its heart.
- Offering effective outpatient care on each hospital site, so hospital beds are only for those who really need to be admitted.
- Making sure our hospitals work together and with community and social care to deliver seamless, patient-centred care.
- Making sure our buildings and our workforce can support local people from cradle to grave.

2 Transform the way care is provided: encourage self-care, offer care close to home and make sure secondary care is high quality

We will empower people to manage their own health and wellbeing where possible, and make sure the care they receive is of a consistently high quality. We want to make this happen by:

- Transforming primary care by addressing areas of poor quality/access, including offering care from 8am to 8pm, seven days a week.
- Making sure that people receive high quality care in the right setting, ideally close to their home.
- Delivering coordinated care to support the health and wellbeing of people with complex health and social care needs.
- Making sure that when people fall seriously ill or need emergency care, hospitals provide strong, safe, high-quality services.
- Improving hospital services: streamlining outpatient pathways, delivering better urgent and emergency care, coordinating planned care/surgery, offering more birthing options and encouraging hospital trusts to work together.
- Changing the way and order that people are treated (triage) in urgent and emergency care so that patients receive the right care at the right time according to their needs. Only patients who need more intensive care should be admitted to hospital, reducing the demand for costly hospital beds.
- Developing services that provide planned, short term intensive help so people can stay independent, rather than have to go into hospital.

3 Secure the future of our health and social care providers

Many of our health and care providers face challenging financial circumstances, and although they have made significant progress in improving services and making savings, more needs to be done to make sure we have better quality, innovative services which deliver value for money. The challenge is to work together to develop a plan to support organisations providing local services. This will involve:

- changing the way services are provided so fewer people attend or are admitted to hospitals unnecessarily (and that those are admitted can be treated and discharged more efficiently).
- driving greater efficiency and productivity initiatives within and across organisations providing services (e.g. procurement, clinical services, back office and bank/agency staff).
- looking at formal ways to work together.
- exploring opportunities for the NHS to work more closely with local authorities through local devolution pilots.

4 Improve specialised care

Specialised services are expert services such as some rare cancers provided in relatively few hospitals and accessed by small numbers of patients. Demand for these services is growing, and we need to work with other NHS organisations in London to become a world class destination for specialised services.

Spotlight on workforce

We cannot achieve any change without our staff – they are crucial to the success of the STP. We will transform our workforce by:

- **Retaining staff** - by making our organisations great places to work, offering career development, education and training so our staff have the skills needed to deliver amazing care, and keeping our staff happy and healthy.
- **Promoting north east London as a great place to live and work** – in order to recruit staff/ talent, we need people to recognise this part of London is a great place to live and work. We must create career and education opportunities for people so they want to live and work here.

Finances – how will we pay for this?

We are clear that things need to change. If we carry on as we are in north east London, we will have a shortfall of £527m by 2021. We have identified ways to help close this gap and find savings, including through:

- Individual CCGs' and providers' savings programmes – to run the organisations more efficiently and effectively.
- Working together – using our transformation programmes such as Transforming Services Together to achieve savings.
- Standardising and combining back office functions - in many cases, back office functions such as HR, finance, facilities management and IT are duplicated across providers and cost and quality vary. Consolidating services and sharing good practice can improve productivity and save money.
- Using our buildings more efficiently – so we are making the best use of our spaces.
- Capitalising on our collective buying power – where it is better value for money to do so, we will procure contracts and spend at a north east London level, for example buying medicines in bulk will save money and ensure consistency.
- Working with local people to co-design new services and identify opportunities for productivity and efficiency improvements.

We can also receive funding from the national Sustainability and Transformation Fund, but this is conditional on the quality of our STP.

5 Work together to tackle challenges, identify solutions, make decisions and improve the health of local people

We need to change the way we work if we are to improve care and create models of care that are truly people-centred and sustainable. This will involve:

- pooling health and social care budgets
- joining previously separate services, where practical
- close working between local authorities, the NHS and other voluntary and community organisations.

6 Use our buildings better

We want care to be provided in modern buildings suitable for healthcare. We are developing an estates strategy that looks at our buildings, what services are based in them and where there are opportunities to use them more effectively, or if they should be sold. We also need to look at how we can better manage our private finance initiative (PFI) buildings, which place significant financial pressure on some providers.

How we will know our plan is making a difference

We will:

- Make sure people live longer and healthier lives by reducing major health risks such as obesity, smoking and alcohol misuse.
- Develop new ways to deliver care, focusing on keeping people well (prevention) and keeping them out of hospital.
- Make sure all our hospitals provide care that is safe, compassionate, effective and efficient, every time.
- Make sure all local health and social care services provide high quality care that local people need, do it well, and are sustainable.
- Work together to make sure health and social care services are planned and delivered innovatively, efficiently and safely.
- Break down organisational barriers so care is provided seamlessly between GPs and hospitals, between physical and mental health services, between health and social care.
- Better support patients and unpaid carers, and further develop our work with voluntary organisations and local communities.
- Make sure we can afford to run a safe and sustainable NHS.

What do you think?

We'd like to know what you think about our STP. It's still a draft, so the content can and will change. We'd like to hear from as many people as possible about what you think so we can refine our ideas and further develop our STP, based on your comments, before it is finalised later in the year.

- What do you think about what we've chosen to focus on?
- Do you think we have the right priorities?
- Is there anything missing that you think we should include?

Please send us an email and tell us what you think:

nel.stp@towerhamletsccg.nhs.uk

To find out about STP-related events, sign up to our newsletter or read a more detailed version of the STP visit: **www.nelstp.org.uk**

HEALTH AND WELLBEING BOARD

27 September 2016

Title:	Improving Post – Acute Stroke Care (Stroke Rehabilitation)
Report of the Barking and Dagenham CCG	
Open Report	**For Decision**
Wards Affected: All wards	**Key Decision:** No
Report Author: Sharon Morrow, Chief Operating Officer Barking and Dagenham CCG	**Contact Details:** Tel: 0203 6442370 E-mail: Sharon.morrow2@nhs.net
Sponsor: Conor Burke, Chief Officer Barking and Dagenham CCG	

Summary:
Barking and Dagenham, Havering and Redbridge CCGs consulted on proposals to reconfigure the stroke rehabilitation pathway between January and April 2016. A number of public engagement/drop in sessions were held and presentations were made to the Health and Wellbeing Board and Heath and Adult Social Care Scrutiny Committee (HASSC). Three hundred and thirty responses to the consultation were received and there was clear support for the preferred new service model which was to commission a combined Early Supported Discharge (ESD) and Community Rehabilitation Service (CRS) service covering all Barking and Dagenham, Havering and Redbridge from one provider, with one inpatient unit based at King George Hospital.

Whilst the overall response was positive there were some concerns raised regarding the proposed reduction of stroke beds, though the question stated 'if it can be shown they are not used and not needed'. Concern was also expressed about travel and transport issues whatever the location of a stroke inpatient unit.

The Governing Body agreed a business case to commission the new model in July 2016. A project board meeting is planned in mid-September to develop an implementation plan and timelines for delivery.

Recommendation(s)

The Health and Wellbeing Board is asked to note the outcome of the public consultation and decision made by the CCG Governing Body to approve the business case for the stroke rehabilitation service.

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

1. Introduction and Background

1.1 Improving the stroke rehabilitation pathway is one of the agreed CCG commissioning priorities that are being taken forward in the commissioning plan this year in collaboration with Redbridge and Havering CCGs.

1.2 In June 2015, a Case for Service Change was accepted by the Governing Body of each CCG. The CCGs subsequently undertook a review of local stroke rehabilitation services, benchmarked against best practice in NICE clinical guidelines. The CCGs, in partnership with key stakeholders, developed a list of options in response to the challenges raised in the Case for Service Change which were scored through a stakeholder workshop and tested for affordability.

1.4 A pre-consultation business case which set out the preferred model for care was approved by the Governing Bodies in November 2015. Barking and Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Groups (CCGs) launched a 12-week consultation on proposed changes to local stroke rehabilitation services on 8th January 2016.

1.5 The consultation response provided clear support for the CCG preferred option which was to commission a combined Early Supported Discharge (ESD) and Community Rehabilitation Service (CRS) service covering all Barking and Dagenham, Havering and Redbridge from one provider, with one inpatient unit based at King George Hospital.

1.6 A business case to redesign stroke rehabilitation services, outcome of the consultation process and equality impact assessment were considered by the CCG Governing Bodies in July and the business case was agreed subject to the development of a robust implementation plan.

1.7 The purpose of this paper is to provide the Board with further information on the outcome of the consultation process and proposed next steps.

2.0 Consultation report

2.1 A public consultation took place from 8 January to 1 April 2016. Four thousand eight hundred printed consultation documents were distributed throughout Barking and Dagenham, Havering and Redbridge, including to GP practices, local libraries, hospitals and community groups and voluntary services. There was also significant engagement with stroke survivors and their carers. The consultation document, an easy read version, questionnaire and pre-consultation business case were published on each CCG's website. The consultation was also extensively promoted through the CCGs' Twitter accounts.

2.2 Four public engagement/drop-in sessions were held at libraries, supermarkets and at Queen's Hospital. GP stroke leads and CCG officers attended 27 meetings with groups of up to 100 people to discuss the consultation proposals and answer questions. Public engagement sessions were also held at the two affected sites – Grays Court in Dagenham and Beech ward at King George Hospital.

2.3 Three hundred and thirty responses to the consultation were received: 320 questionnaires and 10 letters/emails. Fifty seven percent of those who responded to

the questionnaire (and shared where they lived) were from Redbridge, 20% were from Havering and 9% from Barking and Dagenham. The remaining 14 per cent were from outside the BHR area or did not share what borough they lived in.

2.4 Responses were received from providers of stroke services locally: from NELFT NHS Foundation Trust, Barking, Havering and Redbridge University Hospitals NHS Trust, and Barts Health NHS Trust. A number of people who worked in stroke services provided individual responses responded. Barking and Dagenham and Redbridge's health scrutiny committee responded. Havering and Redbridge's Healthwatch both provided responses.

2.5 In addition to the distribution of consultation materials through the channels described above, the consultation was promoted to Barking and Dagenham residents through a number of local events:

- Presentation to Barking and Dagenham Health and Wellbeing Board (26 January)
- A drop-in session at Queen's Hospital (22 February)
- Barking and Dagenham Patient Engagement Forum (26 February)
- Stroke Association event at Beech ward, King George Hospital (26 February)
- CCG and Local Authority "Staying Healthy" event at Barking Learning Centre (16 February)
- Drop in session at ASDA, Merrielands Crescent Dagenham (29 March 2016)

2.6 The Barking and Dagenham Health and Adult Social Care Scrutiny meeting held an extra-ordinary meeting on 13 January to discuss the consultation and provided a written response. The Committee supported the case for change and made some representations in respect of the proposed new model that the CCG were asked to take into account.

2.7 The response to the consultation showed strong support for the preferred option of home-based services where possible and one stroke rehabilitation unit on the King George Hospital site. Whilst there was strong support for establishing new home based services there was opposition to the proposed reduction of stroke beds, though the question stated 'if it can be shown they are not used and not needed'. Concern was expressed about travel and transport issues whatever the location of a stroke inpatient unit. The headlines responses are set out below:

Headlines from the consultation

	Support %	**Opposition %**
Inpatient stroke rehabilitation should be provided at one specialist unit	88%	12%
All stroke patients should have access to the same stroke rehabilitation services, regardless of where they live	96%	4%
The local NHS should provide more stroke rehabilitation services in patients' homes, provided it is safe for them to be there	91%	9%
The local NHS should reduce the number of stroke beds if it can be shown they are not used and not needed.	51%	49%

A full copy of the report is attached.

3.0 Proposed service changes and next steps

3.1 The proposed new model for the service is for a specialist stroke rehabilitation service to be provided from the King George Hospital site for residents of Barking and Dagenham, Havering and Redbridge, with one provider responsible for delivering services across the stroke rehabilitation pathway – a combined early supported discharge and community rehabilitation service and stroke rehabilitation beds.

3.2 This will have the following benefits:

- A more seamless pathway across acute and community services and a reduction in the number of transfers between providers
- Equity of access to specialist rehabilitation support with more people cared for at home. Evidence shows that people who receive care at home are able to live more independently that those who have had all of their rehabilitation in hospital.
- A reduction in length of stay in acute hospitals which means better outcomes for patients as well as reduced costs to the hospital which enables them to focus more on the acutely ill patients
- A more efficient use of workforce through the development of a multi-speciality team that meets best practice requirements and can flex to manage service demands
- The opportunity to redesign stroke rehabilitation services to meet the needs of growing demand.

3.3 The development if an implementation plan has been delayed as resources have been focused on the development of the Referral to Treatment (RTT) improvement plan, which has taken priority over other projects. Some more detailed work is being undertaken to model activity against the new service model which will underpin the development of a specification. A project board meeting is planned in mid-September to consider procurement options and timelines for implementation.

4 Mandatory Implications

4.1 Joint Strategic Needs Assessment

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

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

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

4.2 Health and Wellbeing Strategy

The consultation proposes service improvement that will support delivery of the Health and Wellbeing Strategy outcomes:

- To increase the life expectancy of people living in Barking and Dagenham.

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

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

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

4.3 **Integration**

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

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

4.4 **Financial Implications**

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

4.5 **Legal Implications**

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

4.6 **Risk Management**

4.7 **Patient/Service User Impact**

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

- A more streamlined pathway with a reduction in the number of transfers between providers.
- Access to the best care is improved. All people that are eligible for ESD will receive the rehabilitation and support they need in their homes
- More people will receive their care at home. Evidence shows that people who receive care at home are able to live more independently than those who have had all of their rehabilitation in hospital.
- The length of stay in hospital is reduced which means better outcomes for patients
- A better quality of service provision for patients with equity of access across all three boroughs.

- Patients will receive the same quality of care regardless of where they live or which hospital they have been in. Each team will have the right number of staff with the right specialist skills to deliver rehabilitation at home. This includes equal access to speech and language therapy and psychology.
- There are benefits for carers too, as there will be less travelling required and the carer will liaise with a single team throughout each phase of the rehabilitation; so less duplication.
- Service provision can be based on patient need rather than prescribed only by time

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

5. Non-mandatory Implications

5.1 **Crime and Disorder**
N/A

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

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

List of Appendices:

Appendix A - Report of the consultation on proposed changes to stroke rehabilitation for Barking and Dagenham, Havering and Redbridge

Report of the consultation on proposed changes to stroke rehabilitation for Barking and Dagenham, Havering and Redbridge

Prepared for Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

May 2016

Contents

1. Executive summary

Barking and Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Groups (CCGs) were concerned that stroke rehabilitation services locally were not as good as they could be. The care provided depended on where people lived and was not flexible enough to meet the individual rehabilitation needs of stroke survivors, meaning people were not recovering from strokes as well as they could.

Inpatient care was provided at Grays Court in Dagenham (a community hospital site with no other inpatient beds and some outpatient clinics) and Beech ward at King George Hospital (an acute hospital site with A&E, critical care and other acute inpatient wards. General Community rehabilitation beds are also located on this site).

The BHR stroke pathway transformation project was established to identify what needed to change in the way community stroke rehabilitation services were currently commissioned and delivered, through the development of a case for change.

The case for change found that existing stroke rehabilitation services followed a pathway that was reliant on the use of inpatient rehabilitation services, that the care people received depended on where they live, creating a postcode lottery situation and, most significantly, people who had a stroke were not achieving the best possible outcomes. A pre-consultation business case agreed by each of the CCG governing bodies agreed to go out to publicly consult on a proposed model for stroke rehabilitation service locally, which involved more home-based care and a single stroke rehabilitation inpatient unit, based at King George Hospital.

A public consultation took place from 8 January to 1 April 2016. Four thousand eight hundred printed consultation documents were distributed throughout Barking and Dagenham, Havering and Redbridge, including to GP practices, local libraries, hospitals and community groups and voluntary services. There was also significant engagement with stroke survivors and their carers. The consultation document, an easy read version, questionnaire and pre-consultation business case were published on each CCG's website. The consultation was also extensively promoted through the CCGs' Twitter accounts.

Four public engagement/drop-in sessions were held at libraries, supermarkets and at Queen's Hospital. GP stroke leads and CCG officers attended 27 meetings with groups of up to 100 people to discuss the consultation proposals and answer questions. Public engagement sessions were also held at the two affected sites – Grays Court in Dagenham and Beech ward at King George Hospital.

Three hundred and thirty responses to the consultation were received: 320 questionnaires and 10 letters/emails. Fifty seven percent of those who responded to the questionnaire (and shared where they lived) were from Redbridge, 20% were from Havering and 9% from Barking and Dagenham. The remaining 14 per cent were from outside the BHR area or did not share what borough they lived in.

Responses were received from providers of stroke services locally: from NELFT NHS Foundation Trust, Barking, Havering and Redbridge University Hospitals NHS Trust, and Barts Health NHS Trust. A number of people who worked in stroke services provided individual responses responded. Barking and Dagenham and Redbridge's health scrutiny committee responded. Havering and Redbridge's Healthwatch both provided responses.

Headlines from the consultation

	Support %	Opposition %
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The local NHS should provide more stroke rehabilitation services in patients' homes, provided it is safe for them to be there.	91%	9%
The local NHS should reduce the number of stroke beds if it can be shown they are not used and not needed.	51%	49%

There was strong support for the preferred option: home-based services where possible and one stroke rehabilitation unit on the King George Hospital site.

There was strong support for establishing new home based services.

There was considerable opposition to the proposed reduction of stroke beds, though the question stated 'if it can be shown they are not used and not needed'.

There was concern about travel and transport issues whatever the location of a stroke inpatient unit.

2. Introduction

Barking and Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Groups (CCGs) undertook a 12 week public consultation on proposed changes to stroke rehabilitation services from 8 January to 1 April 2016.

This report documents the consultation process, explaining how the consultation was run and describing the engagement. It also provides a summary of the responses received. It identifies the key issues highlighted by the consultation which the CCGs will need to take into account as part of its decision making process regarding the future of local stroke rehabilitation services.

The documents referred to in this report are all available on the stroke webpage of the BHR CCGs' websites: www.barkingdagenhamccg.nhs.uk/stroke
www.haveringccg.nhs.uk/stroke
www.redbridgeccg.nhs.uk/stroke

3. Background

Current stroke care

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

In BHR, GPs wanted to make improvements to the next step in the stroke care pathway, rehabilitation. They recognised that local stroke rehabilitation services followed a disjointed pathway that was too reliant on the use of inpatient rehabilitation services, and that as a result people who have had a stroke were not achieving the best possible outcomes. The CCGs agreed to identify what needed to change in the way community stroke rehabilitation services were currently commissioned and delivered, through the development of a case for change.

The BHR stroke pathway transformation project was established to take this forward.

BHR stroke pathway transformation project

This project involved working with partners to identify what needs to change about stroke rehabilitation and identifying solutions to make sure stroke rehabilitation users get the best possible outcomes.

The project identified that although three types of community stroke rehabilitation - Early Supported Discharge (ESD), Community Rehabilitation Service (CRS) and inpatient rehabilitation unit care - exist locally, there is variation in provision and quality. Different providers with differing commissioning and delivery arrangements mean that the stroke care pathways are complex and confusing to articulate.

For patients, the current stroke rehabilitation services mean that if they have a stroke:

- They spend more time in hospital than needed, even when it is better to be at home
- They won't always be cared for by specialist stroke staff
- Their recovery will take longer.

A case for change was developed, setting out why stroke services need to change, highlighting:

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

The CCG governing bodies reviewed and discussed the findings and agreed that there was a need to:

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

It was agreed to consult on a new model for stroke rehabilitation services.

4. Reaching a preferred option for stroke rehabilitation

Learning from the case for change and responding to the challenges raised by the CCG governing bodies, a list of options for a future model of stroke rehabilitation was developed, with a preferred option to be agreed through a scoring process.

There were two separate processes for reaching a preferred option for stroke rehabilitation services, involving scoring options against non-financial and financial criteria. These had a weighting ratio of 60:40 applied respectively.

Non-financial criteria

Clinical outcomes and safety
- Does the option improve patient outcomes and patient safety?

Patient/carers' experience
- Does the option improve patient / carers' experience?

Access to services
- Can everyone use the services, wherever they live?

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

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

Financial criterion

Commissioner affordability
- Can the BHR CCGs afford the option proposed within its projected financial envelope?

Stakeholder workshop

On 16 October 2015 a stakeholder workshop took place to look at these options in detail. This involved discussing the options, the advantages, disadvantages and implications and deciding through a scoring process what was the preferred option.

The workshop took the form of two sessions.

Session one – setting the scene

Session one looked at the case for change, the options, and the scoring process. There were discussions regarding the pros and cons of each option and the impact they would make on services for local stroke patients.

It was attended by:
- Stroke clinical reference and steering group members
- Service users
- Voluntary organisations
- NHS England stroke leads
- Local authority representatives
- Carers organisation representatives
- Healthwatch
- GPs

At the end of this session, representatives from provider organisations left, to avoid any conflict of interest.

Session two – assessment of the options against non-financial criteria

Session two scored the options against the non- financial criteria, taking into consideration feedback from the first session.

It was attended by:
- BHR clinical director lead GPs for stroke
- Nominated BHR CCG commissioning officers
- Nominated leads from BHR local authorities
- Public Health lead (Havering)
- BHR finance lead
- NHS England leads for stroke
- Patient representatives
- Healthwatch
- Carer organisation representatives

Participants identified a preferred model of care that included the following features:
- A shift towards more rehabilitation provided at home
- Streamlining the ESD service with one provider
- Extending ESD provision to the whole of Redbridge
- Enhancing community service to provide high quality specialist stroke multi-disciplinary teams
- All patients will receive up to six weeks of ESD based on need
- Common service provider with common standards covering all of BHR
- Combining the provision of ESD and CRS across BHR
- Inpatient stroke rehabilitation services to be located at King George Hospital with access through a single set of criteria.

Participants considered the following potential options for stroke rehabilitation services:

> **Option 1:** Do nothing – services stay the same as they are now.
>
> **Option 2:** A single separate ESD service and a single separate CRS, covering all three boroughs.
>
> **Option 3:** A combined ESD and CRS service covering all three boroughs, offered by one provider, with one inpatient unit.

Following detailed discussion, participants at the workshop agreed that their preferred option was option 3.

Looking at the location of inpatient rehabilitation beds, workshop attendees discussed what they thought were the pros and cons of each location. They agreed the following:

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

Participants agreed that King George Hospital would be a better location mainly because there would be 24 hour medical cover available, with easy access to other relevant services, which would benefit these patients with more complex needs.

They then considered two options for inpatient rehabilitation:

> **Option A:** Consolidate the inpatient rehabilitation beds and locate them at King George Hospital.
>
> **Option B:** Consolidate the inpatient rehabilitation beds and locate them at Grays Court.

Following detailed discussion, participants at the workshop agreed that their preferred option was option A.

Assessment of options against the financial criterion

In a separate process, on 22 October 2015, the stroke project lead and CCG finance leads assessed each option against the financial criteria, looking at how much each option would cost and if it was viable.

The CCGs had agreed that making changes to stroke rehabilitation services were not cost driven, the priority being to improve patient outcome. As such the options did not need to make financial savings, but any changes should cost no more than the current service, as it was felt that funding allocated to stroke rehabilitation services could be spent more effectively so that people recover more quickly and fully.

Following detailed discussion, the participants at the workshop agreed that their preferred option was option 3 and option A.

Taking into account the results of both scoring processes, the preferred option was:

A combined ESD and CRS service covering all three boroughs, offered by one provider, with one inpatient unit. Consolidate the inpatient rehabilitation beds and locate beds at King George Hospital.

5. Governance and responsibilities

Clinical leadership

A clinical director from each CCG is responsible for stroke care, supported by Clare Burns as project lead. The clinical directors for stroke rehabilitation services are:

- Dr Ravali Goripathi, Barking and Dagenham CCG
- Dr Alex Tran, Havering CCG
- Dr Sarah Heyes, Redbridge CCG

The clinical directors were involved in the development of the case for change and the pre-consultation business case, and presented these to the CCG governing bodies for consideration and approval. The three CCG governing bodies separately agreed to hold a public consultation to ensure the views of local people and other key stakeholders were taken into account when deciding on the future of stroke rehabilitation services. The stroke leads reviewed and signed off the consultation document before it went to print.

The stroke leads will consider the results of the consultation contained in this report (and by examining the data), ensuring that this report is used to inform the development of a decision-making business case, which will make recommendations to the governing bodies of the three CCGs to individually consider and make decisions about the way forward for stroke rehabilitation services.

Policy overview

There are two main relevant legal requirements relating to consultation and engagement:

> **For the NHS to promote public involvement and consultation**
> (Section 14Z2, Health and Social Care Act 2012, as amended)
>
> This duty applies where there are changes proposed in the way in which services are delivered, or in the range of services available. The duty applies to health services commissioned by clinical commissioning groups, which are responsible for involving or consulting the people who are or may be using the service.
>
> **For the local authority to review and scrutinise the NHS**
> (Part 4, Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013)
>
> Under the Local Authority Regulations 2013, local authorities may review and scrutinise any matter relating to the planning, provision and operation of the health service in their area.

All BHR CCGs are also signatories to borough-level compacts, joint agreements between public bodies and voluntary groups that help partners improve their relationship for mutual advantage and community gain. The principles for effective consultation and engagement, set out in the compacts, were also considered when planning the delivery of the consultation.

6. Structure of the consultation

A 12 week public consultation on proposed changes to stroke rehabilitation services ran from Friday 8 January, closing at 5pm on Friday 1 April 2016.

The consultation document

A consultation document was published explaining the preferred option, why the CCGs wanted to make changes, the potential implications and including a questionnaire to fill in.

It aimed to provide the information stakeholders needed to be able to respond to the consultation and was written in plain English and designed to be as accessible as possible to the general public.

Healthwatch representatives, the CCGs' patient engagement forum chairs and vice-chairs and governing body lay members were asked to review and comment on the consultation document at first draft stage, and again with a designed version of the consultation document. Special thanks in particular go to Richard Vann from Barking and Dagenham Healthwatch, who provided detailed comments and suggestions on how to improve the consultation document, which were incorporated.

On the recommendation of Cathy Turland from Redbridge Healthwatch, an easy-read version of the consultation document was also developed.

The consultation document included a statement on the back page in seven other languages asking people to contact the CCGs if they wanted to know more about the proposals but could not read the document. It asked them to say what help they might need and if they needed a large print version

or different format. The decision about which languages was based on information from local councils about the most frequent language requests they receive for translation. No requests for other formats or languages were received.

A dedicated consultation email address, haveyoursay@onel.nhs.uk, was publicised so that people could direct their questions and queries.

The questionnaire

The consultation sought views through a questionnaire, where respondents were asked to indicate how they felt about a set of statements. They were also asked to comment about anything else about the stroke rehabilitation proposals that they felt it was important for the CCGs to know.

The questionnaire could be returned via a Freepost address. There was also an identical online questionnaire, accessed through all of the CCGs' websites.

Other consultation materials

A standard set of slides was developed for the CCGs to present the proposals to health scrutiny committees, health and wellbeing boards and more widely.

Distribution: hard copy

A total of 4800 consultation documents were printed - 3800 standard consultation documents and 1000 easy read consultation documents – and were distributed across Barking and Dagenham, Havering and Redbridge.

The consultation documents were sent to all local MPs, GP surgeries and libraries in the three boroughs early in the consultation period. The GP surgeries and libraries were asked to display the consultation document prominently. Local MPs were encouraged to distribute the document to anyone in their constituency with an interest, as well as to respond to the consultation themselves. Consultation documents were sent to community and voluntary organisations such as Healthwatch and Age UK, as well as to local hospital's stroke units for distribution to patients and staff. Further printed copies were available by post to organisations and individuals on request.

Consultation documents were distributed at every event and meeting that the project team attended to discuss the consultation proposals.

Distribution: electronic

On the day the consultation launched, emails were sent to stakeholders telling them the consultation had launched with a link to the consultation page on each CCG's website and information on how to respond. The stakeholders contacted were:

- MPs
- Council health scrutiny committee chairs and officers, cabinet members for health and adult services
- Council leaders, chief executives and directors of public health and adult services (or equivalent)
- Health and wellbeing board chairs and officers
- Service providers (NELFT, BHRUT, Partnerships of East London Co-operative, Barts Health and London Ambulance Service)
- GPs
- Professional organisations (Local Medical Committee, Local Pharmaceutical Committee, Local Dental Committee, Local Optical Committee)
- Healthwatch (in the three boroughs)

- Neighbouring CCGs (Newham, Waltham Forest, West Essex, Thurrock)
- Patient groups, interest groups and community and voluntary organisations.

Each CCG's website had a page on the consultation, including the consultation document, questionnaire, case for change and pre-consultation business case in PDF format, as well as a link to the online questionnaire. The consultation was prominently advertised on the homepage of each CCG website throughout the consultation period.

An email was also sent out towards the end of the consultation period reminding stakeholders to respond to the consultation before it closed on 1 April 2016.

Consultation document downloads and webpage views

For those with internet access, a stroke webpage was established on all three websites and the consultation documents were also available to download.

Downloads
Consultation document: 561
Easy read consultation document: 275

Webpage views
Barking and Dagenham: 266
Havering: 605
Redbridge: 408

7. Consultation activities

Attending meetings

The CCGs in Barking and Dagenham, Havering and Redbridge engaged with a range of organisations during the consultation period, with a particular focus on stroke groups.

The format of these meetings usually involved the stroke lead presenting, followed by a question and answer session. Attendees discussed the proposals, asked questions and then some submitted responses.

The specific meetings were as follows:

Date	Borough	Name of meeting
13 January 2016	Barking and Dagenham	Health and Adult Services Select Committee (extraordinary meeting arranged to discuss the consultation)
19 January 2016	Barking and Dagenham, Havering and Redbridge (Waltham Forest and Essex representatives also in attendance)	Outer north east London joint health overview and scrutiny committee
25 January 2016	Redbridge	Health and wellbeing board

Date	Borough	Name of meeting
26 January 2016	Barking and Dagenham	Health and wellbeing board
4 February 2016	Barking and Dagenham and Havering	Local Medical Committee meeting
15 February 20016	Redbridge	Redbridge Pensioners' Forum
17 February 2016	Havering	Havering Asian Social and Welfare Association
18 February 2016	Redbridge	Redbridge Carers' Support Service Older Carers Group
19 February 2016	Redbridge	Different Strokes Group
22 February 2016	Barking and Dagenham, Havering and Redbridge	Drop-in session at Queen's Hospital
23 February 2016	Havering	Havering Carers Forum
25 February 2016	Redbridge Barking and Dagenham Redbridge	Redbridge Stroke Club Barking and Dagenham Patient Engagement Forum Redbridge Patient Engagement Forum
26 February 2016	Barking and Dagenham, Havering and Redbridge Redbridge	Stroke Association event at Beech Ward, King George Hospital Community Support Workers Woodford Green
1 March 2016	Redbridge Redbridge	Redbridge Healthwatch Project Development Group Parkside Stroke Club
2 March 2016	Havering	Havering and Districts Stroke Club
9 March 2016	Redbridge	Healthwatch public meeting
14 March 2016	Redbridge	Health Scrutiny Committee meeting
18 March 2016	Havering	YMCA stroke exercise group, Romford
21 March 2016	Havering	Drop in session, Hornchurch Sainsbury's

Date	Borough	Name of meeting
29 March 2016	Barking and Dagenham Redbridge Havering	ASDA Dagenham Redbridge Asian Mandal Tapestry

The chairs and chief officer of BHR CCGs also met with local MPs Jon Cruddas and Wes Streeting as part of a regular meeting programme during the consultation period, and the consultation was mentioned at these meetings.

Drop-in sessions

A number of drop-in sessions were held to promote the consultation to the general public. These were designed for, and open to, all members of the public, and invitations were sent to local stakeholders and potentially interested parties known to the project team. CCG staff staffed the stands to listen to feedback, answer questions and discuss any concerns.

They took place as follows:

Queen's Hospital foyer, Romford (22 February 2016) – this was promoted to Barking, Havering and Redbridge University Hospitals NHS Trust staff through posters and on their intranet, but not to the general public, as the CCGs did not want to encourage 'well' people to come to hospital.

Redbridge Central Library, Ilford (7 March 2016) – local stakeholders were advised of this event by email, but the CCG was keen to capture 'everyday' people at this event.

Sainsburys, High Street Hornchurch (21 March 2016) – to capture local shoppers

ASDA, Merrielands Crescent Dagenham (29 March 2016) – the Barking and Dagenham Health and Adult Services Select Committee and Health and Wellbeing Board recommended a drop-in session was held in Dagenham, and the impact of the preferred option was greater in Dagenham, as this was where Grays Court was located. The health and wellbeing board asked for the session to take place at ASDA, which proved difficult to organise, and so was held later in the consultation than preferred.

Barking and Dagenham CCG and the London Borough of Barking and Dagenham also held a joint staying healthy event on 16 February 2016 at Barking Learning Centre, to ask local people their thoughts on health and wellbeing locally. The stroke team had a stand at this event to promote the consultation.

Engagement with GPs

Local GPs were emailed encouraging them to respond to the consultation when it launched and again towards the end of the consultation period. The proposals for stroke rehabilitation services were also presented to Redbridge GPs at the Redbridge Protected Learning Event and the Redbridge CCG members' committee, and to Havering GPs at the Havering CCG members' committee and more informally in other meetings.

Engagement with stroke staff

Havering Healthwatch recommended that acute stroke services staff were involved in the consultation, and so copies of the consultation document were sent to the hyper acute stroke units at Queen's Hospital Romford and the Royal London Hospital in Whitechapel, and to the acute

stroke units at Queen's Hospital Romford and Whipps Cross Hospital Leytonstone. Copies were also sent to the two wards which were the subject of the consultation: Beech ward at King George Hospital and Grays Court Dagenham. Engagement sessions were also held with staff from both these wards.

> **Beech ward, King George Hospital** - 11 February 2016, engagement session with staff at the BHRUT-run stroke rehabilitation ward.
>
> **Grays Court Dagenham** - 22 March 2016, engagement session with staff at the NELFT-run stroke rehabilitation ward.

Queen's Hospital stroke staff were also encourage to come to the drop-in session run in the **Queen's Hospital foyer** on 22 February 2016.

Engagement with health scrutiny committees and health and wellbeing boards

Given the potential impact on the consultation on Barking and Dagenham in particular, the Barking and Dagenham Health and Adult Services Select Committee (HASSC) held an extraordinary meeting on 13 January 2016 dedicated to discussing the consultation in detail. The stroke project lead and clinical lead presented to councillors, and included a specific presentation about Grays Court, as requested by the committee, to make sure they were fully informed. The CCG was also scheduled to attend the committee's February meeting, to answer any further questions, but the committee decided this was not needed, due to the comprehensive nature of the initial presentation.

Havering Health and Overview Scrutiny Committee decided to scrutinise the consultation through the outer north east London Health Overview Scrutiny Committee, which also includes the London Borough of Waltham Forest and Essex County Council. The stroke clinical lead for Redbridge presented to the committee and took questions on 19 January 2016. The representative from Essex County Council, Cllr Chris Pond, took a particular interest in the consultation and asked some detailed questions, which were answered by email and shared with the committee.

The project lead presented to Redbridge Health Scrutiny Committee on 14 March 2016 and answered questions from the committee.

Clinical leads and senior managers discussed the consultation with the health and wellbeing boards for all three councils. A detailed presentation was given to Barking and Dagenham Health and Wellbeing Board given their particular interest in the consultation, as owners of Grays Court.

Media activity and coverage

Media releases for each CCG were sent to local media on the day the consultation launched. In addition, the Barking and Dagenham CCG chair's monthly Barking and Dagenham Post column for February 2016 focused on the consultation and encouraged people to respond. Toward the end of the consultation, the Ilford Recorder published an article advising people that there was still time to have their say.

In Havering, an item on the consultation was included in the January edition of Havering council's health e-newsletter (5,513 subscribers) and its general email newsletter (99,636 subscribers), plus a final call for consultation responses in the March editions. 'Living in Havering', the council's free magazine which is delivered to 106,000 households in the borough also published an article on the consultation.

All media items directed people to the website and to other sources of information such as public engagement events. The following table shows all coverage, across both print and online editions:

Title	Circulation	No of web articles	No of newspaper articles	Total
Wanstead and Woodford Guardian	3,847	1	0	1
Ilford Recorder	8,251	1	4	5
Romford Recorder	15,302	1	1	2
Barking and Dagenham Post	6,403	0	1	1
Other websites	N/A	10	0	10
Total	**33,803**	**13**	**6**	**19**

All circulation figures were obtained via Newspaper Society and Audit Bureau of Circulation. Based on these figures and using newspaper articles alone, coverage of the consultation was viewed **54,709 times**[1]

Social media

The following table breaks down stroke rehabilitation consultation-related Twitter activity from the three CCG accounts during the period, showing the number of tweets about the consultation by each CCG during the period, as well as the potential reach of those tweets:

Twitter account	Followers	No of tweets	No of retweets	Potential reach	Click-throughs
Barking and Dagenham	629	40	13	16,918	107
Havering	4,720	37	36	31,618	75
Redbridge	563	61	53	30,742	83
Total	**5,912**	**138**	**102**	**88,966**[2]	**265**

A basic estimate of potential reach for each CCG's stroke rehabilitation consultation-related Twitter activity is calculated by adding together the account's followers and the followers of all unique users who retweeted at least one tweet from that CCG. Potential reach indicates the maximum number of people who could have been exposed to the Twitter activity; it does not take into account individuals who may follow more than one of the Twitter users whose followers were counted.

Click-throughs are the number of times users clicked on a link that was in a tweet and accessed CCG website content about the consultation. It is not possible to determine how many of these clicks resulted in the consultation document being completed.

[1] This is calculated for each newspaper, by multiplying the circulation figure by the number of articles in that paper, then adding them all to reach a final total.

[2] The overall total is not equal to the sum of the individual reach figures for the three CCG accounts, because it takes into account five Twitter users who retweeted from more than one CCG, counting each of these users' followers only once.

8. Responses to the consultation

Types of consultation responses

All written responses were recorded and collated. Most of the written responses answered the consultation questions directly either using the questionnaire, though some chose to write an email or respond by letter.

The vast majority of responses were received within the consultation period but a small number were received a few days late. Although they were late, they have all been included in the formal responses.

A breakdown of the responses received is given in the table below.

Type of response	Number of responses
Questionnaire	Online: 80 Paper copy: 240
Letters/emails (N.B. some of these did not directly address the specific questions posed in the questionnaire, but gave views about stroke rehabilitation services.)	Organisation: 7 Individual: 3

The groups or organisations which responded were:

- Barts Health NHS Trust
- Barking, Havering and Redbridge University Hospitals NHS Trust
- Healthwatch Havering
- Healthwatch Redbridge
- London Borough of Barking and Dagenham Health and Adult Services Select Committee
- London Borough of Redbridge Health Scrutiny Committee
- NELFT NHS Foundation Trust

Who responded to the consultation?

The demographic information below relates to the 320 individuals who completed the questionnaire, as those who sent in letters or emails did not give us these details about themselves. Percentages are given after the total number of responses. It should be noted that all the numbers are too small to be statistically significant representations of the population.

Borough	Total
Redbridge	181 (57%)
Havering	65 (20%)
Barking and Dagenham	28 (9%)
Other	20 (6%)
No response	26 (8%)
Sex	
Female	213 (67%)
Male	81 (25%)
Prefer not to say/no response	26 (8%)

Age	
16-25	3 (1%)
26-40	25 (8%)
41-65	76 (24%)
66-74	58 (18%)
75-79	45 (14%)
80 or over	87 (27%)
Prefer not to say/no response	26 (8%)
Ethnic background	
Any White background	228 (71%)
Any Asian background	40 (13%)
Any Black background	17 (5%)
Any other ethnic group	5 (2%)
Prefer not to say/no response	30 (9%)

Out of the 20 responses received from people living outside the BHR boroughs, the majority of respondents were from neighbouring boroughs, worked for the NHS, or identified as caring for someone who has had a stroke.

Capacity in which individuals were responding People could choose more than one option, so percentages are not given	
A local resident	175
Someone who has experience of a friend or family member having a stroke	94
NHS staff member	51
Someone who has had a stroke	47
A carer	29
Other	23
Prefer not to say/no response	15

Over half of the respondents identified they were responding as local residents and approximately one third of people categorised themselves as someone who has experience of a friend or family member having a stroke.

9. Analysis of responses

A consultation is a valuable way to gather opinions about a topic, explore the issues and understand the reasons behind them. However when interpreting the responses, it is important to note that:

- the respondents were self-selecting, and certain types of people may have been more likely to contribute than others - typically, there can be a tendency for responses to come from those more likely to consider themselves affected and particularly from anyone who believes they will be negatively impacted upon by the implementation of proposals.
- the responses therefore cannot be assumed to be representative of the population as a whole
- a consultation is not a poll or referendum

This section explains how the responses have been summarised and organised for this report. It analyses and contains figures for all responses received, including those from people who asked for their response not to be published. As a result, numbers may appear to be inconsistent in places.

What did people think of the proposals?

The majority of respondents supported the preferred option for stroke rehabilitation care and thought it sensible. Comments in favour included:

> *Get on with it! Monitor it, improve it if it is successful, correct it is it is not. Always make it patient-focused.*
>
> Male, Redbridge, 66-74

> *I believe this model of care will ensure that stroke patients receive rehabilitation that meets their individual needs and helps them to recover more quickly and more fully.*

> *What matters with a stroke is getting the right treatment, in the right place, at the right time. With all patients with a suspected stroke being taken to a hyper-acute stroke unit for fast, expert care, more people than ever now survive a stroke, which is excellent news.*

> *Rehabilitation for stroke patients now needs to deliver the same outcomes. It is not fair that the rehabilitation service local patients receive depends on where they live and I welcome the efforts by Barking and Dagenham, Havering and Redbridge CCGs to change this.*
>
> Dr Sreeman Andole, stroke lead clinician, BHRUT

> *We support the CCGs' view that there is a good case for changing the way stroke rehabilitation services are delivered. We hope that the CCGs take into account… the views of local residents and use these to shape the new services.*
>
> Health and Adult Services Scrutiny Committee, LB of Barking and Dagenham

> *Overall NELFT would support the changes to consolidate the stroke rehabilitation bed provision at King George Hospital and to provide specialist rehabilitation in one unit on this site. We would further support a single model of stroke rehabilitation care, in both a rehabilitation bed and as part of early support discharge, as a consistent offer across the BHR CCGs.*
>
> NELFT

> *We fully support the need for there to be a review of both the delivery of service and the way the service specifications are written, quality standards are determined and the standard of commissioning is raised.*
>
> Havering Healthwatch

> *As long as it's the best service for stroke victims it doesn't matter where it is based and by who.*
>
> Barking and Dagenham resident

> *I agree with the proposals to move stroke beds to King George Hospital as it provides logistical as well as medical benefits with a whole transfer of beds to one location.*
>
> Male carer, Redbridge, 16-25

> *Centralised service/one stop shop negates the possibility of patients not receiving correct and appropriate medical and rehab services.*
>
> NHS staff member

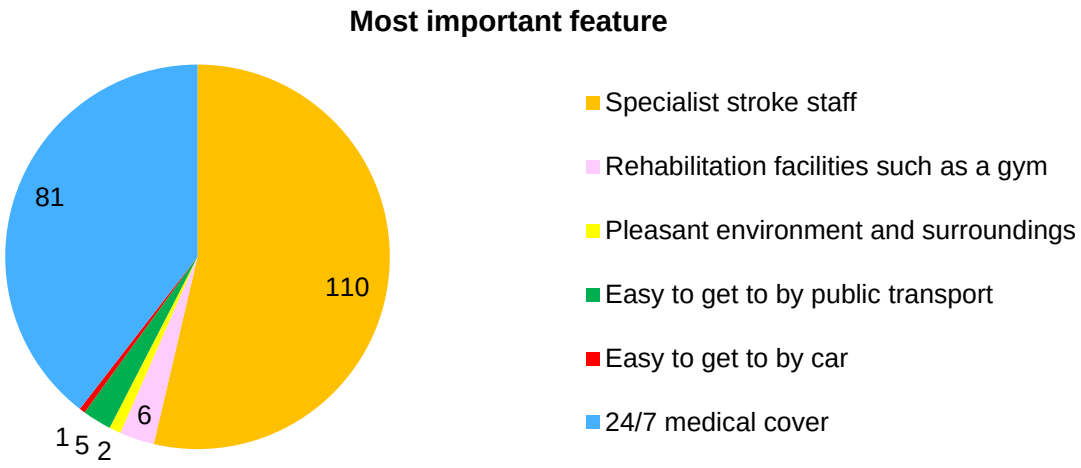
> *In a time of constraints on NHS resources I feel that all efforts should be made to ensure that the stroke service is not only responsive to patients' needs (e.g. more services offered closer or in the patients' home), but that the services should provide good value for money, reducing waste and increasing efficiency to ensure that they are sustainable and therefore available for future generations.*
>
> Carer and NHS staff member, Havering 26-40

Some people were generally in favour of the proposals but their support was conditional e.g. there must be appropriate safeguards in place before a patient can return home. Others rejected the proposals because, when followed through, they led to an unacceptable conclusion in their view – in the most instances - a reduction of inpatient stroke rehabilitation beds. Analysis of responses by question is explored in more detail below.

Question 1: Inpatient stroke rehabilitation services in order of importance

Respondents were asked to rank the following options in order of importance, with one being the most important, and six being the least important, to help us understand better what people's priorities are and guide how we develop these services.

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



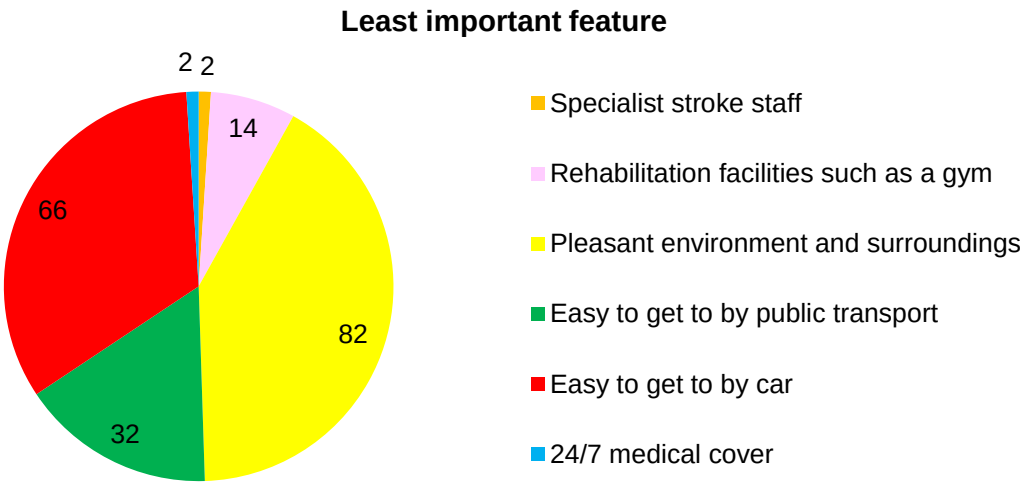
By far the most important feature to most people was that the service should have specialist stroke staff. This was chosen in first place by more than half of all respondents, and in second place by almost all the remainder.

The next most important feature to people was that the service should have 24/7 medical cover. This was selected as of first or second importance by 87% of respondents.

Ease of access by public transport, and the presence of rehabilitation facilities such as a gym mostly received middle ratings, with very few people rating these in first or second place.

This was followed by ease of access by car, which, while fewer people put it in last place, was actually voted last or second last by slightly more people – 63% of respondents.

The least important feature to the greatest number of people was that the service should have a pleasant environment and surroundings. Forty one percent of respondents rated this their least important feature. Though very few people placed this as a top priority, around a third of people did put it in third or fourth place, suggesting they felt there were some benefits to the service having a pleasant environment.

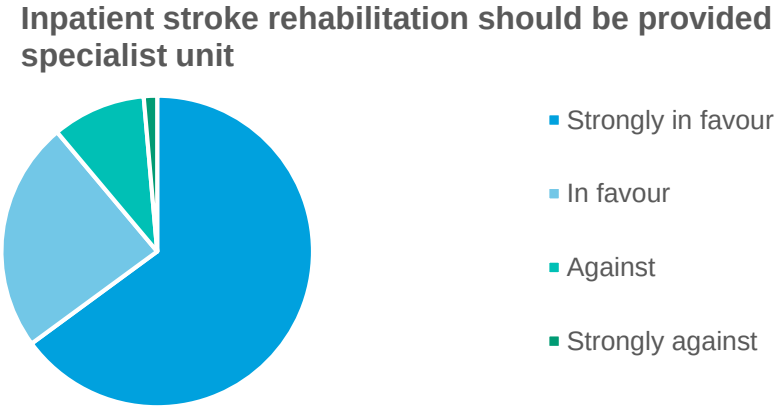


We calculated the average weighted score of each option, where a score of 1 indicates a feature is very important to people, and a score of 6 indicates that it is of very low importance, as listed below:

Specialist stroke staff	1.58
24/7 medical cover	1.82
Rehabilitation facilities, such as a gym	3.70
Easy to get to by public transport	4.16
Easy to get to by car	4.79
Pleasant environment and surroundings	4.85

Question 2: Inpatient stroke rehabilitation at one specialist rehabilitation unit

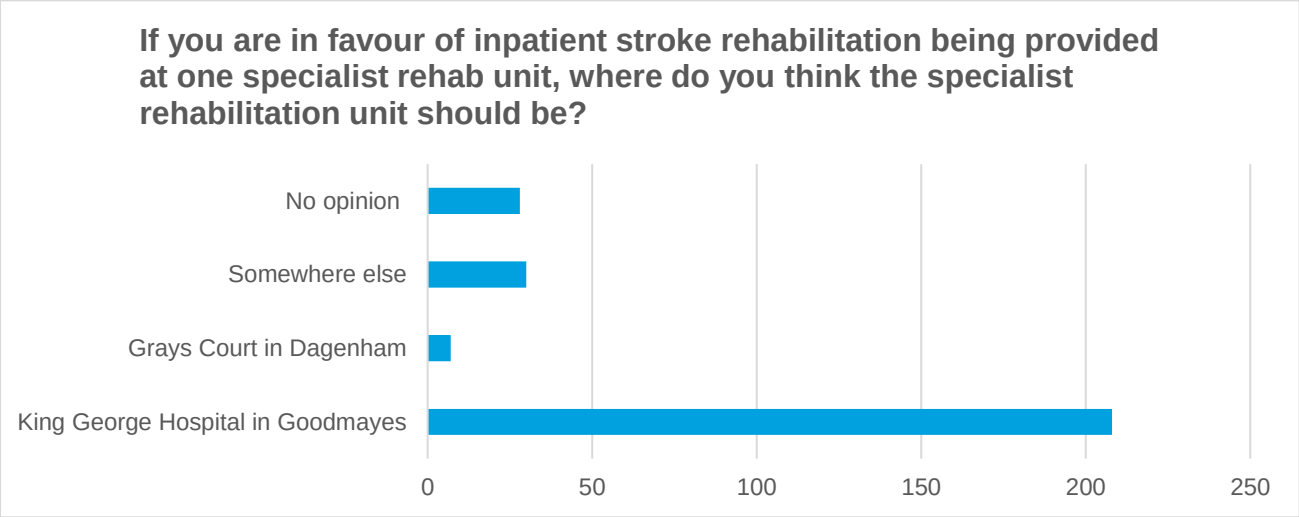
Respondents were asked to indicate how they felt about the following statement: Inpatient stroke rehabilitation should be provided at one specialist unit. The majority of respondents were strongly in favour or in favour of this.



Question 3: Location of a specialist stroke inpatient unit

Respondents in favour of the statement 'Inpatient stroke rehabilitation should be provided at one specialist unit' were then asked to choose from the following options:

- King George Hospital in Goodmayes (the preferred option)
- Grays Court in Dagenham
- Somewhere else - please tell us where
- No opinion



Over two thirds of respondents supported the preferred option of placing the specialist inpatient unit at King George Hospital, some wanted it to be at Grays Court, and a small minority suggested other locations, usually close to where they lived. Five respondents suggested Whipps Cross Hospital in Leytonstone. Four Havering respondents wanted the unit to be based at the now-closed St George's Hospital. Four Wanstead respondents suggested the now-closed Heronwood and Galleon unit.

The patient needs to feel confident in their surroundings- staff as well as their environment. Stand-alone unit at King George would be better.

Female, Havering, 41-65

I do agree services should be at King George Hospital for ease of access to A&E

Female, Havering, 26-40

The unit at Grays Court provides an essential local service.

Male, Havering, 41-65

Unit at Whipps Cross Hospital - local to my home.

Female, Redbridge, 66-74

Wanstead hospital in Makepeace Road Snaresbrook was ideal for stroke patients and visiting family in the Snaresbrook and Wanstead area where there are many elderly people. I do not agree with the CCG proposal. King Georges Hospital is too far for people of Wanstead and Snaresbrook.

Female, Redbridge, 75-79

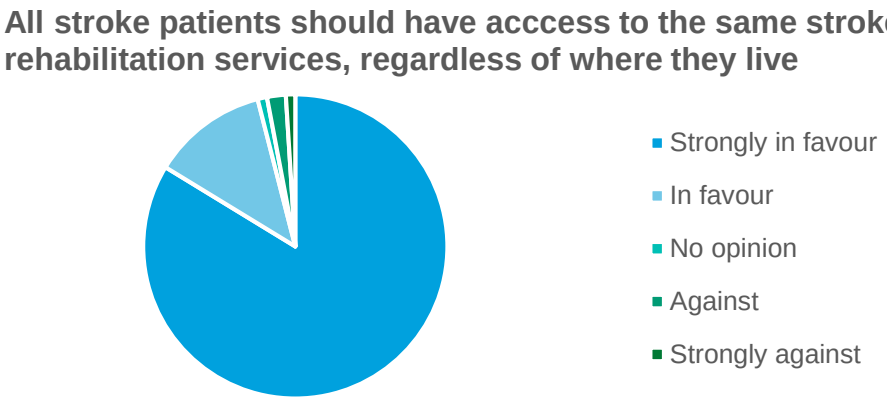
I think the specialist rehabilitation inpatient unit, also community rehab should be based at St Georges Hospital Hornchurch.

Female carer, Havering, 66-74

Question 4: Access to stroke rehabilitation services

Respondents were asked to indicate how they felt about the following statement: All stroke patients should have access to the same stroke rehabilitation services, regardless of where they live.

The vast majority of respondents strongly agreed or agreed that this should be the case.



Easy access is important. While I believe that everyone is entitled to the same level of service, I do not think it is beneficial to concentrate such services in one location.

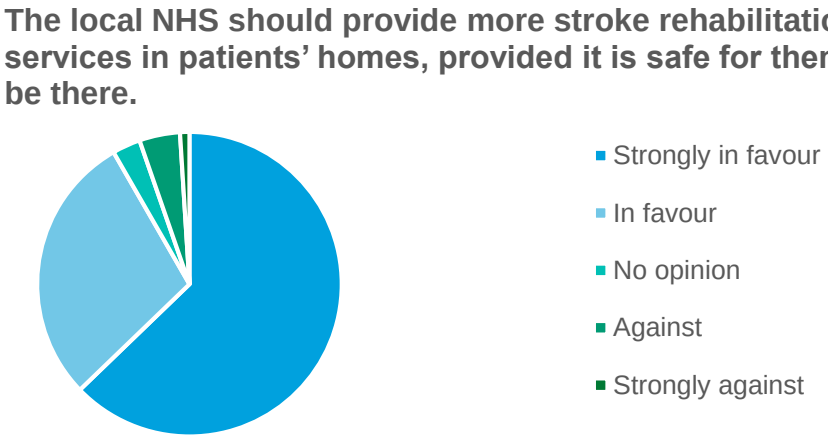
Female, Havering, 80+

All felt that patients should be able to access a service regardless of where they lived, however some felt the service needed to be close to their homes to allow for families and friend to be part of the rehabilitation process as much as possible.

Redbridge Healthwatch

Question 5: Stroke rehabilitation services in patients' homes

Respondents were asked to indicate how they felt about the following statement: The local NHS should provide more stroke rehabilitation services in patients' homes, provided it is safe for them to be there.



Again, the vast majority of people supported this. Comments relating to this question tended to focus on ensuring people were safe at home and well supported.

> *My experience of care provided in the home to elderly relatives and friends shows that it varies very much in quality and reliability. Caring for stroke patients after expert care at first in an ASU [acute stroke unit] needs a greatly improved and closely monitored level of community support.*
>
> Female, Redbridge, 80+

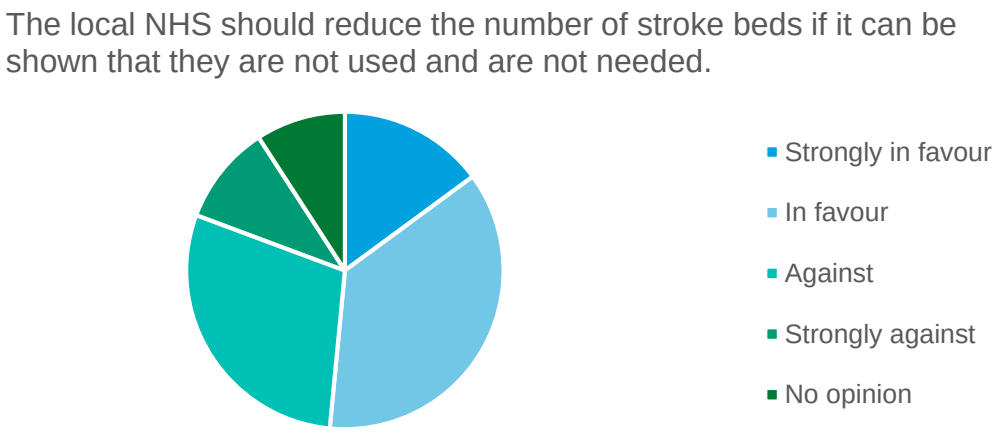
> *It is okay to be discharged from hospital as long as there is enough support when you are home.*
>
> Female stroke survivor, Redbridge, 80+

> *More information for friends and family on how to care for stroke victims when they are sent home*
>
> Female, Havering, 66-74

> *I think stroke patients do better when rehab is carried out in their own environment but that must have a suitably adapt home and have the family/carers available.*
>
> Female, Barking and Dagenham, 66-74

Question 6: Number of stroke rehabilitation beds

Respondents were asked to indicate how they felt about the following statement: The local NHS should reduce the number of stroke needs if it can be shown that they are not used and are not needed.



Just over 50% of respondents were strongly in favour or in favour of this option. This question received the most opposition, with just under half of respondents who responded to this question were against or strongly against this statement. Reasons given for opposing this often referenced the growing local elderly population who it was felt would need stroke rehabilitation beds in the future.

> *I am in favour of reducing the number of beds if they are not used I won't if the beds are needed by more patients.*
>
> Female, Redbridge, 75-79

As long as accurate and predictive modelling using demographic and population needs has been considered we would support a reduction in specialist stroke rehab [beds].

NELFT

I cannot see a situation where one unit with fewer beds will be enough to accommodate the growing number of older people who are probably most at risk from stroke.

Male, Redbridge, 66-74

With an ageing population, nos. of strokes, along with falls etc, are likely to increase and clearly bed-blocking is not desirable (so beds nos. should not be cut).

Female, Havering, 41-65

The public needs to be reassured that there are still sufficient inpatient beds.

Female, Barking and Dagenham, 41-65

However, some respondents felt more work was needed to look at how many beds would be needed, and to have flexibility as increased home-based services were introduced.

It is really important that consideration is given to the number of inpatient stroke beds which will be required in the future. Whilst I'm in favour of therapy at home, it needs to be remembered that with greater numbers surviving strokes due to medical advances, there is still a real need for inpatient rehab for those more dependant with access to a gym and equipment to assist with rehab to maximise functional independence.

Female, Havering, 26-40

Beds' needs seem to fluctuate over months and longer or shorter periods and so any stroke bed reduction as a start-up option is extremely unwise.

Redbridge resident, 66-74

It is dangerous to consider reducing the number of stroke beds or centralising rehab services until the appropriate home services are available.

Male, Redbridge, 41-65

We noted that there were currently no details in the consultation document on the number of inpatient stroke rehabilitation beds that would be available in King George Hospital (KGH) and we asked for assurance that the number of beds would be sufficient to meet demand. Whilst at the meeting we were assured that this was currently being worked out, we strongly feel that the CCGs should make publically available the details of the number of inpatient beds that will be provided, and how this conclusion was reached, so that local people can have confidence that the bed-modelling is robust.

Health and Adult Services Scrutiny Committee, LB of Barking and Dagenham

10. Common issues raised

Respondents were also asked to tell the CCGs anything else about the stroke rehabilitation proposals that they thought it was important for them to know. The majority of responses can be grouped into the following themes.

Personal experiences
People shared their experiences of having or caring for someone who had a stroke, and the impact it had on them.

> *My husband had three strokes... On coming home someone came here to help him for about one hour a day with his speech problem, after that a women came in for about one hour from Age Care she was magnificent and we become very close with her. I can only praise both these groups so highly. The Stroke Club is wonderful and Tracey from the Stroke Association is a delightful woman.*
>
> Female, Redbridge, 75-79

> *I found after care/physio very poor and felt we were on our own when nursing my father.*
>
> Female, Redbridge, 41-65

> *As I had a stroke 18 years ago and had to wait four days to get a CT scan, I am pleased to learn this is now being done earlier and I agree with all the changes you are trying to implement anything that benefits the patient getting home earlier than the three months it took me*.
>
> Female, Redbridge, 80+

> *I had a stroke in March 2010. I was admitted by ambulance called by emergency telephone... I stayed in hospital for three weeks. I had double vision but got well and the after care at King Georges Outpatients as I was left with a wobble when I walk but manage this by walking with a four wheel walker when I walk long distance. I have just celebrated my 90th birthday and I am reasonably fit.*
>
> Female, Barking and Dagenham, 80+

Patients as individuals

Respondents were clear that each patient's situation is different, and what care is best for the individual circumstances should be considered.

> *Each patient should be assessed and given the services to meet their needs. Because each persons ability will be different*
>
> Female, Redbridge, 75-79

> *Rehabilitation is different for each patient, so a long transition from ESD to community needs to be factored in to ensure that every patient receives the right level of care to maximise their recovery rate and overall outcome.*
>
> Male, Barking and Dagenham, 41-65

> *Rehab should be personalised, some patients may want to receive rehab at home and others would benefit from group rehab as a form of assisting with the socialisation aspect often missed with stroke rehab. There needs to be better support for patients to understand how a stroke changes personalities and reduces confidence.*
>
> Female carer, Havering, 26-40

Ideal model of care

Respondents were keen to offer suggestions about how, in an ideal situation, stroke rehabilitation services should be run.

More co-ordination is needed for community stroke services, preferably one provider for three boroughs, to provide continuity of care for the patients and ease and clarity for the staff. Having ESD based in the hospital is a more beneficial location for patients, enabling in reach, better patient flow and continuity and enables joint working.

Male, 16-25

The time where you want a seamless transition of care is at the point of discharge from hospital as this is the most anxious time period for patient and family. An ESD service should be six weeks. If you have two providers for a stroke service i.e. BHRUT and NELFT at some time you are going to require a transition of care. The riskiest period of time for a patient is from discharge from hospital to home it makes no sense for this to be the handover period of care, it would be better for the team dealing with the discharge to settle the patient in their home environment and then refer to the appropriate setting once their six week rehab has commenced. Whether that be community or outpatients. On average, our patients (BHRUT ESD team) are seen within 24 hours of discharge from hospital and the main exceptions are those who are discharged late on Friday (we currently don't run a seven day service). This information is on the SSNAP [sentinel stroke national audit programme] post-acute clinical audit. In fact, our team meets the client on the ward within 24 hours of receiving a referral (data also in SSNAP post-acute clinical audit).

BHRUT ESD team

Patients show benefit from receiving a continuity of care which emphasises the importance of increasing the ESD pathway to six weeks and covering all areas.

Female, Havering, 26-40

I think provided a joint ESD and Community Rehabilitation Service, currently as the ESD service is based within the acute hospital team the in reach service is quick meaning that on complex cases and the simpler cases are able to be discharged quicker as the team is also based on sight. It is also easier to have discussions with the team when you can speak to the therapists to plan treatment etc. allowing for a continuity of care which often allows patients to feel more secure about going home early as they meet the team and are aware we are all linked. Also allows the teams to deal with any issues on discharge easier as they are linked to the hospital. I feel separate services not provided by Trust but the community would affect the way and timeframe in which we can get patients out. The community teams have had significant difficulties in recruiting staff and therefore being able to provide that rehabilitation to patients, this would have a significant impact on providing an appropriate service if they are unable to recruit and retain staff.

NHS staff member

There were calls for increased and improved therapy for stroke survivors.

More hand and arm rehabilitation is essential not optional. Occupational therapy - more cooking practice needed.

Stroke survivor and carer, Redbridge, 66-74

Provision of early physiotherapy is important (in hospital and early days at home) those who do not have this can take longer to recover. Follow-up therapy for strengthening weak areas, i.e. exercises for hands, legs/walking and speech therapy at home or in stroke unit.

Female, Havering, 80+

Speech therapy at least one week after stroke. I had to wait 16 weeks. My first stroke I had speech therapy four days a week. Need more aftercare speech and exercise possible in our local venues - library, sports centres etc.

Male, Redbridge 66-74

Speech and Language Therapies (SALT) needed radical improvement. Some participants felt the services already lacked capacity. Although it was proposed to increase access to this service, participants were concerned that recruitment (of therapists) would be an issue. Some participants commented that although they might feel safer in hospital, they also welcomed services being offered within their home environment provided that the service could meet their planned needs.

Redbridge Healthwatch

It is very important to ensure good recruitment and retention of therapy staff as patients' value continuity of care and no delay in getting rehab underway, especially the SALT department.

Female, Redbridge, 66-74

Others commented on how to ensure safe, high quality care at home for all:

If anyone is to be cared for in their own home it is very important to consider their social care and if they have anyone at home to assist them and keep them company.

Female, Redbridge, 41-65

We commented to the CCGs' representatives that the average home in Barking and Dagenham was significantly smaller than those of Redbridge and Havering and questioned whether this would present challenges for residents and the future provider of home-based rehabilitation services. Whilst representatives assured us that in the majority of cases, rehabilitation equipment would not require large amounts of space (such as those in need of speech and language therapy), we wish to emphasise the need to ensure a model for home-based services that takes into account the person's individual circumstances as far as possible, including the space available in their home.

Health and Adult Services Scrutiny Committee, LB of Barking and Dagenham

Some commented on length of rehabilitation support and seven day working:

Some patients need more than the maximum of 12 weeks support. Will this be factored in to the new service?

Redbridge Healthwatch

Additionally monitoring of patient seven days a week sickness is not a five day Monday-Friday event. Consultants need to be aware of this.

Male, Havering, 75-79

The issue of seven day working in the NHS is a topical one and we would encourage the CCGs to use this service reconfiguration as an opportunity to put this into practice as we believe it is in the best interests of our residents. However, in the event that the CCGs ultimately opt to continue the "five days a week" model, we strongly feel that the offer must be entirely flexible. Experience of other services offered to vulnerable residents tells us that a Monday to Friday model for example, can leave some residents isolated and without support during the weekends when family members may not be around, which may leave them vulnerable.

Health and Adult Services Scrutiny Committee, LB of Barking and Dagenham

These proposals seem fine for someone who recovers quickly but many people need much longer support than six weeks. Brain injury is life changing and these proposals seem to be bare minimum.

Female, Havering, 41-65

Joined up care, working across organisation boundaries, was seen as key to successful rehabilitation:

> *More co-ordination is needed for community stroke services, preferably one provider for three boroughs, to provide continuity of care for the patients and ease and clarity for the staff. Having ESD based in the hospital is a more beneficial location for patients, enabling in reach, better patient flow and continuity and enables joint working. Especially specialist therapists seeing and assessing patients for the ESD service.*
>
> Male NHS staff member, 26-40

> *Better closer working relationships with adult social care is required.*
>
> Female carer, Havering, 44-61

> *It was raised a number of times as to the input of Barts Health (and Whipps Cross Hospital in particular) due to the number of potential users in the West of Redbridge. Most participants felt that the relationship between the commissioners, Barts Health and BHRUT was crucial to the success of the proposed changes.*
>
> Redbridge Healthwatch

> *Social workers should be included as part of a multi-disciplinary team as there are many non-physical needs for both the person and their (unpaid) carer if they have one.*
>
> Female, Redbridge, 41-65

> *Good communication between all involved is vital, both internally and with the patient and his/her family, especially when transfers from The London and/or Whipps Cross Hospitals are involved.*
>
> Female, Mrs K, Redbridge

Impact on family and carers

Many respondents raised the issue of the impact any changes might have on family members and carers and that they need support too.

> *The public needs to be reassured… that the needs of carers are recognised. Will there be a named person for carers to raise any problems with?*
>
> Female, Barking and Dagenham, 41-65

> *When looking at people being treated or rehabilitated at home, it is important to consider the needs of their carers and wider families, so there may be occasions when treatment and/or rehabilitation should be at hospital even if the patient would ideally have preferred to go home.*
>
> Female, Redbridge, 41-65

> *I think stroke patients do better when rehab is carried out in their own environment but that must have a suitably adapted home and have the family/carers available. The professionals must be accessible to the carers when problem arise.*
>
> Female, Barking and Dagenham, 66-74

> *No one appears to consider the importance for patients and relatives for family visits during treatment and rehabilitation.*
>
> Female, Havering, 66-74

Transport and accessibility

Parking issues at Grays Court, Parking issues and cost of parking at King George Hospital, the length of time it takes to visit patients when relying on public transport were all raised by respondents.

> *My concerns for one specialist unit is the distance some people will have to travel.*
>
> Male, Havering, 80+

> *Rehabilitation units should be readily accessible within 1-2 miles of the persons home. Visits from relatives and friends are important for recovery.*
>
> Female, Redbridge, 66-74

> *Focusing all hospital care into one centre in a large area like this makes it very difficult for patient and visitor access - especially without a car - and many older people cannot or should not have to drive in these circumstances. Public transport to King George, say from here, Upminster, is not direct, requiring changes of bus/train, is slow and expensive - not what you want when already stressed as, or with, a stroke patient.*
>
> Female, Havering, 41-65

> *For those of us dependent on public transport attending clinics or visiting relatives at King George travel is extremely difficult.*
>
> Male, Havering, 41-65

> *Impossible to park at Grays Court for relatives to visit.*
>
> Female, Havering, 41-65

> *Whilst we acknowledge that travel times to KGH will be less of an issue as more people will be treated in their own homes, it is also the case that some residents will require inpatient treatment and their family and friends will wish to visit them. There needs to be recognition that KGH will not be easy for everyone to travel to by public transport from the different parts of our borough.*
>
> *For this reason, some residents who wish to visit inpatients are more likely to travel by car than by public transport. We ask the CCGs to work with the Barking, Havering and Redbridge University Trust to ensure that the inpatient and their close friends and family, who wish to visit on a regular basis, are given parking concessions. A resident who undertakes lengthy visits to an inpatient receiving stroke rehabilitation services on a regular basis could therefore face substantial charges.*
>
> Health and Adult Services Scrutiny Committee, LB of Barking and Dagenham

Value for money and sustainability

Some respondents were concerned about the financial implications of the proposed changes.

> *Though I am strongly in favour of option 3, I would like assurances that this option isn't going to become a cost cutting exercise. i.e. operating out of a single venue, the same number of staff will not be required, and that existing space at King George will be increased to accommodate the extra patients that closure of Grays Court will bring.*
>
> Female, Barking and Dagenham, 80+

A balance between inpatient and at home care costs is required. In the future the cost of therapist travel can become a target and ruin the service.

Male, Redbridge, 66-74

In a time of constraints on NHS resources I feel that all efforts should be made to ensure that the stroke service is not only responsive to patients' needs (e.g. more services offered closer or in the patients' home), but that the services should provide good value for money, reducing waste and increasing efficiency to ensure that they are sustainable and therefore available for future generations.

Female, Havering, 26-40

Staffing

Some respondents raised concerns about ensuring there were adequate staff employed to provide the service, and how the services would run.

Being a therapist, I know that the rehab service is essential post stroke. I agree that there needs to be a more extensive rehabilitation service provided and having a combined service would improve the rehab for service users.

However there will need to be a large influx of therapists for this to work as currently BHRUT is running at a very limited service due to staff shortages. This is why the ESD service and rehab service is struggling to take patients into the community as there is not the staff to enable patients to be seen and discharged… If the duration of ESD rehab is going to increase from the current two weeks up to six weeks this will also require a large influx of all therapy staff to allow for the increased capacity.

Female, Redbridge, 26-40

It is vitally important that enough staff are employed to cover the home based services effectively

Female, Havering, 41-65

On the face of it the improvements seem to be good. However we would like to hear health workers views and concerns. My point would be, would there be an increased level of staff? As it looks as if there is a lot of work to be focused in one place. So staffing levels would be a major issue. We would not want an overstretched department trying to cope alone.

Local residents, details not provided

The community teams have had significant difficulties in recruiting staff and therefore being able to provide that rehabilitation to patients, this would have a significant impact on providing an appropriate service if they are unable to recruit and retain staff.

Female, Havering, 26-40

Staff should be trained properly and have empathy with the situation patients are in. Ample staff should always be on site.

Female, Havering, 41-65

Not run by agency staff but specialist staff.

Female, Redbridge, 66-74

How will the proposed Barking/Dagenham and Redbridge ESD/CST team be staffed as now would be one team for two services.

Barts Health

There is currently no formal meeting or forum where outcomes being achieved can be presented across the entire pathway, something that local stroke physicians have expressed frustration about.

Havering Healthwatch

NHS staff are already too busy and under stress.

Barking and Dagenham resident

Long term recovery from a stroke

Respondents also raised what happens when people leave hospital after a stroke, and that people living with the effects of stroke often require ongoing therapy.

Really important that home adaptations are quick!

Female, Tower Hamlets, 41-65

Vital to have on-going specialised follow-up care 6-12 monthly.

Stroke survivor and carer, Redbridge 66-74

I think the after care patients receive after a stroke is vital to reducing the level of isolation they feel and to increase their quality of life.

Male, 41-65

Clients need access and encouragement to attend social groups in their particular borough when they are ready. This is sometimes a year down the line.

Female, 41-65

No info here about long term care of patients unable to "come home" for one reason or another. Not everyone has a family able to provide specialist care at home!

Female, Redbridge, 41-65

Other issues raised

There were some comments from respondents (across questionnaires and letters/emails), which were not directly related to the questions asked. Of the responses where such an issue could be identified, the most frequently raised issues were:

Better communication about stroke services and prevention

Others raised the need for better information about stroke services, processes and prevention.

Good communication between all involved is vital, both internally and with the patient and his/her family, especially when transfers from The London and/or Whipps Cross Hospitals are involved.

Female, Redbridge, 66- 74

Need for excellent administration. e.g. good contact between staff and patients and carers. Provision of good information, well understandable for all involved.

Female, Havering, 75-79

It should be accessible, specialist advice available for GPs and rehab is extremely important. - Currently I don't know where to refer to or the timelines for referral.

Female NHS staff member, Barking and Dagenham 41-65

I think there should be more advertisements about a person having a stroke, there should be more to inform people. There should be more stroke clubs and information banks.

Female, Redbridge, 41-65

Conduct of the consultation

Two people said they didn't like the way the consultation was phrased in reference to Grays Court. A small number of people or felt the way the statements were worded didn't reflect what they wanted to say, or wanted more detail before making comments, while another was complimentary.

Whilst I do agree services should be at King George Hospital for ease of access to A&E, it is unfair to portray the current very good rehab services at Grays Court as anything less beneficial compared to the current offer at King George rehab.

Female, Havering, 26 – 40

The Committee commends the CCGs for producing a comprehensive consultation document which provides members of the public with clear information about stroke, the case for changing the way stroke rehabilitation services are offered, the different options being considered by the CCGs, and their potential impacts.

Health and Adult Services Scrutiny Committee, LB of Barking and Dagenham

11. Borough snapshots

Redbridge

57% of respondents to the questionnaire were from Redbridge, and they thought…	**Support %** **Higher (↑) or lower (↓) than overall results**	**Opposition %** **Higher (↑) or lower (↓) than overall results**
Inpatient stroke rehabilitation should be provided at one specialist rehabilitation unit.	**91% ↑**	**9% ↓**
All stroke patients should have access to the same stroke rehabilitation services, regardless of where they live.	**98% ↑**	**2% ↓**
The local NHS should provide more stroke rehabilitation services in patients' homes, provided it is safe for them to be there.	**94% ↑**	**6% ↓**
The local NHS should reduce the number of stroke beds if it can be shown that they are not used and not needed.	**57% ↑**	**43% ↓**

- Redbridge respondents were in favour of each of the proposals
- Redbridge respondents were more positive about all the proposals than respondents overall
- Just under half (43%) of Redbridge respondents were opposed to reducing the number of stroke beds if they are not being used or needed
- 90% of Redbridge respondents thought the specialist inpatient unit should be located at King George Hospital, Goodmayes and 10% chose the ‘somewhere else’ option
- Redbridge respondents ranked ‘24/7 medical care’ and ‘specialist stroke staff’ as the top two most important inpatient stroke rehabilitation services
- ‘Pleasant environment and surroundings’ was ranked by Redbridge respondents as the least important inpatient stroke rehabilitation service.

Havering

20% of respondents to the questionnaire were from Havering, and they thought…	Support % Higher (↑) or lower (↓) than overall results	Opposition % Higher (↑) or lower (↓) than overall results
Inpatient stroke rehabilitation should be provided at one specialist rehabilitation unit.	89% ↑	11% ↓
All stroke patients should have access to the same stroke rehabilitation services, regardless of where they live.	95% ↓	5% ↑
The local NHS should provide more stroke rehabilitation services in patients' homes, provided it is safe for them to be there.	95% ↑	5% ↓
The local NHS should reduce the number of stroke beds if it can be shown that they are not used and not needed.	52% ↑	48% ↓

- Havering respondents were in favour of each of the proposals.
- Havering respondents were more positive about three out of four of the proposals than respondents overall.
- Havering respondents showed most support for providing more stroke rehabilitation services in patients' homes.
- Havering respondents showed least support for reducing the number of stroke rehabilitation beds, but just over half were in favour.
- 62% of Havering respondents thought the specialist inpatient unit should be located at King George Hospital, Goodmayes, 7% selected Grays Court Community Hospital, Dagenham, 7% suggested Queen's Hospital, Romford, 4% suggested the former St George's hospital site in Hornchurch and 20% chose the 'somewhere else' option.
- Havering respondents ranked 'specialist stroke staff' and '24/7 medical care' as the top two most important inpatient stroke rehabilitation services.
- 'Easy to get to by car' was ranked by Havering respondents as the least important inpatient stroke rehabilitation service.

Barking and Dagenham

9% of respondents to the questionnaire were from Barking and Dagenham, and they thought…	Support % Higher (↑) or lower (↓) than overall results	Opposition % Higher (↑) or lower (↓) than overall results
Inpatient stroke rehabilitation should be provided at one specialist rehabilitation unit.	96% ↑	4% ↓
All stroke patients should have access to the same stroke rehabilitation services, regardless of where they live.	100% ↑	0% ↓
The local NHS should provide more stroke rehabilitation services in patients' homes, provided it is safe for them to be there.	93% ↑	7% ↓
The local NHS should reduce the number of stroke beds if it can be shown that they are not used and not needed.	77% ↑	23% ↓

- Barking and Dagenham respondents were in favour of each of the proposals.
- Barking and Dagenham respondents were more positive about all the proposals than respondents overall.
- Barking and Dagenham respondents showed most support for stroke patients having access to the same stroke rehabilitation services regardless of where they live, with 100% in favour.
- Barking and Dagenham respondents showed most support for reducing the number of stroke beds, if it can be shown that they are not used or needed.
- 73% of Barking and Dagenham respondents thought the specialist inpatient unit should be located at King George Hospital, Goodmayes, 13.5% selected Grays Court, Dagenham and 13.5% chose the ‘somewhere else’ option.
- Barking and Dagenham respondents ranked ‘specialist stroke staff’ and ‘24/7 medical care’ as the top two most important inpatient stroke rehabilitation services.
- ‘Pleasant environment and surroundings’ was ranked by Barking and Dagenham respondents as the least important inpatient stroke rehabilitation service.

12. What this report will be used for

This report be given to BHR CCGs to consider. It is anticipated it will form part of a business case, which will set out recommendations for the way forward for stroke rehabilitation, for consideration by the CCGs governing bodies. This report does not, therefore, respond to the issues raised or make conclusions about the solutions to be chosen.

We are not able to confirm timescales but anticipate decisions will be made later in 2016.

Information will be published on the stroke webpage as soon as it is available and stakeholders will be kept informed.

BHR CCGs is committed to continuing to engage with all those who have given their time and effort to provide valuable input into the consultation process. A number of useful contacts with key stakeholders have been made through the consultation process and methods for engaging with people have been established. Contact details of stakeholders, including people who have provided formal responses, have been recorded and these individuals will be notified when the key reports are available and any decisions announced. Anyone who wants to be added to this list should email haveyoursay@onel.nhs.uk

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HEALTH AND WELLBEING BOARD

27 September 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 25 July and 22 August 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: 25 July 2016

Appendix B: 22 August 2016

Appendix A

System Resilience Group (SRG) Briefing	Meeting dated – 25 July 2016
	Venue – Board room A, Becketts House
Summary of paper	This paper provides a summary of the key issues discussed at the System Resilience Group meeting. The meeting was chaired by Conor Burke (Chief Officer, BHR CCGs) and attended by members as per the Terms of Reference.

Agenda	Areas/issues discussed
Planned Care delivery plan	Members received an update on the latest position for RTT and Cancer including the progress of the demand management work.
Urgent and Emergency Care delivery plan	Members received the new dashboard format with metrics/measures aligned to the UEC workstreams. Members were updated on the progress of each workstream, the majority are on track. Delivery plans will come to the next SRG following sign off at the UEC Programme Delivery Board. BHRUT updated members on the outcome of the first week of a redirect pilot which members agreed to extend. A full evaluation will be taken to the August meeting.
NEL U&EC network update	Members were updated on the latest work going on as part of the North East London Urgent and Emergency Care Network. The remit will now focus on NHS 111.
Sustainability and Transformation Plan	Members were advised the STP was submitted on 30/6 and a meeting took place with NHSI who gave positive feedback on the progress made. A viable and robust plan will need to go back to NHSI in September.
Next meeting:	Monday 22nd August 2016 1pm-3pm Boardroom, Queens Hospital, Rom Valley Way.

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APPENDIX B

System Resilience Group (SRG) Briefing	Meeting dated – 22 August 2016
	Venue – Board room, 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
Planned Care delivery plan	Members received an update on the latest position for RTT and Cancer including the progress of the demand management work.
A&E improvement plan	Members agreed to the revised SRG TORs and recommendations to reflect the national requirement to establish local A&E delivery boards.
Urgent and Emergency Care delivery plan	Members received an update on the UEC programme dashboard. Members were updated on the progress of each workstream, all are progressing well. Detailed reports on activity / performance to come to the next meeting. BHRUT updated members on the outcome of the four week redirect pilot which members agreed to establish permanently, with routine performance updates to be provided at these meetings.
NEL U&EC network update	Members were updated on the latest work going on as part of the North East London Urgent and Emergency Care Network.
Next meeting:	Monday 26th September 2016 1pm – 3pm Conference room, Barking Learning Centre, 2 Town Square, Barking, IG11 7NB

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HEALTH AND WELLBEING BOARD

27 September 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 no sub-groups have held meetings since the last Health and Wellbeing Board, so there are no updates.	
Recommendations: As no sub-groups have held meetings since the last Health and Wellbeing Board, there are no recommendations to the Board.	

List of Appendices

None

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HEALTH AND WELLBEING BOARD

27 September 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

In this edition of my Chair's Report, I talk about World Mental Health Day in October and the introduction of new A&E Delivery Boards. 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

World Mental Health Day

World Mental Health day takes place every year and is an opportunity to raise awareness of mental health issues around the world and mobilising efforts in support of mental health.

We are currently planning a number of events for World Mental Health Day on the 10th October. NELFT is leading on this with support from a number of partners, including Adults' Care and Support, Drug and Alcohol Services, Public Health and a number of Mental Health teams. The theme of the campaign and events will be supporting people to look after their mental health.

Mental Health First Aid (MHFA) England are promoting a campaign called "Take 10 Together for World Mental Health Day". A stall will be in Barking Asda to engage the public as well as a planned stall in the Heathway Shopping Centre in Dagenham. Drug and alcohol services will be giving talks in the borough's schools on substance misuse and the effects it can have on your mental health.

The NOUS Organisation, who work to create awareness about mental health issues in the Black and Minority Ethnic Communities will be also be hosting an event in Barking and Dagenham to mark World Mental Health Day.

As events are confirmed they will be publicised, so I urge Board members to promote these events closer to the day.

Learning Disability Week

In my previous report I highlighted the upcoming Learning Disability Week, which was held in Barking and Dagenham on Monday 18 July to Friday 22 July 2016. A number of events were held during the week, focussing on the personal growth and development of residents with learning disabilities and particularly focused on employment and resilience.

The feedback from those who attended events during the week was positive, with coverage in the Dagenham Post with an article with pictures from the sports day.

Thank you to all those who helped to organise the week and to all those who took part in it.

New A&E Delivery Boards

There has recently been a high level of national media coverage about issues facing the NHS, including challenges in hitting A&E waiting time targets. as part of this there were recently announced plans to strengthen financial performance and accountability with a particular focus on improving A&E waiting time performance. NHS England and NHS Improvement regional teams have worked together to identify systems requiring the most support based on their current and historic performance. These systems will be the subject of the most intensive support and attention, provided by an expanded ECIP (Emergency Care Improvement Programme).

Changes to system leadership and governance were identified, with System Resilience Groups (SRGs) transforming into Local A&E Delivery Boards. These will focus solely on Urgent and Emergency Care, and will be attended at the executive level by member organisations.

In addition, five mandated improvement initiatives have been identified, which relate to streaming, flow and discharge and represent actions that have already been adopted by the most successful systems. The five actions include:

- Streaming at the front door to ambulatory and primary care which will reduce waits and improve flow through emergency departments by allowing staff in the main department to focus on patients with more complex conditions.
- NHS 111 and increasing the number of calls transferred for clinical advice, which will decrease call transfers to ambulance services and reduce A&E attendances.
- Ambulance changes, which will help ensure that all those who contact the ambulance service receive an appropriate and timely clinician and transport response, with the aim to decrease conveyance and increase 'hear and treat' and 'see and treat' to divert patients away from A&E.
- Improved flow, with a set of must do's to reduce inpatient bed occupancy and reduce length of stay.
- Mandating 'Discharge to Assess' and 'trusted assessor' type models.

News from NHS England

Funding to set up centres of global digital excellence

12 Trusts of the most digitally advanced trusts have been selected by NHS England to receive a £100m funding pot to become centres of global digital excellence and drive forward better use of technology in health.

In a bid to win up to £10m each to invest in digital infrastructure and specialist training, 26 acute trusts, already advanced in their use of technology in hospitals, were asked to demonstrate their potential to become world leaders in health informatics. 12 trusts were selected to become centres of global digital excellence.

Once established, the centres will lead the way for the entire system to move faster in getting better information technology on the ground, delivering benefits

News from NHS England cont…

for patients and sharing learning and resources with other local organisations through networks.

To be selected, trusts showed that they are able to deliver:

- Comprehensive use of electronic patient records – making patient records available to doctors and nurses in real time and use of electronic medicines management.
- Information sharing across the local health and care system – digital correspondence and test results for patients and online medical record and care plan sharing between health and care teams.
- Robust data security – a plan to respond to threats to data security

Of the 12 Trusts slected, one was from London, Royal Free London NHS Foundation Trust.

NHS learning from Pokemon Go

A recent blog by the Senior Fellow to the Chief Executive of NHS England, Dr Mahiben Maruthappu, looked at what lessons the health system could learn from Pokemon Go, the game that encourages people to go out and finding virtual Pokemon in the real world using their smartphones.

The game uses the players' smartphones, as well as the surrounding environment, to create the game and has been successful in part because it uses technology that people have on them at all times and are comfortable with. The majority of the population owns a smartphone, but while they have access to NHS services online, single digit percentages of the population use smartphones to interact with the health service.

Dr Maruthappu highlights that if medical records aren't built to run off patient's smartphones, then they will need to be retrofitted in the future so they are able to be easily viewed on smartphones.

Pokémon Go blends offline with online, real with virtual by using augmented reality. Augmented reality is being used at the Royal London, where colorectal surgeon Shafi Ahmed has pioneered the use of Google Glass in surgery to teach students and trainees. In the Netherlands AED4U is an App that shows you the location of nearby defibrillators using your phone.

Pokemon Go represents a gamification of people's lives, an approach that could be explored more when it come to people's health, especially around self-care, and A&E avoidance.

Health and Wellbeing Board Meeting Dates

Tuesday 22 November 2016, Tuesday 31 January 2017, Tuesday 14 March 2017, Tuesday 9 May 2017

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

27 September 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) The next full issue of the Forward Plan will be published on 24 October 2016. Any changes or additions to the next issue should be provided before 2.00 p.m. on 19 October 2016.

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 November 2016 Edition

Publication Date: 24 October 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
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: 22.11.16	**Contract: Healthy Child Programme (0-19) - Procurement Strategy** : Financial The contracts for the 0-5 and 5-19 Healthy Child Programmes (HCP) respectively are due to expire on 30 September 2017. This Board will be asked to approve the procurement strategy for the competitive procurement of these services as an integrated 0-19 HCP and to delegate authority to award a contract to the successful provider. • Wards Directly Affected: All Wards	Open	Christopher Bush, Interim Commissioning Director, Children's Care and Support (Tel: 020 8227 3188) (christopher.bush@lbbd.gov.uk)
Health and Wellbeing Board: 22.11.16	Learning Disability Partnership Board Strategic Delivery Plan - Update The report will provide and update of the Learning Disability Partnership Board Strategic Delivery Plan, including the strategic frameworks that drive improvements for learning disability services. • Learning Disability Self Assessment Framework Improvement plan • Adults Autism Strategy • Challenging Behaviour Strategy • Carers Strategy The Board will be asked to note the report and discuss any comments within it. • Wards Directly Affected: All Wards	Open	Karel Stevens-lee, Integrated Commissioning Manager (Learning Disabilities), Joint Service (Tel: 0208 227 2476) (karel.stevens-lee@lbbd.gov.uk)

Health and Wellbeing Board: 22.11.16	Children and Maternity Sub-Group Assurance Update The report will provide an update on the work of the Children and Maternity Sub-Group, providing the Board assurance that the Sub-Group is delivering against its strategic objectives. The Board will be asked to note the report and discuss any comments within it. • Wards Directly Affected: All Wards	Open	Karel Stevens-lee, Integrated Commissioning Manager (Learning Disabilities), Joint Service (Tel: 0208 227 2476) (karel.stevens-lee@lbbd.gov.uk)
Health and Wellbeing Board: 22.11.16	Involvement of Barking and Dagenham Residents in Health and Social Care Provision The report will provide an overview of what work partner organisations do around the involvement of the public in services, including statutory responsibilities, as well as other approaches used. The Board will be asked to consider whether current approaches address the needs of local people and whether any changes should be made. • Wards Directly Affected: All Wards	Open	Andrew Hagger, Health & Social Care Integration Manager (Tel: 020 8227 5071) (andrew.hagger@lbbd.gov.uk)
Health and Wellbeing Board: 22.11.16	**Mental Health Strategy** The report will present the newly developed Mental Health Strategy for Barking and Dagenham. The Board will be asked to support and adopt the Mental Health Strategy. • Wards Directly Affected: All Wards	Open	Melody Williams, Integrated Care Director Barking & Dagenham (Tel: 0300 555 1201) (Melody.williams@nelft.nhs.uk)

Health and Wellbeing Board: 22.11.16	**Children's Therapies** The Board will be provided with a report from the Children and Maternity Sub-Group that will provide a broad system-wide view of children's therapies and will: – Set out the work done by the CCG on AHP, the role of other commissioners in developing pathways as well as the role of schools and early intervention. – Highlight the most pressing issues in this area, emphasising areas where linkages and interdependencies occur, as no one commissioner can address the complexity of the problem. – Present a clear ask to the Board on the strategic direction and leadership required to further this issue. • Wards Directly Affected: All Wards	Open	Melody Williams, Integrated Care Director Barking & Dagenham (Tel: 0300 555 1201) (Melody.williams@nelft.nhs.uk)
Health and Wellbeing Board: 22.11.16	Safeguarding Children Board Annual Report 2015/16 The Board will be presented with the Annual Report of the Safeguarding Children Board for 2015/16. • Wards Directly Affected: All Wards	Open	Sarah Baker, Independent Chair Safeguarding Board (Tel: 0208 227 3353) (Sarah.Baker@lbbd.gov.uk)

Health and Wellbeing Board: 22.11.16	**Mental Health Sub Group Assurance Report** The report will provide an update on the work of the Mental Health Sub-Group, providing the Board assurance that the Sub-Group is delivering against its strategic objectives. The Board will be asked to note the report and discuss any comments within it. • Wards Directly Affected: All Wards	Open	Melody Williams, Integrated Care Director Barking & Dagenham (Tel: 0300 555 1201) (Melody.williams@nelft.nhs.uk)
Health and Wellbeing Board: 22.11.16	Safeguarding Adults Board Annual Report 2015/16 The Board will be presented with the Annual Report of the Safeguarding Adults Board for 2015/16. • Wards Directly Affected: All Wards	Open	Sarah Baker, Independent Chair Safeguarding Board (Tel: 0208 227 3353) (Sarah.Baker@lbbd.gov.uk)
Health and Wellbeing Board: 22.11.16	Health and Wellbeing Outcomes Framework Report - Quarter 2 2016/17 The report will present the Board with the Health and Wellbeing Outcomes Framework Report and the performance information for Quarter 2 2016/17. The Board will be asked to discuss and the data within the report. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
Health and Wellbeing Board: 31.1.17	**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: 31.1.17	Health and Wellbeing Outcomes Framework Report - Quarter 3 2016/17 The report will present the Board with the Health and Wellbeing Outcomes Framework Report and the performance information for Quarter 3 2016/17. The Board will be asked to discuss and the data within the report. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)

APPENDIX 1

Membership of Health and Wellbeing Board:

Councillor Maureen Worby, Cabinet Member for Social Care and Health Integration (Chair)
Councillor Sade Bright, Cabinet Member for Equalities and Cohesion
Councillor Laila Butt, Cabinet Member for Cabinet Member for Enforcement and Community Safety
Councillor Evelyn Carpenter, Cabinet Member for Educational Attainment and School Improvement
Cllr Bill Turner, Cabinet Member for Corporate Performance and Delivery
Anne Bristow, Strategic Director for Service Development and Integration and Deputy Chief Executive
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)
Bob Champion, Executive Director of Workforce and Organisational Development (North East London NHS Foundation Trust)
Dr Nadeem Moghal, Medical Director (Barking Havering and Redbridge University Hospitals NHS Trust)
Sean Wilson, Interim LBBD Borough Commander (Metropolitan Police)
Ceri Jacob, Director Commissioning Operations NCEL (NHS England - London Region) (non-voting Board Member)