

Notice of Meeting

HEALTH & WELLBEING BOARD

Tuesday, 14 March 2017 - 6:00 pm
Conference Room, Barking Learning Centre, 2 Town Square, Barking, IG11 7NB

Date of publication: 6 March 2017

Chris Naylor
Chief Executive

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

Membership

CLlr Maureen Worby (Chair)	(LBBD) Cabinet Member for 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
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

Vision & Priorities (Oct '16)

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 31 January 2017 (Pages 3 - 12)**

BUSINESS ITEMS

4. **NELFT CQC Comprehensive Inspection - Quality Improvement Plan (Pages 13 - 27)**
5. **Barking Riverside Healthy New Town (Pages 29 - 45)**
6. **Health and Wellbeing Outcomes Framework Report - Quarter 3 2016/17 (Pages 47 - 63)**
7. **Future Health and Wellbeing Board Dates 2017-18 (Page 65)**

STANDING ITEMS

8. **Integrated Care Partnership Board Update (Pages 67 - 83)**
9. **Sub-Group Reports (Pages 85 - 118)**
10. **Chair's Report (Pages 119 - 123)**
11. **Forward Plan (Pages 125 - 135)**
12. **Any other public items which the Chair decides are urgent**
13. **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.***

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

(i)

(ii)

This page is intentionally left blank



Our Vision for Barking and Dagenham

One borough; one community; London's growth opportunity

Our Priorities

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

Well run organisation

- A digital Council, with appropriate services delivered online
- Promote equalities in the workforce and community
- Implement a smarter working programme, making best use of accommodation and IT
- Allow Members and staff to work flexibly to support the community
- Continue to manage finances efficiently, looking for ways to make savings and generate income
- Be innovative in service delivery

This page is intentionally left blank

MINUTES OF HEALTH AND WELLBEING BOARD

Tuesday, 31 January 2017
(6:00 - 7:59 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, Frances Carroll, Sue Lloyd and Dr Andy Heeps

Also Present: Sarah Baker and Ian Tompkins

Apologies: Bob Champion, Matthew Cole, Ceri Jacob, Dr Nadeem Moghal and Cllr Bill Turner

59. Declaration of Members' Interests

Frances Carroll, Healthwatch Barking and Dagenham, declared a pecuniary interest in Agenda Item 8, 'Contract: Re-Commissioning Healthwatch Arrangement'.

There were no other declarations of interests.

60. Minutes - 22 November 2016

The minutes of the meeting held on 22 November 2016 were confirmed as correct.

61. Barking and Dagenham CCG Operating Plans 2017-2019

Councillor Butt, Cabinet Member for Enforcement and Community Safety, arrived during this item.

Sharon Morrow, Chief Operating Officer Barking and Dagenham Clinical Commissioning Group (CCG), presented the update and explained how this was the first time that the planning process had been for a two-year period. The report flagged the financial position of the Barking and Dagenham, Redbridge and Havering CCGs and the risks associated with the operating plan requirement to deliver the financial control total for 2017/18 and 2018/19. This would require a savings requirement of £55m in 2017/18, which equated to around £15m for Barking and Dagenham CCG. £35m of the £55m savings requirement related to the BHRUT contract.

The Board's attention was drawn to the Operating Plan Priorities for the commitments for primary care, urgent and emergency care, referral to treatment and elective care, cancer, mental health and learning disabilities.

The Board was also informed that the planning guidance for the Better Care Fund should be received imminently but that it was generally expected to be an evolution of earlier versions and was likely to also cover the period 2017 to 2019. A number of national conditions, targets and metrics would need to be achieved, the details of which were set out in the report.

The Board questioned the targets set out in the mental health commitments as these seemed low. Sharon advised that these were the Government's minimum national standards and achievement in some areas was already higher, as an example the target for those 'people experiencing their first episode of psychosis beginning treatment with a care package' had been expanded from 50% last year to 53% this year. Locally performance was already achieving above that standard and work was continuing with NELFT to improve delivery further.

Anne Bristow, Strategic Director for Development and Integration, stated that Head Teachers within the Borough continually raise concern about the need for mental health support for children and young people. Anne stressed that the earlier support was provided to children and young people, the more positive the outcomes and life chances for those concerned would be and the less support they may require at a later stage.

The Chair reminded the Board that concern had been expressed previously about the effect that the STP and the effect of the BCF locally.

Conor Burke, Chief Operating Officer B&DCG, advised that an initial 'early thoughts' meeting had taken place the previous week and that work was continuing to clarify several issues around commissioning options and discretionary services. This was a significant component of priority setting and was being driven by the unprecedented £55m funding reduction. Conor advised that it was hoped that some 'in principle' agreements would emerge shortly in regards to what would be done, how we would do it and, perhaps more importantly, what would we may stop doing. A further update report would be provided at the next Board meeting.

The Board raised concern about the Governments low expectations and felt that the targets locally needed to be looked at more robustly and that this should be done by the Integrated Care Sub Groups.

The Board:

- (i) Noted the CCG Operating Plan for the two-year period 2017/19, the Five Year Forward View priorities and the targets set by the Government, as set out in the report; and
- (ii) Raised concern about the low targets expected by the Government and how those had influenced the targets in regards to mental health service standards, which were set out in page 16 of the Agenda. The Board tasked the Integrated Care Sub Groups to review those targets and delivery options to ensure that performance targets are more stretching, in order to achieve a significant impact on mental health service(s) provision and support for residents.

62. Overview of Council Transformation Proposal for Children's and Adults' Social Care and Community Solutions

Anne Bristow, Strategic Director for Development and Integration, introduced the report and presentation and reminded the Board that Ambition 2020 was a programme to transform services to ensure their sustainability and continued effectiveness, bearing in mind the projected £63m budget gap to 2020/21 and the

£10m savings for children and adults care and support that needed to be achieved. There were four key elements of the transformation programme that were relevant to the Board and its partners, the details of which were set out in the report. Anne then drew attention to:

- Growth and competing pressures, including demographic changes.
- The different types of needs for adults and children.
- Complexity of needs of clients, such as children coming through special needs schools into adulthood.
- London-wide shortage of social workers and the recruitment initiatives being undertaken by the Borough.
- Services updating so they are fit for the 21st century including the use of technology.
- Ensuring the right support was be provided to the right people, at the right time.
- Building on the work that was already happening in GP surgeries.
- Innovation and joint commissioning to allow partners to work better and cheaper.
- A new way of signposting individuals to care and support, whilst tailoring that access for existing long-term users.

Chris Bush, Commissioning Director for Children's Care and Support, explained that for his area the clients were children that met the threshold of needing acute / high level support. Chris drew attention to:

- Services had to be flexible, reactive, holistic and provide a joined-up response.
- The consistency of the professionals the families contacted was clearly important. The principles of planning the services and stability of the workforce was a primary aim.
- The service would be moving to locality based assistance.
- A key change would be the creation of a cradle to grave, children and adults' disability service.
- Work being undertaken to ensure commissioning was more cost effective, offered good value for money and that the right services were available across the Borough.
- The savings anticipated would be in the order of £4.4m.

Chris stressed that by targeted early intervention, before children come into care, could have a significant effect on the family and life choices of the child.

Mark Tyson, Commissioning Director of Adults' Care and Support, advised that his service concentrated on people with frailty and older people with mental health problems. It was important that clients had choices in their care and that people feel safe and connected to the wider community. Mark explained what the changes would mean and drew attention to:

- The new IT system to support teams.
- Preventative, front end support.
- New accommodation based support options
- Work with partners to review and improve delivery models.
- Stronger commissioning.
- The savings would be in the order of £5.4m

Tudur Williams, Operational Director, Service Development and Improvement, advised that over the last few months the work of designing the new service had been based upon the consultation that had been undertaken with service users on what they wanted. Tudur drew attention to:

- The end of age limits by providing for need, not age.
- There would be a one-stop-shop for all people regardless of age, with a few exceptions, to create a cradle to grave seamless service.
- The operating model for the Disability Service and the new combined Disability Service would start operating by late April.
- A holistic service, which would include social workers, sensory and therapy teams.
- Increased use of assisted technology.
- New IT system would come into use in February 2018, which would provide better support to teams.
- The savings would be in the order of £1.7m

The Boards attention was also drawn to the potential impacts on health partners, contact routes and the live sharing of data feeds as the new IT systems come on line, which would reduce duplication and repeated form filling.

The Board discussed several issues, including:

The Chair stressed that the overview shows the significant changes that were being put into place. Community solutions should remove silo working and would help residents know what they could do for themselves and how they could access the support they need. An important aspect was to stop residents relying on the Council as a paternalistic service and to encourage them to look for and seek what meets their needs themselves.

Cllr Carpenter, raised concern about how schools would be able to access the educational psychology service. Anne Bristow advised that this had already been considered at a high level and more detailed work would be done to look at how the offer to schools could be improved alongside the commissioning of 0-19 health services and the CAMHS transformation programme.

Sarah Baker, Independent Chair of LBBDD Safeguarding Adults Board and LBBDD Safeguarding Children Board, felt that both those Boards could offer support and help and that such work would need to be built into their priorities next year. Sarah would contact appropriate colleagues to arrange this.

Healthwatch were concerned that help was all being moved to an on-line service and this might be difficult for the frail and elderly or those with little or no IT experience. The Chair reminded Partners that Care City was developing IT systems to enable quick and direct access to services and suggested that all partners visit Care City to see these.

Sharon Morrow confirmed that colleagues had been sharing plans and the impact on health had been considered, including potential joint commissioning strategies and opportunities. The aim was to ensure that, wherever possible, the plans and changes come together at the same point in time.

The Chair advised that further reports on progress would be presented in due course.

The Board:

- (i) Received the report and comprehensive presentation and noted the work being undertaken by the Council in transforming the children and adult social care services in the Borough, including the new Community Solutions initiative; and
- (ii) Noted that further reports will be presented in due course, which would provide additional information on the educational psychology services, the potential to work with the LBBB Safeguarding Adults Board and LBBB Safeguarding Children Board, implementation progresses, impacts the programme may have on partnership activity and any potential opportunities for further integrated activity.

63. Developing an Oral Health Strategy in Barking and Dagenham

Susan Lloyd, Public Health Consultant, presented the Oral Health Strategy which identified the oral health issues that affect children and adults in the Borough and set out the ambition to improve the oral health of residents. The strategy also set out the key priorities, which had been devised with partners through an oral health partnership group. The strategy included encouraging people to visit the dentist on a regular basis, improved diets and reducing the consumption of sugary food and drinks, oral hygiene and preventative dental care as well as increasing exposure to fluoride through toothpaste and varnishing. There were added health benefits from better diet as well.

Susan explained that the Borough had a high level of tooth decay in children, and that although this had improved over recent years, it was still higher than the London average. On the plus side 94% of adults have 21 or more of their own teeth, which was the level considered as a 'functioning mouth'.

Tooth brushing and wider education programmes would be undertaken. This included 7,000 children receiving a toothbrush and education linked to the 'Child Smile' Programme.

It was noted that the programme would cover all early years settings in the Borough.

The Board were delighted with the report and the evidence based simple and practical initiatives, which could have a positive impact for low cost. The Chair stressed that the pester power on parents from a child being provided with a 'funky toothbrush' and their teacher encouraging its use should not be underestimated.

Anne Bristow reminded the Partners that all contact with parents should count. If the programme results in a parent(s) and child going to a dentist, then they would be more likely to keep going. The effect on Partners should not be underestimated as on average over 300 children from LBBB were admitted to hospital for dental treatment each year, so improved dental health would help BHRUT pressures as well.

The Board:

- (i) Approved the Oral Health Promotion Strategy, attached at Appendix A to the report; and
- (ii) Agreed the next steps, as set out at section 6 of the report.

64. Contract: Children's Emergency Duty Team - Four Borough Shared Service Arrangement

Chris Bush, Commissioning Director for Children's Care and Support, presented the report and explained that the Council was required to have an Emergency Duty Team for Children (EDT) to meet the statutory duty to safeguard children and respond to referrals out-of-hours for children at risk of harm or in need of emergency care.

A review of the options on how this EDT service would be provided had been undertaken, including the benefits and risks of each option, the full details of which were set out in the report. The review had resulted in a recommendation for the future procurement of the Children's EDT service to be procured as a new service alongside neighbouring local authorities through an open tender exercise (option 3) as set out in the report.

The Board:

- (i) Agreed to enter into a new three-year shared service arrangement with the London Boroughs of Redbridge, Waltham Forest and Havering for the delivery of the four-borough Children's Emergency Duty Team from the 1 April 2017; and
- (ii) Agreed a total contract value for the London Borough of Barking and Dagenham of £691,231.49, with the annual amounts anticipated to be in the order of:

2017/18 - £228,398.26
2018/19 - £230,403.76
2019/20 - £232,429.47.

65. Contract: Re-Commissioning Healthwatch Arrangement

Frances Carroll declared a pecuniary interest and the Healthwatch Team left the meeting at this point and took no part in the discussion or decision.

Andrew Hagger, Health and Social Care Integration Manager, presented the report and explained that Healthwatch had a statutory place on the Board and was a key part of the local health and social care landscape. National guidance sets out the key functions that Healthwatch must deliver and their role included being a consumer champion for users of health and social care services, signposting of residents to the correct service and collection of people's views and experiences as part of the scrutiny of service provision. The Council was required to commission a local Healthwatch organisation under the Health and Social Care Act 2012. The organisation that hosted or delivered the healthwatch function could

of course change

Andrew explained the financial position and that the current Healthwatch contract was due to expire on 31 March 2017. The recommended route for procurement of the service was the open procurement procedure for the award of a two-year contract from 1 July 2017 to 30 June 2019 with the option to extend for a further 1 (1+) year(s). The Board noted the estimated cost of the contract and the set up costs. The anticipated spend had been benchmarked across London and some efficiencies from bidders would be required to meet the funding available. In addition, bids would be robustly tested against the framework. Should Partners wish to participate in the process they should contact Andrew Hagger.

The details for the procurement strategy and estimated contact value were set out in the report.

The Board:

- (i) Agreed that the Council should proceed with the procurement of a contract for a local Healthwatch for Barking and Dagenham, in accordance with the strategy set out in the report; and
- (ii) Delegated authority to the Strategic Director Service Development and Integration, in consultation with the relevant Cabinet Member(s), the Chief Operating Officer and the Director of Law and Governance, to conduct the procurement and enter into the contract and all other necessary or ancillary agreements with the successful bidder(s) in accordance with the strategy set out in the report.

Frances Carroll and the Healthwatch Team re-joined the Board.

66. Update on the work of the Integrated Care Partnership for Barking & Dagenham, Havering and Redbridge

Mark Tyson Commissioning Director of Adults' Care and Support presented the report and advised that its purpose was to provide an update and recap on the strategic and business case to date.

The report set out the details on why the ACO was not justifiable, at present, and the alternatives that had resulted in the formation of the Integrated Care Partnership (ICP), which in turn had resulted in joint commissioning, joint system oversight and a new locality structure being the key components to the proposed way forward for managing the health and care in the three boroughs. Workshops had also assisted in concentrating the requirements and aims of the ICP.

The Chair reminded the Board that a commitment had been given that once the Integrated Sub Groups agreed on an action, the individual partners would make those changes a reality in their own organisations. The important point was this was a delivery vehicle with joint commissioning, it was certainly not a talking shop. Connor Burke advised that significant progress had been made and we would be able to make practical changes in the next few months.

The Chair pointed out that the Government was now serious about health devolution for London and this would need to be borne in mind when developing

the STP and commissioning in the near future.

The Board:

Noted the progress in establishing the new partnership arrangements for the health and social care system for Barking and Dagenham, Havering and Redbridge, and the work being undertaken by the Board's Integrated Care Sub-Group on the establishment of the locality model.

67. Update on North East London Sustainability and Transformation Plan (NEL STP) for Barking and Dagenham Health and Wellbeing Board

Cllr Carpenter left the meeting during this item.

Ian Tompkins, Director of Communications and Engagement NEL STP, advised that the STP draft had been submitted in October and whilst some informal feedback had been received the formal feedback was still awaited.

Work was being undertaken on building bridges both within the NHS and with its partners, included sharing networks and contracts. It was noted that engagement work was being undertaken with Healthwatch during February.

Ian explained that the Memorandum of Understanding was currently being circulated, with the aim of setting up shadow governance structures, together with proposed Terms of Reference, and aims. The hope was for the governance to be sorted out and in place in the next five weeks.

Constancy of service provision and good practice across the whole area would then be the aim.

The Chair advised that there were some concerns and reticence to sign the Memorandum of Understanding as the local authorities were not being represented adequately and the local voice was not transparent. The concern was that unless there was parity of esteem for all the member organisation, it would not be a true partnership. The Councils would like to be asked who they wanted to represent them and not have that representative foisted upon them. There was also concern at local level that any change of policy at a national level would be a threat to long-term achievement and stability. Ian Tompkins advised that there would be further discussion on the representation at the Sub-Board by local authorities.

The Chair pointed out that the eight boroughs that had been put together for the NEL STP were not a natural fit, as they had completely different needs and challenges.

The Board:

- (i) Noted the update and presentation attached as Appendix A and Appendix B respectively to the report and noted the current discussions underway about Sustainability Transformation Plans (STP) governance, and the direction of travel for the STP.
- (ii) Raised concern about the lack of responsiveness to representations sent

by the Councils to the NEL STP team, and in particular, the continued absence of local authority representation on the NEL STP Board, the different needs and challenges faced by the eight boroughs selected and how local resident representation was being selected.

68. A&E Delivery Board (formerly Systems Resilience Group) - Update

Connor Burke, Chief Operating Officer B&DCG, provide an update from which the Board:

- (i) Noted the work of the A&E Delivery Board, which included the issues discussed at the A&E Delivery Board meetings held on 31 October and 23 November 2016 and that two meetings had also been held in December and January, the details of which would be reported at the next meeting;
- (ii) Noted that the CCG were now well into the period for Winter reporting and had performed well so far, including during the Christmas and New Year period. The Board wished to place on record its appreciation of the hard work undertaken by the staff to achieve the improved performance; and
- (iii) Noted that planning was already underway for the Easter period.

69. Sub-Group Reports

The Board noted the reports on the work of the:

- Learning Disability Partnership Board (LDPB), which included:
 - New format of the LDPB meetings
 - Sub Group Forums
 - Annual Health Checks for People with Learning Disabilities
 - Independent Housing Strategy
 - Improving Employment Opportunities for People with a Learning Disability
 - Offender Health and the Criminal Justice System
 - Action and Priorities for the LDPB over the coming period

70. Chair's Report

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

- Breast Screening Information Update.
The Chair highlighted the publicity that the Council had given to this issue and to the fact that the mobile Breast Screening unit will be in Barking for a number of weeks making access easier.
- Primary Care and Community Pharmacy 2017

- Adult Social Care Survey 2017
- News from NHS England
 - NHS England Review of 2016
 - Allied Health Professions
Had joined forces to help shape future healthcare and the new guidance and commitment published by NHS England entitled 'Allied Health Professions into Action'.

71. Forward Plan

The Board noted the draft March 2017 edition of the Forward Plan and the deadline for any changes to be made.

HEALTH AND WELLBEING BOARD

14 MARCH 2017

Title: NELFT CQC Comprehensive Inspection – Quality Improvement Plan	
Report of the Executive Director London, NELFT	
Open Report	For Information
Report Author: Melody Williams, Integrated Care Director, NELFT	Contact Details: Tel: 0300 555 1201 X65075 E-mail: melody.williams@nelft.nhs.uk
Accountable Director: Melody Williams, Integrated Care Director, NELFT	
Board Sponsor: Bob Champion, Executive Director of Workforce & Organisational Development, NELFT	
Summary: Overview report on the Quality Improvement Plan following the CQC outcome for services in Barking and Dagenham as part of the CQC Comprehensive Inspection of NELFT.	
Recommendation(s) The HWBB is recommended to agree to: (i) Note the report and presentation on overall CQC judgement rating (ii) Note the NELFT quality improvement action plan and progress to date	
Reason(s) The CQC undertook an inspection of NELFT in April 2016 and published its report in September 2016.	

1. Introduction and Background

- 1.1 The Care Quality Commission, or CQC, is the independent regulator of health and adult social care services in England. Its purpose is to make sure health and social care services provide people with high-quality care and to encourage care services to improve. The CQC's role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety these are known as Essential standards of quality and safety.
- 1.2 NELFT received its first full comprehensive inspection during the week of 4th-8th April 2016 and the outcome of this inspection was made public on the 27th September 2016.
- 1.3 Of our 14 core services that were inspected, the CQC rated nine as 'Good' and four as 'Requires Improvement' and one as 'Inadequate'. This has led to an overall CQC rating of 'Requires Improvement' for the Trust.

- 1.4 The CQC has regulatory authority to issue two levels of action and priority:
- (i) Enforcement (to which the trust responded immediately – April 2016) related to services/ domains rated as Inadequate.
- Safety and appropriateness of environments and facilities across acute inpatients for adults / older people and child and adolescent wards.
 - Quality of risk assessments and risk planning across the acute wards for adults of working age and psychiatric intensive care units needed improvement.
- (ii) Requirement – relates to the MUST and SHOULD do's in 4 core services and corporate well-led good governance. The trust has a total of 58 must do's and 77 should do's.
- 1.4 The CQC held a Quality Summit on 14th October 2016 and representatives from all partner organisations, Governors, patient groups and staff attended and a series of development workshops to look at how the partnership can work together to support an improvement plan took place.
- 1.5 The NELFT board agreed a Quality Improvement Plan and governance structure on the 25th October 2016 to review, develop and implement the plan with expected outcomes to be achieved in the main by 31st March 17.
- 1.6 A senior governance framework including Directors across departments and localities have been identified as accountable for driving forward the quality improvement plan and the progress is monitored formally at the Board meeting on a monthly basis (reports of which are in the public domain – Part 1 Papers)
- 2. Progress to date reflecting activity up to the end of December 16 (as reported to the January 17 NELFT Board)**
- 2.1 Priorities for development include:
- Ensuring safe and effective assessment and management of clinical risk across all mental health services, with a particular emphasis in the Acute Wards for Adults of Working Age and Psychiatric Intensive Care Unit. All are subject to audit to monitor and achieve improvement.
 - Ensuring care plans reflect patient needs and include patient contribution in mental and community health services.
 - That the environmental ligature reduction programme is expedited
 - That the ward environmental ligature risk assessments in mental health services are known and understood by staff that works there
 - Providing a safe and clean clinical environment in the adolescent mental health unit.
 - Providing facilities and an environment that promote recovery without blanket restrictions.
 - Ensure safer staffing in identified areas and a strengthened governance reporting of clinical risk.
 - Address the under reporting of incidents in the adolescent mental health unit
 - Assessment of needs and planning of care in specific services identified by the CQC.
 - Apply the Fit and proper persons test
- 2.2 Urgent patient safety improvements have been worked on continuously since and before April 2016; the progress was reported to the NELFT Board and partners and the Brookside Unit (Adolescence Mental Health Unit) was re-inspected in September 2016 at the point of re-opening the unit. The report published in

February 2017 indicated a rating of 'Good' across all five domains which demonstrated the significant progress in environmental work, risk management and recruitment to a full complement of staff.

- 2.3 The Corporate good governance relating to fit and proper persons has been corrected and achieved.
- 2.4 As reported at the January 2017 NELFT Board there is none of the total 'should do/must do' that are reported as red i.e. with no progress.
- 2.5 Of the 58 'must do' requirements, 17 (30% Green) are now reported and evidenced as completed and the remaining 41 (reported as Amber) are on track to deliver a positive outcome by the end of March 2017.
- 2.6 For the 'should do' requirements a further 13 (17%) have been achieved to date and the remaining 64 actions are also progressing with an anticipated delivery date for end of March 2017. Where action plans are reviewed and noted as requiring further implementation actions to be agreed these will be reported to the board and revised trajectories agreed.
- 2.7 The quality improvement plan is a tool by which to plan, measure and monitor progress, examples of direct improvements to services and the patient experience include: Quality Improvement Accelerator Programme to improve care planning across all identified services. This has commenced to ensure that care plans are based on risk, needs and personal to the individual. The assessment of clinical risk is now part of the mandatory training matrix that all clinical and professional staff are expected to attend. Significant environment and estates plans have been accelerated and received additional investment to ensure that the ligature risk reduction programme is achieved and those areas identified as not being dementia friendly or young person friendly have been transformed. For example the Broad Street Memory Service in Dagenham has recently been respected using the MSNAP (Memory Services National Accreditation Programme), having achieved 'Excellent' in 2015-16 we are looking to revalidate in 16-17 (MSNAP results due in April 2017) now that additional estates modifications have been completed.
- 2.8 Furthermore the CQC plan identified that there were significant areas that required a partnership approach to resolve; such as the commissioning of capacity relevant to need within paediatric therapies. The CCG as the key partner has worked with NELFT to review capacity and has invested additional funding to these services for 17-19 contract period. This agreement will enable NELFT to recruit the additional workforce required to reduce waiting list and ensure that caseload numbers are within national guidelines for these areas and therefore resolve further should do/must do actions.
- 2.9 The CCG have not confirmed any further contract reductions for NELFT services within their recent published saving plan to achieve resolution of the financial deficit in the health economy.
- 2.10 Additional actions related to the achievement of staff appraisal and mandatory training. Progress has been made across all core service areas within the Trust in meeting the expected standards and thus ensures that there is an adequately trained and developed workforce to deliver the commissioned services.
- 2.11 Finally a repeated concern identified across the CQC core service reports related to staffing levels and vacancies. Much has been achieved in terms of data cleansing in the electronic staff register (ESR), additional electronic systems to support recruitment processes and a focused targeted resourcing team have been

introduced which has seen the Trust make a significant step in reducing the overall vacancy. In Barking and Dagenham this has meant that rolling vacancy levels have reduced from 25% to approx. 14%.

- 2.12 The Trust has undertaken a review across the governance process and structures within the trust and has identified additional actions and processes to ensure that risks are identified, mitigated, reported and monitored consistently. This will remain under review as part of the ongoing compliance remit within the Trust.

3. Future Inspection

- 3.1 As with all other organisations who have been graded as requires improvement NELFT will be re-inspected by the CQC. The date and programme for re-inspection has not been confirmed by the CQC however they are in regular attendance at the Quality Improvement Steering group meetings and meet with the Chief Nurse and Executive Director with responsibility for compliance.
- 3.2 Brookside was re-inspected in September 2016 following its reopening after closure and complete refurbishment and the published report in February 2017 identified that all 5 domains were reported as Good which was a significant improvement from the previous inadequate.
- 3.3 As a mental Health provider the CQC also complete regular Mental Health Act and other unannounced inspections to review compliance with the law – all of which have demonstrated achievement of the required standards.
- 3.4 Commissioning bodies have also implemented a series of inspections programmes including unannounced inspection visits and the CQC Quality Improvement plan is monitored via the Clinical Quality Review Meetings and the contractual forums.

Additional Information:

- NELFT's inspection rating posters can be viewed via the link below.
<http://www.cqc.org.uk/provider/RAT/posters>
- Care Quality Commission website listing all reports from comprehensive inspection in April 2016: <http://www.cqc.org.uk/provider/RAT/reports>
- NELFT Board Report January 2017: <http://www.nelft.nhs.uk/about-us-board-papers>

Quality Improvement Plan following CQC inspection of NELFT (April 2016)

Presentation update: February 2017



Ratings community health services



	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires Improvement	Good	Good	Good	Good	Good
Community health services for children, young people and families	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Community health inpatient services	Requires Improvement	Good	Good	Good	Good	Good
End of life care	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Community dental services	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Ratings for mental health services



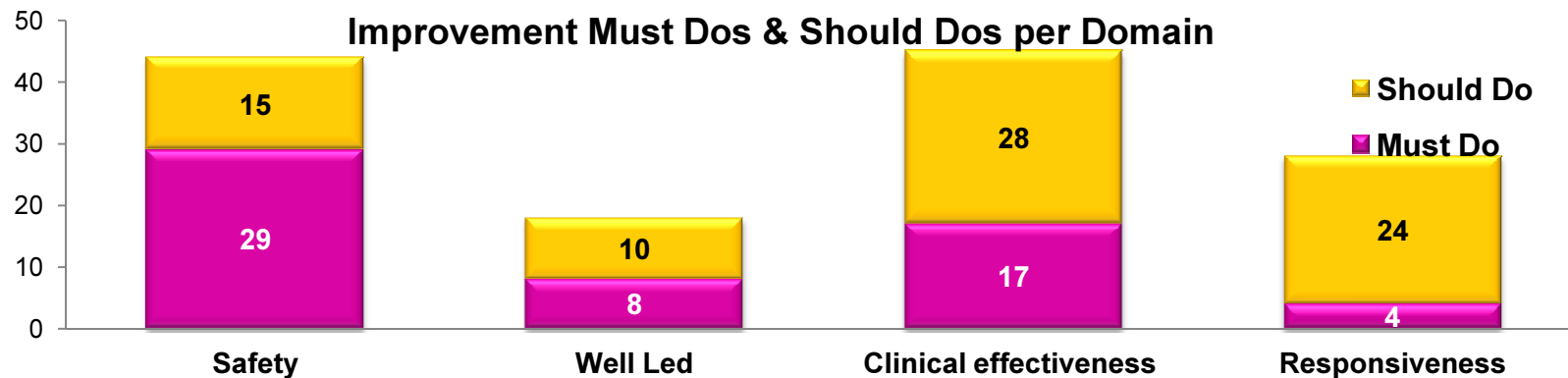
	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units (PICU's)	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Long stay/rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Forensic inpatient / secure wards	Good	Good	Good	Outstanding	Good	Good
Child and adolescent mental health wards	Inadequate	Inadequate	Requires Improvement	Inadequate	Inadequate	Inadequate
Wards for older people with mental health problems	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Wards for people with a learning disability or autism	Good	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires Improvement	Good	Good	Good	Good	Good
Mental health crisis services and health based places of safety	Good	Requires Improvement	Good	Good	Good	Good
Specialist community mental health services for children and young people	Good	Requires Improvement	Good	Good	Good	Good
Community-based mental health services for older people	Requires Improvement	Good	Good	Good	Good	Good
Community mental health services for people with a learning disability or autism	Good	Good	Good	Requires Improvement	Good	Good
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Overall CQC summary



- **10** of the **14** core services we inspected were rated as **good**.
- The trust has over **58** 'Must Do' actions it must take to improve care – a large number relate to Brookside Adolescent unit
- Furthermore there were an additional **77** 'Should Do' actions

Page 20



CQC Quality Improvement Plan

- The Trust immediately commenced work against areas for improvement following the initial CQC feedback, therefore by the time of publication in September 2016 many issues had already been corrected or had plans in place to support rapid resolution
- The framework for the CQC quality Improvement plan was presented to the NELFT Board in November 16 and all actions have an end of March 2017 completion date.
 - Action plan focused to four of the five domains:
 - Safe, Effective, Responsive and Well led
 - Caring (5th Domain) achieved an overall rating of Good and is not part of the CQC Improvement plan but is fundamental in the NELFT Best Care Strategy and Quality Improvement Strategy



CQC Quality Improvement Plan

- Delegation by 'core service report' means that key Trust leads are now focusing on embedding and sustaining improvement
 - Community Health Services for children, young people and families
 - Specialist community mental health services for children and young people
 - Child and adolescent mental health wards
- Each domain is led by an Executive Director with support of a senior manager (ICD), quality improvement lead, Associate Medical Director and Director of Nursing
- Each group reports to the NELFT Board via a CQC Quality Improvement Plan Steering Group (Chaired by the Executive Nurse)
- The Children and Young People Community of Practice will have oversight and clinical leadership for embedding change and quality improvement across the Trust



Priority areas

- Ensuring safe and effective assessment and management of clinical risk across all mental health services, with a particular emphasis in the Acute Wards for Adults of Working Age and PICU. All are subject to audit to monitor and achieve improvement.
- Ensuring care plans reflect patient needs and include patient contribution in mental and community health services.
- That the environmental ligature reduction programme is expedited
- That the ward environmental ligature risk assessments in mental health services are known and understood by staff that works there.



- Providing a safe and clean clinical environment in the adolescent mental health unit.
- Providing facilities and an environment that promote recovery without blanket restrictions.
- Ensure safer staffing in identified areas and a strengthened governance reporting of clinical risk.
- Address the under reporting of incidents in the adolescent mental health unit
- Assessment of needs and planning of care in specific services identified by the CQC.
- Apply the Fit and proper persons test.



Brookside re-inspection

The CQC returned to the unit in October 2016 for a re-inspection and rated it 'Good' overall because:

- The Trust had fully addressed, or significantly improved, the problems that were identified in April 2016
- Young people received care and support according to their individual needs
- The service was adequately staffed and staff turnover was low
- The unit had been extensively configured and refurbished
- Staff now managed ligature risks appropriately



- Staff generally had a good understanding of risk and risk assessments were frequently updated
- The issue of access to doctors out of hours had been reviewed
- Staff members were routinely receiving clinical supervision
- The unit had reviewed practices previously regarded as restrictive with no episodes of seclusion
- Incident reporting and staff awareness of safeguarding had improved
- Robust and effective governance procedures had been put in place



This page is intentionally left blank

HEALTH AND WELLBEING BOARD

14 March 2017

Title:	Barking Riverside – London’s Healthy New Town		
Report of the Director of Public Health			
Open Report	For Decision No		
Wards Affected: ALL	Key Decision: No		
Report Author: Dr Fiona Wright, Consultant in Public Health Medicine, lead author	Contact Details: 020 8227 2867 fiona.wright@lbbd.gov.uk		
Sponsor: Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham			
Summary: Barking Riverside is one of the largest of several growth areas in the borough and will contribute over a quarter of the growth of homes in the borough. 10,800 homes and about 30,000 people will move into the area by 2030. In a borough of deprivation and poor health outcomes, growth can provide an opportunity, but it is essential that the growth benefits the rest of the borough as outlined in the Growth Commission report “No one left behind”, commissioned by the council. Barking Riverside has unique features such as the 2km river frontage and plentiful green spaces, 800 homes that have won numerous design awards, the opportunities provided by a brownfield site and the Community Interest Company (CIC) established to manage the public assets, ensuring they are community led. Recognising the potential of Barking Riverside for healthy and inclusive growth, the Council, Care City and Barking Riverside Limited applied for Healthy New Town (HNT) status under a new scheme initiated by NHS England; we were successful, and the only demonstrator site of 10 in the country that is in London. The Healthy New Town status brought a small amount of funding for project support and some key activities, access to experts and best practice, and a network of other Healthy New Towns. Above all, it is a convening power for local organisations to focus on making Barking Riverside a healthy and inclusive New Town and to bring health related activities under one umbrella. It provides an important opportunity for the borough to test out approaches and learn from them from other growth areas. We also have a responsibility to share this learning across London and nationally. Our vision for Barking Riverside is: “a place which is healthy for all who live and work in and around the area” In the first year as Healthy New Town partners – including the NHS (local and national), council, developers, academics and other healthy new town sites – we have worked with the community to deliver activities, embed health in planning frameworks and develop plans and approaches for future years. For example, we had a four-month community engagement activity to find out from local residents what health would “look like” for them,			

and we have undertaken local health promoting activities. We developed 10 Healthy New Town principles (see appendices) based on best practice, and are embedding them in the section 106 and other emerging planning frameworks. These principles have been adopted by other Healthy New Town sites and can be used to promote health in other developments across the borough. The NHS financial envelope and estates planning does not allow for a new health and care facility until there is a larger population within the area. Local GP practices are being expanded and a pharmacy is now on site to support the residents of Barking Riverside. We are working with the NHS to maximise access to, and quality of, the interim facility. Plans for a new facility and an innovative, integrated model of provision in Barking Riverside for 2020 are being embedded in the planning frameworks in a Health and Care Delivery Plan. These models will be developed further, alongside the Barking Havering and Redbridge locality models over the next few years, with Barking Riverside providing a strong opportunity for innovation and integration.

To plan for the future of the development, as well as hearing from the community, we have undertaken data modelling and engaged with researchers. For example, we undertook cutting edge modelling of size and demographics of the population to help estimate future needs, as well as holding a research and innovation summit focused around the 10 Healthy New Town principles. We have submitted a delivery plan to NHS England (NHSE) highlighting our key priority themes and “investable propositions” for the next two years. We are one of the higher performing HNTs and will get additional funding as well as ongoing funding for project management for the next two years. We expect to hear imminently from NHSE regarding funding and the central support they will offer. Our priority themes are: “no one left behind” - a connected community; lifelong health; sense of place; healthy mind and body; and future health and care; we have planned activities for the next two years. The community have told us that access to healthy food and to quality green spaces is important to them. Sustrans have started work on active travel plan – further promoting walking and cycling. We will develop a community programme, including skill development to support local healthy food, and food on a budget. We are commissioning action research with local people as to how to improve the local environment. In keeping with our vision of ensuring “no one is left behind”, Barking Riverside, together with Ebbsfleet HNT, will work with leading academics and practitioners to develop and test a tool for maximising “inclusive growth”. Alongside these activities and others that will be developed over the next years, we will continue to take opportunities to embed healthy and inclusive growth within the planning frameworks. We will work with the community and the Community Interest Company so that the community is at the centre of the development of Barking Riverside. We will work with the community, academics and other Healthy New Towns to evaluate the benefit of what we achieve in Barking Riverside and inform future actions and share our learning locally in the borough, across London, and nationally.

Recommendation(s)

The Health and Wellbeing Board is asked to

- Endorse the vision of Barking Riverside Healthy New Town.
- Recommend that each locality ensures that the 10 Healthy New Towns principles are embedded within the growth areas of their locality.
- Ensure that the learning from Barking Riverside Healthy New Town is considered on a regular basis to inform other developments within Barking

and Dagenham.

Reason(s)

Barking Riverside is the largest of several growth areas in Barking and Dagenham. The status of Barking Riverside as London's Healthy New Town provides opportunities to test out and implement approaches to ensure the growth area maximises opportunities to improve health for all within Barking Riverside and the surrounding area. It is important that the learning from the Healthy New Town benefits other growth areas in the borough and beyond.

1 Introduction

- 1.1 This paper introduces the Health and Wellbeing Board to Barking Riverside's Healthy New Town (HNT). We are sharing our vision, achievements to date, and future plans. Barking Riverside is one of a number of growth areas in the Borough. The Healthy New Town status offers an opportunity, not only for Barking Riverside, but for the surrounding area and for the other growth areas in the borough. It is important that the Health and Wellbeing Board and partners shape the priorities of the Healthy New Town and ensures the learning from Barking Riverside Healthy New Town informs other development within the borough.

2 Barking Riverside – a Healthy New Town

The NHS England Healthy New Town Programme

- 2.1 NHS England's Five Year Forward View set out ambitions to scale up prevention and deliver new models of care. Recognising the importance of a healthy, built environment in supporting behaviour change and connecting communities, and the opportunities provided by new housing developments to develop innovative health and care services, NHS England developed the 3-year Healthy New Towns programme. Key aims of the programme are to shape new towns to promote health, develop new models of care, and spread learning and good practice to other local areas and the national programme.

London's Healthy New Town

- 2.2 Early in 2016, the Council, Care City, Barking Riverside Limited (BRL, the strategic developer) and other partners successfully bid and became one of the 10 Healthy New Town demonstrator sites; the only one in London. This has brought us a small amount of funding, access to experts, a network of best practice, and has acted as a pivotal focus of local organisations and a catalyst for strong partnership working. Verbally, we have been told we are one of the higher performing sites and have achieved a lot so far. In January, we submitted our delivery plan for the next two years to NHS England and are awaiting an imminent decision about which of our propositions will be funded.

3 Barking Riverside in context

- 3.1 Barking and Dagenham is London's growth opportunity. Barking Riverside is one of our largest developments and will deliver over a fifth of the 50,000 (and increasing) homes to be built in Barking and Dagenham: 10,800 homes and about 30,000 people – a population similar to the size of Windsor.
- 3.2 Barking Riverside is unique as a place through its history, size, location and physical infrastructure, and of significant strategic importance to the borough and London. It is one of Europe's largest brownfield sites – a traditional industrial area, with much of the site utilised for major power stations and heavy industry. It is set in Thames ward, one of the most deprived wards in Barking and Dagenham, and south of the A13 where residential developments have been socially and economically isolated from the rest of the borough. The new development provides an important opportunity for this area. It is essential that it grows out in an inclusive way that benefits the existing local community of 800 homes and the surrounding community. The growth stalled due to lack of transport infrastructure, but there is now a new impetus with a recently approved masterplan for the scheme and the extension of the London Overground to the site in 2021. Barking Riverside also has many other assets, such as the plentiful green space, 2 km of Thames riverside frontage, and unique biodiverse natural landscapes. The early part of the development has won numerous design prizes for ecological sustainability; a feature of Barking Riverside Community Interest Company (CIC) that will, in time, mean the community will manage the assets

4 Our vision

- 4.1 The borough as a whole is committed to “No One Left Behind” – the title of the Growth Commission report commissioned by the council to ensure we maximise opportunities from our growth areas. Given the unique context of Barking Riverside, the challenges within the borough and the opportunities that such a development brings our vision for Barking Riverside Healthy New Town is to be:

‘A place which is healthy for all who live and work in and around the area.’

- 4.2 Central to this vision is our ambition that the benefits of the healthy new towns are achieved by all, irrespective of age, ability, gender, ethnic or socio economic background, and whether from new or existing communities. We want Barking Riverside to be a destination for living, work, and recreation, encouraging workers and families to visit the site to participate in the employment and lifestyle opportunities it offers. There needs to be strong connections (social, economic, and physical) between Barking Riverside and the surrounding Thames ward so that the surrounding area benefits from the Barking Riverside development.

5 Our approach

- 5.1 Delivering this vision is challenging: to find ways of doing this requires strong partnership working, involvement of the community, and access to cutting edge research on how to put our vision and principles into practice. We have worked as a team of partners with the following key elements central to our approach:
- *Small and active team:* with some project management resource and one off funding the project group have worked with NHS England, other healthy new

towns, partners, and the community under the guidance of the multi agency steering group (see Appendix for the governance structure).

- *Community at the centre*: active community engagement such as a 4-month engagement programme on Barking Riverside, discussion at the CIC and at tenants' associations.
- *Political leadership* – advocating for Barking Riverside's Healthy New Town.
- *Partnership*: working with a range of partners – Council, Care City, developers, NHS England, CCGs (Barking and Dagenham and Barking and Dagenham, Havering and Redbridge), academics, and others.
- *Evidence based*: best practice and evidence reviews such as the Research and Innovation summit, input from Care City, linking with Healthy New Town network events, and cutting edge modelling of population projections and space requirements for a health and care facility.
- *Embedding health in planning frameworks*: including the Section 106, sub-framework plans, and placemaking strategy .
- *Proactive communications – internal and external*: for example, an article in the BOLD magazine, local press, and presentations at national conferences (see appendices for our approach to communications).
- *A governance model*: that ensured tight co-ordination and strong leadership from the developers, Council, Care City and other key actors (see appendices).

6 Our achievements to date

- 6.1 An important first step as a Healthy New Town has been the development of 10 Healthy New Town Principles (see Appendix), derived from a review of evidence and good practice, and which are now central to Section 106 and will be embedded in other planning frameworks.
- 6.2 These principles have been picked up by other HNT sites and should be a blueprint for other growth areas in the borough. We have placed our community at the centre of the work we do and adopted a community-centred approach from the outset. We commissioned engagement activities to understand community perceptions and identify leaders, and have been engaging actively with the CIC. Health and care space requirements are embedded in the revised Section 106 (S106) for a new facility in 2020 on Barking Riverside, and a Health and Care Delivery Plan is drafted for inclusion in the next sub-framework plan.; these are based on an innovative and integrated model linked to the Barking, Havering and Redbridge locality model, developed in partnership with stakeholders. We have also facilitated engagement with the NHS and developers to strengthen the interim offer for health and care for local residents. Proactive communications is at the heart of what we do: we have pursued an active a communications strategy which has utilised multiple channels to build awareness of the programme and foster relationships with stakeholders, including other HNT sites.
- 6.3 Several undertaken activities inform and support our future approaches to healthy and inclusive development; these include:

- Population projections based on leading-edge practice, with the involvement of the GLA, Public Health England and others. This suggests the population is likely to be particularly young, with families and children (further detail is available).
- A research and innovation summit bringing together researchers and practitioners from across the UK to ensure our work is evidence-based, with integral research and knowledge exchange.
- Development of a logic model with NHS England.

7 Our priority themes

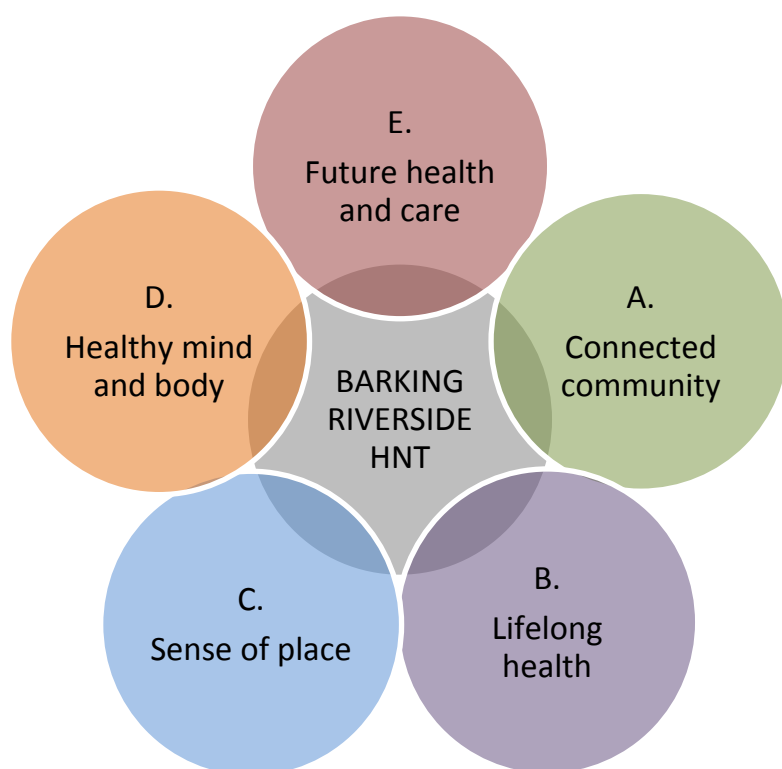


Figure 1. Our priority themes

7.1 We have used our approach above to develop the priority themes outlined in Figure 1 and detailed below:

A. No-one left behind in a ‘connected community’

Connecting the whole community of Barking Riverside and surrounding areas, and the new and existing communities physically, socially and economically, making a positive contribution to physical and mental health. “No one [is] left behind”, irrespective of their economic or social circumstances.

B. Lifelong health

A place which meets and adapts to people’s needs and actively promotes health from the very youngest to the very oldest, as well as between the generations.

This is through the planning, design, and delivery of services and the wider environment.

C. Sense of place

An inspiring place which enhances wellbeing, valued by its citizens and visitors for its social, cultural, economic and environmental assets, diversity, and distinctive attributes. It is a destination drawing people and businesses to live, work, visit, and invest in the area.

D. Healthy mind and body

A place which promotes and enables good physical and mental health, healthy choices for the whole community through a healthy, built environment, and access to a rich set of public assets and services.

E. Future health and care

Innovative, integrated service provision linked with strengthened community infrastructure with prevention and early intervention at its heart.

8 Proposed activities

- 8.1 In addition to the cross-cutting activities outlined in our approach above (section 5), in the Delivery Plan we have set out proposals for each of our priority themes.
- 8.2 These sought funding from NHS England, alongside some that can be delivered in house. We have verbal assurance of project management funding for a further 2 years (the NHSE programme is a 3-year programme in total). We are one of the higher performing HNTs and, therefore, will get additional investment for proposed “investible propositions”. We are expecting feedback imminently from NHS England as to which will be funded.

A. Connected Community and “No one left behind”

Connecting with the community of Barking Riverside and the surrounding area is central to achieving improved outcomes for the Healthy New Town. Building on the community engagement additional proposed activities include:

- Working with the community to develop effective and sustainable communication vehicles shaped by them and delivered with/by them. The programme will encompass skill development and capacity building, and is likely to include: digital interface to promote activities and events, community noticeboard, and a printed newspaper/letter for all residents.
- Engaging with and supporting the development of the CIC, including embedding the 10 Healthy New Town principles in the development.
- Co-developing and testing, with the Ebbsfleet HNT, a best practice guide/tool for supporting “inclusive growth” through (but not limited to): community engagement, the built environment, and community asset management.

B. Life Long Health

Some key examples of our future activities are:

Pop-Up PEARL (People Environment Action Research Labs) led by Professor Nick Tyler, University College London, that will focus on topics relating to access, mobility, and the design of the built environment, to inform:

- People’s physical activity and how that is linked to the design of the built environment and sense of place.
- Access for all to interim and longer-term health and care facilities (and other community assets).
- The way in which the built environment can support older people’s mobility and inclusion.

We will also hope to collaborate on additional research funding opportunities to inform the development of an age-friendly built environment.

The borough-wide older people’s housing programme has identified a need for older people’s “village” at Barking Riverside. A 300-home scheme – promoting independent living and preventing and delaying health and care needs – is being considered in the forthcoming plan for the district centre. In addition, there is provision for 25 homes for people with mental health needs.

C. Sense of Place

A “sense of place” is a priority for the Healthy New Town and for all partners in Barking Riverside. Barking Riverside Limited (the strategic developer) have commissioned a placemaking strategy. This key document will sit alongside the planning frameworks and link with the council’s cultural strategy and open spaces strategy (including ambitious projects for the area and with the active travel plan (see section D)). There is a particular interest in maximising the rivers as assets – “blue space” – so we have bid for funding for this.

D. Healthy Mind and Body

These priorities relate directly to feedback from the community in our engagement events, and their concerns for healthy food and opportunities for activity.

- Sustrans are commissioned to develop (March 2017 to March 2018) engagement, education and behaviour change interventions focusing on improving local air quality and promoting active travel. It includes plans for an area-wide travel plan, with targets to reduce journeys by car and increase levels of walking/cycling by working with the LEPT to implement personalised travel planning and roll out of a comprehensive cycle training programme targeting schools and residents.
- Developing local healthy food and food skills. Examples would include healthy eating on a budget, skills, and enterprise development opportunities.
- As part of the design of the District Centre, a new Leisure Centre will be included. Although this will be a standalone facility, innovative ideas for co-location and shared working between nearby facilities will be given.
- Maximising the use of the river for leisure (e.g. walking and water sports) and active travel will be important.

E. Future Health and Care

Barking Riverside provides an opportunity for developing new models of care.

The NHS is developing increased capacity in GP surgeries bordering on Barking Riverside. The NHS financial envelope and capacity planning does not allow for Barking Riverside to have a new facility on site until 2020, when the local population

in Barking Riverside will have increased. In the future, Barking Riverside will make up one of the localities of the Barking, Havering and Redbridge model.

We are working with the NHS and other partners to maximise the accessibility to the interim facilities for Barking Riverside residents. A new pharmacy is on site at Barking Riverside, near the Rivergate centre. They will offer a range of services such as public health programmes. We are also keen to engage them as a test bed for digital solutions, such as those from Care City.

For 2020, the local NHS, planning team, public health, and national experts have been working to develop a truly integrated, innovative model of care that links with the emerging locality model for Barking, Havering and Redbridge. Barking Riverside provides a unique opportunity to link with community assets and infrastructure in the area, such as leisure centres and to test new approaches. A Health and Care Delivery plan is being submitted in March/April alongside the sub-framework plan for the district centre. This will specify the amount of space, flexible approach to the building, and briefly outline the developing model of care. The aim is for this to go to the CCG board for approval at the end of March (further information available on request). We will continue to develop our future model with the community, informed by population modelling, best practice, and by evaluating the approach of the interim provision.

9 Conclusion

9.1 Barking Riverside Healthy New Town presents a major opportunity for Barking and Dagenham. We are rated as one of high performing HNTs by NHS England. The moderate funding, project management support, and access to learning networks and expertise is enabling us to implement key activities, develop a programme, and evaluate and learn. This learning can then inform activities in other areas as London's growth opportunity. Central to our vision is "no one left behind". To aim to achieve this is ambitious; however, we are a borough of great ambition and, given the poor health and social outcomes in Barking and Dagenham, there is an imperative to rise to this challenge. Engaging with the community and working with partners is key to our approach.

10 Recommendations

10.1 The Health and Wellbeing Board is asked to

- Endorse the vision of Barking Riverside Healthy New Town.
- Recommend that each locality ensures that the 10 Healthy New Town principles are embedded within the growth areas of their locality.
- Ensure that the learning from Barking Riverside Healthy New Town is considered on a regular basis to inform other developments within Barking and Dagenham.

11 Mandatory implications

Joint Strategic Needs Assessment

11.1 The Joint Strategic Needs Assessment, identified growth populations for the borough. It described the socio economic profile and health issues of the borough. These have informed our ambition and priorities for the development of Barking Riverside.

Joint Health and Wellbeing Strategy

11.2 Core to the Joint Health and Wellbeing Strategy is addressing inequalities and prevention across the lifecourse and improving healthy life expectancy. These are strongly reflected in the outcomes and priorities for the Healthy New Town. In turn the Healthy New Town offers an opportunity to improve health outcomes for the borough.

Integration

11.3 The 2020 health and care facility on Barking Riverside offers a unique opportunity to develop an innovative and integrated model of provision alongside the development of the Barking, Havering and Redbridge locality models.

Financial

Financial implications completed by: Katherine Heffernan, Group Manager, Finance

11.4 Barking Riverside Healthy New Town was successful in securing revenue grant of up to £150,000 for 2016-17, as one of ten demonstrator sites selected by NHS England. The purpose of the grant is to fund activity or the delivery of outputs that will support the achievement of the programme objectives. Following an underspend position nationally on the Healthy New Towns programme, additional funding of £40,000 has been awarded to Barking Riverside Healthy New Town for 2016-17.

11.5 Around £110,000 of the original £150,000 grant from NHS England has been spent as at the end of February 2017, with the remaining £40,000 anticipated to be spent prior to 31 March 2017. The £40,000 will be spent on projects to work with the community to develop effective communication vehicles and developing local healthy food and food skills. The additional funding of £40,000 is to be spent on research interventions with UCL and additional community engagement work.

11.6 NHS England have now confirmed funding for this project of a minimum of £75,000 per year for 2017-18 and 2018-19.

Legal

Legal implications completed by: Eirini Exarchou, Senior Safeguarding Lawyer:

11.7 There are no legal implications arising from this report in terms of safeguarding the wellbeing of residents of LBBDD

12 Appendices

- 10 Healthy New Towns principle
- Governance
- Communications
- Logic model
- Outcomes

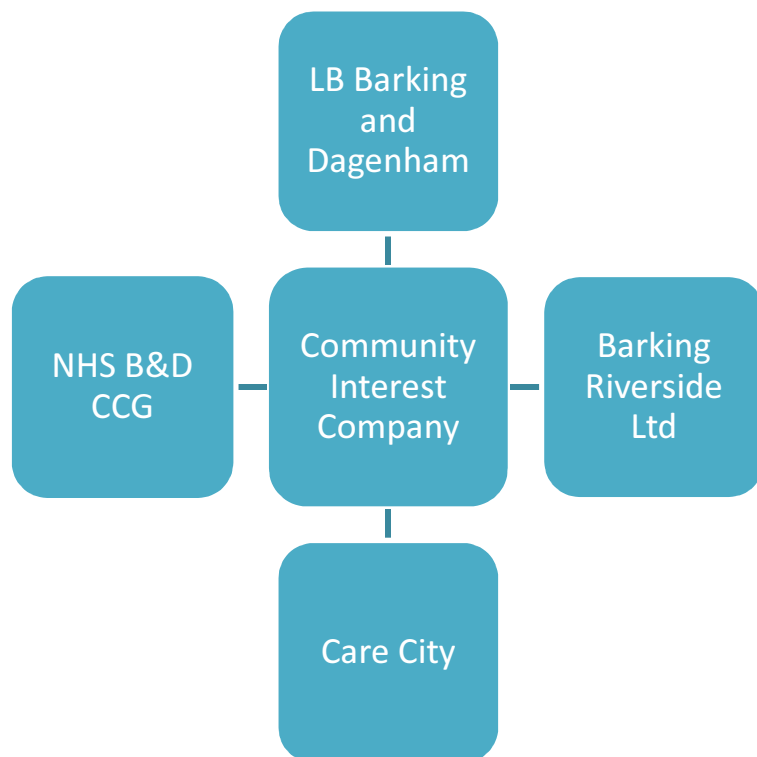
Appendices

- 10 Healthy New Towns Principles
- Governance and partnerships
- Proposed communication plan
- Logic model
- Outcomes

10 Healthy New Town Principles

1. Actively promoting and enabling community leadership and participation in planning, design and management of buildings, facilities and the surrounding environment and infrastructure to improve health and reduce health inequalities.
2. Reducing health inequalities through addressing wider determinants of health such as the promotion of good quality local employment, affordable housing, environmental sustainability and education and skill development.
3. Providing convenient and equitable access to innovative models of local healthcare services and social infrastructure, with the promotion of self care and prevention of ill health.
4. Providing convenient and equitable access to a range of interesting and stimulating open spaces and natural environments (“green” and “blue” spaces) providing informal and formal recreation opportunities for all age groups.
5. Ensuring the development embodies the principles of lifetime neighbourhoods and promotes independent living.
6. Promoting access to fresh, healthy and locally-sourced food (e.g. community gardens, local enterprise) and managing the type and quantity of fast-food outlets.
7. Encouraging active travel, ensuring cycling and walking are safer and more convenient alternatives to the car for journeys within and outside the development, and providing interesting and stimulating cycle/footpaths.
8. Creating safe, convenient, accessible, well-designed built environment, and interesting public spaces and social infrastructure that encourage community participation and social inclusion for all population groups including older people, vulnerable adults, low income groups and children.
9. Embracing the Smart Cities agenda by incorporating and future-proofing for new technology and innovation that improves health outcomes across a range of areas, both at an individual level and also within the public realm.
10. Ensuring workplaces, schools, indoor and outdoor sports and leisure facilities, the public realm and open

Governance and partnerships



Partnership

Governance, oversight and delivery are provided through strong co-operation between key institutional actors locally (see diagram, left). Together, these ensure accountability and programme sustainability, and are represented across borough-wide and local Barking Riverside fora. These partners also contribute substantial in-kind resource (See Slide 51).

Strategic oversight

These bodies provide strategic oversight and ensure alignment with strategic priorities:

- Health and Wellbeing Board
- Care City Executive Group.

Delivery

Delivery is managed by the following groups, supported by a Project Co-ordinator:

- Steering Group – chaired by co-leaders representing the Council and Care City, comprising lead partners and additional cross-sector stakeholders
- Project Delivery Group, reporting to above
- Project teams, responsible for specific activities

Proposed communications plan

Our approach

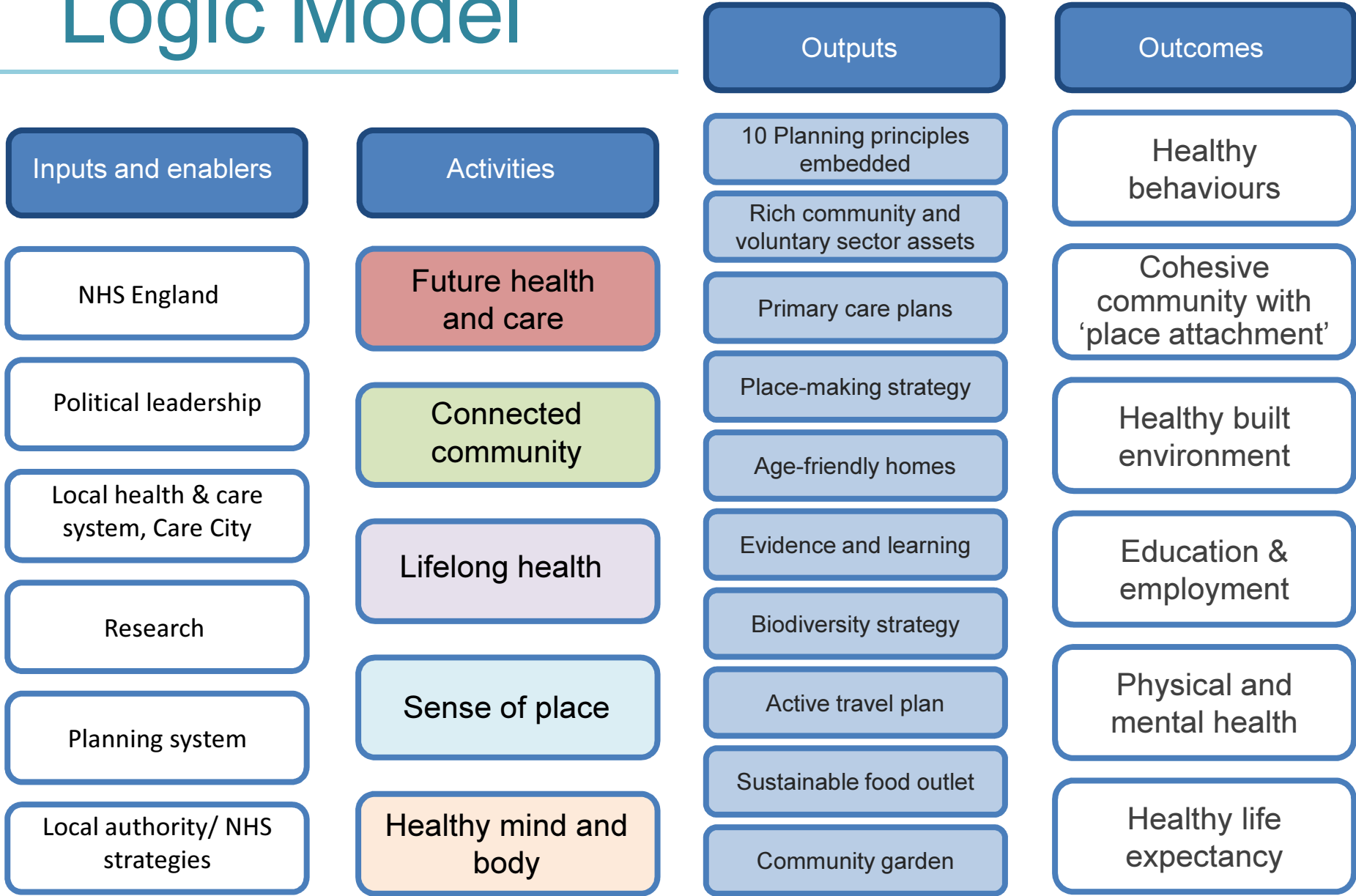
- Raise the profile of our work across the local community to encourage feedback and involvement
- Keep stakeholders informed of HNT milestones, especially delivery partners e.g. planners and developers
- Promote deliverables and achievements as they are realized to all audiences to build confidence and pride, encourage adoption of services and drive new and equitable citizen growth
- Utilise collaboration opportunities with Barking Riverside, GLA, Sustrans, Future of London and L&Q to broaden message reach and impact for all
- Measure impact and review activity based on e.g. direct event feedback, online polls, stakeholder meetings, volume/tone of press coverage, social media engagement.

Our planned activity

- Refine stakeholder map and their message requirements e.g. VCS including social enterprise, local government, transport, health and care, research community, HNTs, developers, private sector, media
- Continue to work closely with Barking Riverside Ltd, LBBD, L&Q, NELFT, GLA and others to further shape and align plans, identifying opportunities to broaden message reach and collaborate where relevant
- Draft key messages based on milestones
- Roll out, as detailed in further proposals (available on request).

Logic Model

Page 43



Outcomes

We will identify measures to evaluate the following outcomes for each of our relevant activities.

We will work up indicators and monitoring methods in conjunction with the community, partners and leading experts. Below we set out the key themes in each outcome.

In particular we are very committed to measure and ensure that benefits of the healthy new towns are:

Achieved by all, irrespective of:

- Age or ability
- New or existing communities
- Within BR or neighbouring areas
- Gender or ethnicity
- Social and economic background.

OUTCOME 1: HEALTHY BEHAVIOURS

- Access and utilization of: green and blue spaces, healthy food options
- Low levels of smoking, obesity
- High physical activity rates
- Better health behaviours for Barking Riverside and surrounding areas compared to historic levels in LBBD
- Innovative, integrated health and care provision.

OUTCOME 2: COHESIVE COMMUNITY

- Functioning community asset management
- Community leadership and voluntary sector delivering services, engaged with public sector
- Physical, social and environmental connections with surrounding areas and between new and established communities
- Improved social and economic indicators for Barking Riverside and surrounding areas compared to historic levels in LBBD.

OUTCOME 3: HEALTHY BUILT ENVIRONMENT

- Housing will be good quality and affordable
- Accessible, high quality green and blue spaces
- Public realm is accessible, safe and convenient to navigate for people of all ages and abilities
- A clean, green environment with clean air, protected and enhanced biodiversity and low levels of waste

These attributes will contribute strongly to overall health and wellbeing and 'sense of

Outcomes

OUTCOME 4: EDUCATION, EMPLOYMENT AND INCOME

- High educational achievement through access to learning at all ages
- Higher employment and income levels compared to LBBB historic
- A thriving local economy.

OUTCOME 5: MENTAL HEALTH AND WELLBEING

- Positive attitudes to mental health
- High levels of good self-reported health
- Low levels of social isolation, and a culture of community cohesion.

... all contributing to

OUTCOME 6: HEALTHY LIFE EXPECTANCY



This page is intentionally left blank

HEALTH AND WELLBEING BOARD

14 March 2017

Title:	Health and Wellbeing Outcomes Framework Performance Report – Quarter 3 2016/17 (October to December 2016)		
Report of the Director of Public Health			
Open Report		For Decision: No	
Wards Affected: ALL		Key Decision: No	
Report Author: Dr Fiona Wright, Consultant in Public Health Medicine, lead author		Contact Details: fiona.wright@lbbd.gov.uk 020 8227 2867	
Sponsor: Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham			
Summary: In order to track progress across the wide remit of the Health & Wellbeing Board, the Board has agreed an outcomes framework which prioritises key issues for the improvement of the public's health and their health and social care services. This high-level dashboard is monitored quarterly by the Board, and this report forms the account of performance at the end of Quarter 3 (to end December 2016) or the latest data available.			
Recommendation(s) Members of the Board are recommended to: <ul style="list-style-type: none"> • 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. 			
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. Added to selected indicators from the Barking & Dagenham Health and Wellbeing Strategy Outcomes Framework are indicators from the Local A&E Delivery Group's Urgent Care Dashboard, as well as information on CQC inspections where the quality of local service provision is highlighted.

2 Structure of the report, and the key performance indicators selected

- 2.1 The following report outlines the key performance indicators for the Health and Wellbeing performance framework. The indicators are broken down across the life course under the following categories:
- Children;
 - Adolescence;
 - Adults;
 - Older people; and
 - Across the life course.
- 2.2 All indicators are rated red, amber or green (RAG) as a measure of success and risk to end-of-year delivery. Any indicator that is RAG rated as 'red' or that has seen a significant change has additional commentary available in Appendix B. Board members should note, therefore, that this means the covering report is focused on poor performance in order to highlight what needs improving, and is not to be taken as indicative of overall performance.
- 2.3 The dashboard is a summary of the important areas from the Health & Wellbeing Board Outcomes Framework. The outcomes framework itself is based on selections from the key national performance frameworks: the Public Health Outcomes Framework; Adult Social Care Outcomes Framework; the NHS Outcomes Framework; and Every Child Matters. Priority programmes such as the Better Care Fund have also been represented in the selected indicators.

3 Performance Overview

Children

- 3.1 The dashboard draws attention to a number of indicators which are performing poorly relative to the targets set where new data is available. These include 'red' RAG ratings for:
- Percentage of Uptake of Diphtheria, Tetanus and Pertussis (DTaP);
 - Percentage of Uptake of Measles, Mumps and Rubella (MMR2) immunisation at 5 years old;
 - Annual health check of Looked After Children;

- 3.2 Appendix B contains further detail on these indicators for Board Members' reference.
- 3.3 In terms of NCMP measures of childhood obesity (Reception and Year 6), finalised data for 2015/16 has been released, and while there are slightly improved figures for those in Reception, children in both Year 6 and Reception have levels of overweight and obesity that are significantly higher than those seen nationally and regionally. Further details can be seen in Appendix B.
- 3.4 The number of children subject to a Child Protection Plan is rated as 'amber'.
- 3.5 It is still not possible to provide a target to 'rate' progress against for the number of children and young people accessing Tier 3/4 CAMHS services. This is due to the lack of national benchmarking information. Performance is currently broadly consistent with previous years.

Adolescence

- 3.6 There remains a 'red' rating for the under-18 conception rate (per 1,000 population) and its percentage change against the 1998 baseline. Additional data is now available for 2015/16 Quarter 2 and can be seen in Appendix B.
- 3.7 There is an 'amber' rating for care leavers 'not in education, employment or training' (NEET).

Adults

- 3.8 There remains a concern about both the performance against the number of four-week smoking quitters and the NHS Health Check performance; both are RAG rated red. Appendix B contains an updated account of actions being taken to address these performance issues.
- 3.9 New data on both Cervical and Breast Screening performance has been released, and continues previous trends, with figures below national averages, but closer in line with regional averages, giving a RAG rating of 'amber'. Further detail can be seen in Appendix A.

Older Adults

- 3.10 The indicators of permanent admissions of older people (aged 65 and over) to residential and nursing care homes, and the level of service provision that follows short term services both remain 'amber'. These continue to be monitored closely for their impact on financial projections in adult social care.
- 3.11 There remains positive performance in injuries due to falls for people aged 65 and over, which is a Better Care Fund measure.

Across the Life Course

- 3.12 There are a number of key indicators that apply across the life course, which include positive, or low-risk performance (and therefore a 'green' or 'amber' rating) for:
- Delayed transfers of care from hospital, which remains a significant national concern but one that is well-managed in Barking and Dagenham;
 - The number of leisure centre visits;
 - The number of children and adult referrals to healthy lifestyle programmes;
 - The percentage of people receiving care and support in the home via a direct payment.
- 3.13 Data on rates of unplanned hospitalisation for chronic ambulatory care sensitive conditions has been updated for 2015/16 (data released 23 February 2017) and this remains a concern.

4 Mandatory implications

Joint Strategic Needs Assessment

- 4.1 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

- 4.2 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

- 4.3 The indicators chosen include those which identify performance of the whole health and social care system, including indicators selected from the A&E Delivery Board's dashboard.

Legal

Legal implications completed by: Bimpe Onafuwa, Solicitor – Contracts and Procurement

- 4.4 There are no legal implications arising from this report

Financial Implications

Financial implications completed by: Katherine Heffernan, Group Manager, Finance

- 4.5 There are no financial implications arising from this report as it is for noting only.

5 List of Appendices

- Appendix A: Performance dashboard
- Appendix B: Performance summary reports
- Appendix C: CQC reports, 2016/17 Quarter 3

This page is intentionally left blank

APPENDIX A

Key

Appendix A: Indicators for HWBB - 2016/17 Q3

..	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		
1 - Children																	
Percentage of Uptake of Diphtheria, Tetanus and Pertussis (DTaP) Immunisation at 5 years old	85.1%	84.4%	83.8%	84.0%	83.3%	85.8%	83.6%	83.0%	..	..	..	↘	R	85.9%	76.8%	1	PHOF
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. Benchmarking data relates to Quarter 2 2016/17.																	
Percentage of Uptake of Measles, Mumps and Rubella (MMR2) Immunisation at 5 years old	82.7%	81.0%	81.2%	80.3%	78.6%	82.4%	80.5%	82.5%	..	..	..	↗	R	87.3%	79.1%	2	PHOF
Benchmarking data relates to Quarter 2 2016/17.																	
Prevalence of children in reception year that are obese or overweight	27.5%					25.4%					..	↘	R	22.1%	22.0%	3	PHOF
Prevalence of children in year 6 that are obese or overweight	40.6%					43.4%					..	↗	R	34.2%	38.1%	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%	76.2%	77.3%	..	..		R	88.0%	90.0%	6	HWBB OF
Benchmark data relates to 2015/16.																	
The number of children subject to Child Protection Plans		320	323	292	253	253	265	271	266	..	..	↗	A			7	HWBB OF
The rate of children subject to Child Protection Plans (per 10,000)	62	54	55	49	43	43	44	45	44	..	..	→	A	43	38	7	HWBB OF
2 - Adolescence																	
Under 18 conception rate (per 1,000 population aged 15-17 years)	34.5	34.5	34.4	..	..	..	..	..	..	..	..	→	R	23.5	21.1	8	PHOF
Data is a rolling 3-year average, with the data presented representing the last quarter of the three year period, i.e. 2015/16 Quarter 2 will represent the time period 2012/13 Quarter 3 - 2015/16 Quarter 2																	
Care leavers in education, employment or training (NEET)		52.0%	43.3%	45.2%	50.2%	48.4%	50.0%	50.8%	52.3%	..	..	→	A	48.0%	53.0%	9	HWBB OF
Benchmarking data relates to 2015/16.																	
3 - Adults																	
Number of four week smoking quitters	635	122	88	131	210	551	191	160	166	..	..	↘	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%					67.9%					..	↘	A	72.7%	66.7%	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.																	
Percentage of eligible population that received a health check in last five years	16.30%	2.56%	2.89%	3.18%	3.20%	11.83%	2.64%	2.67%	2.18%	..	..	↘	R	9.0%	10.7%	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.																	
4 - Older Adults																	
Breast Screening - Coverage of women aged 53-70 years	64.3%					66.5%					..	↗	A	75.5%	69.2%	13	HSCIC
Percentage of women whose last test was less than three years ago.																	

Key

Appendix A: Indicators for HWBB - 2016/17 Q3

..	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		
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes <small>Rates are cumulative throughout the year. Additional benchmark: ASCOF Group - 600.1.</small>	905.9	198.28	452.49	686.36	910.02	910.02	223.70	437.24	615.18	..	..	→	G	628.2	516.5	14	BCF/ASCOF
The outcome of short term services: sequel to service	55.0%					77.5%	58.9%	59.8%	64.9%	..	..	↘	A	75.8%	71.4%	15	ASCOF
Injuries due to falls for people aged 65 and over <small>Directly age-sex standardised rate per 100,000 population over 65 years.</small>	1656.0					..					..	↘	G	2125.0	2253.0	16	BCF/PHOF
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%	70.2%	69.6%	..	..	↘	A	62.1%	67.4%	17	ASCOF
Delayed transfers of care from hospital <small>Benchmarking figure is year to date 2016/17.</small>	135.2	158.0	197.5	213.7	251.8	205.2	185.0	216.1	217.7	..	..	↗	G	429.97	N/A	18	ASCOF
Emergency readmissions within 30 days of discharge from hospital <small>Taken from BHRUT board papers - standard 14.5%.</small>		..	..	..	..	8.99%	..	..	..	..	..	↘	G			19	NHSOF
A&E attendances < 4 hours from arrival to admission, transfer or discharge (type all) <small>Please note this figure is for BHRUT.</small>	85.3%	93.4%	92.3%	86.5%	79.8%	88.0%	81.7%	89.1%	87.1%	..	..	↘	A	95.0%		20	SRG
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	1,015.8					1,099.3					..	↗	R	812.4	714.0	21	NHSOF
The number of leisure centre visits <small>Target 2016/17: 1,490,000. RAG rated amber.</small>	1,282,430	375,338	368,949	340,178	369,460	1,453,925	383,895	371,040	340,089	..	..	↘	A			22	Leisure
The number of children and adults referred to healthy lifestyle programmes		692	753	512	735	2,692	677	620	516	..	..	↘	G			23	Leisure

Appendix B - Performance Summary Reports

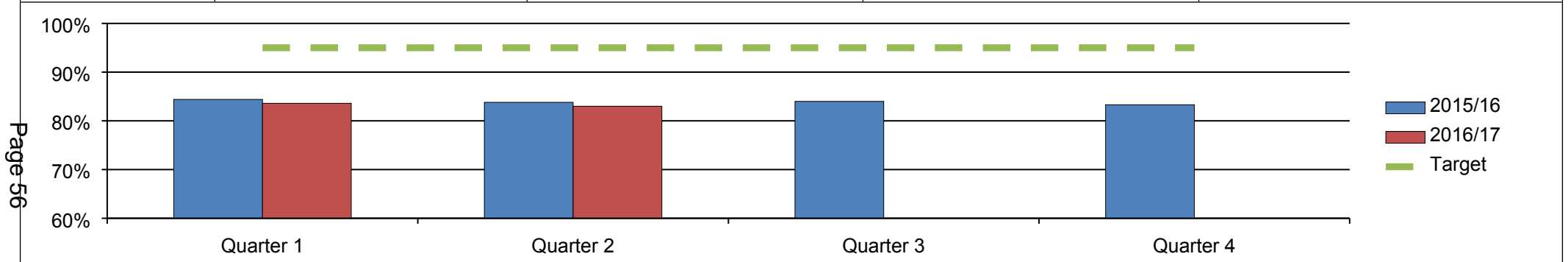
Health and Wellbeing Board Performance Indicators

Meeting date: March 2017, Data: Quarter 2 2016/17

Indicator 1: Percentage uptake of Diphtheria, Tetanus and Pertussis (DTaP)

Source: NHS England

Definition	Percentage uptake of Diphtheria, Tetanus and Pertussis (DTaP) Immunisation at 5 years old.				How this indicator works	The DTaP vaccination booster is given at 3 years and 4 months to 5 years. This is 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	DTaP is a vaccine that helps children younger than age 7 develop immunity to three deadly diseases caused by bacteria: diphtheria, tetanus, and whooping cough (pertussis).						
History with this indicator	2011/12: 82.0%, 2013/14: 83.4%, 2015/16: 85.8%		2012/13: 85.5%, 2014/15: 85.1%		Any issues to consider	Quarter 3 data 2016/17 is expected to be available April 2017.						
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16		84.4%			83.8%			84.0%			83.3%	
2016/17		83.6%			83.0%							



Page 56

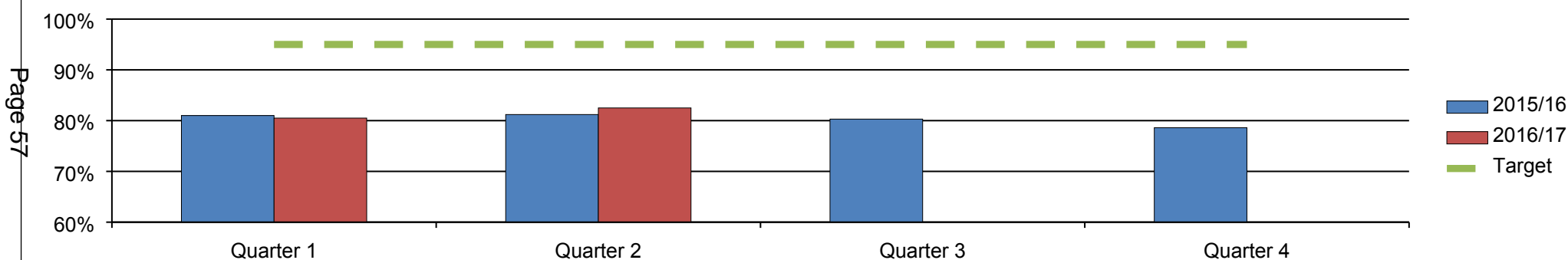
Performance Overview	<ul style="list-style-type: none"> Poor performance is seen across the whole of London with this indicator. Barking and Dagenham are currently performing above the London average but below the national average for England. Low immunisation coverage is a risk to unimmunised children who are at risk of infection from the vaccine-preventable diseases against which they are not protected. 	Further Performance comments	<ul style="list-style-type: none"> Ensure Barking and Dagenham GP practices have access to IT 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 2 2016/17, Barking and Dagenham's DTaP rate (83.0%) was above the London rate (76.8%)		

HWB Performance Indicators
 Indicator 2: Percentage uptake of MMR (measles, mumps and rubella) vaccination
 (2 doses) at 5 years old

Meeting date: March 2017, Data: Quarter 2 2016/17
 Source: NHS England

Definition	Percentage of children given two doses of MMR vaccination by their fifth birthday.	How this indicator works	MMR 2 vaccination is given at 3 years and 4 months to 5 years. This is reported by COVER based on RIO/Child Health Record.
What good looks like	Quarterly achievement rates to be above the set target of 95% vaccination 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%, 2013/14: 82.3%, 2015/16: 82.4%	2012/13: 85.5%, 2014/15: 82.7%	Any issues to consider Quarter 3 data 2016/17 is expected to be available March 2017.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16		81.0%			81.2%			80.3%				78.6%
2016/17		80.5%			82.5%							



Performance Overview	Poor performance is seen across the whole of London with this indicator, and the borough's performance is similar to the London average but below the national average for England.	Further Performance comments	<ul style="list-style-type: none"> Ensure Barking and Dagenham GP practices have access to IT 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	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.		
Benchmarking	In Quarter 2 2016/17, Barking and Dagenham's MMR2 coverage at 5 years was 82.5%, which is marginally above the London rate of 79.1% and below England coverage levels at 87.3%.		

HWB Performance Indicators

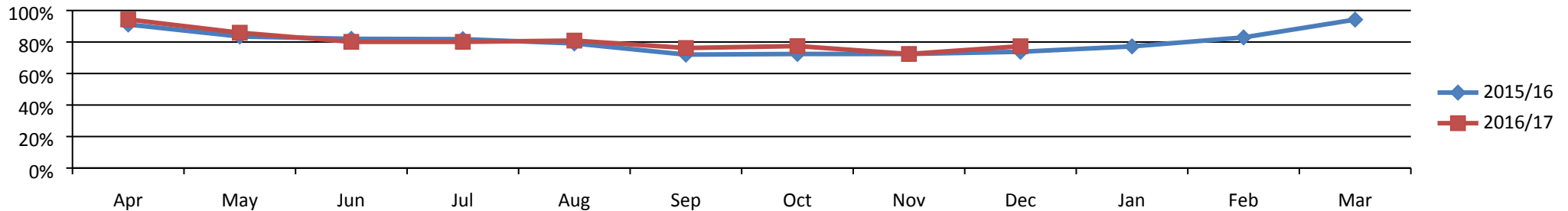
Meeting date: March 2017, Data: Quarter 3 2016/17

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 picture on 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%	72.0%	72.4%	72.4%	73.8%	77.2%	82.9%	94.2%	
2016/17	94.3%	85.9%	80.1%	80.1%	80.9%	76.2%	77.4%	72.4%	77.3%				

Page 58



Performance Overview	In Quarter 3 2016/17, the percentage of looked after children in care for a year or more with an up to date health assessment increased slightly to 77% compared to 76% as at end of Quarter 2. Quarter 3 performance is higher than Quarter 3 2015/16 (77% compared to 74% 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.
RAG Rating			
Benchmarking	Performance on LAC annual health checks exceeded all benchmark data for the last 3 years and remains above national (88%), similar areas (91%) and London (90%) in 2015/16.		

HWB Performance Indicators

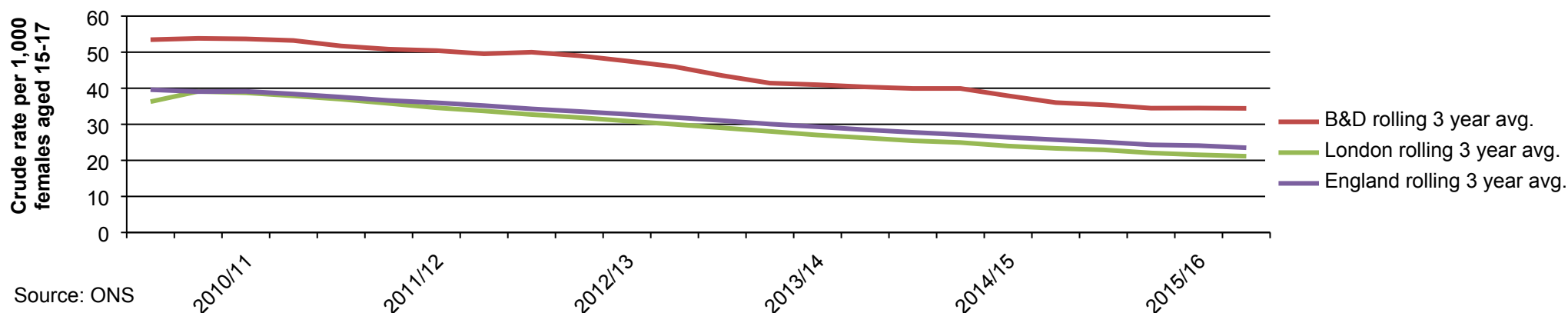
Indicator 8: Under 18 conception rate (per 1,000)

Meeting date: March 2017, Data: Quarter 2 2015/16

Source: Office for National Statistics (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 ONS and refers to pregnancy rate among women aged below 18. Due to low numbers, data has been grouped into rolling 3-year averages, allowing comparisons to be made more easily between time periods, and mitigating seasonal variance.	
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	2012: 35.4 per 1,000 women aged 15-17 years 2013: 40.1 per 1,000 women aged 15-17 years 2014: 32.4 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	37.9	36.0	35.4	34.5
2015/16	34.5	34.4		

Page 59



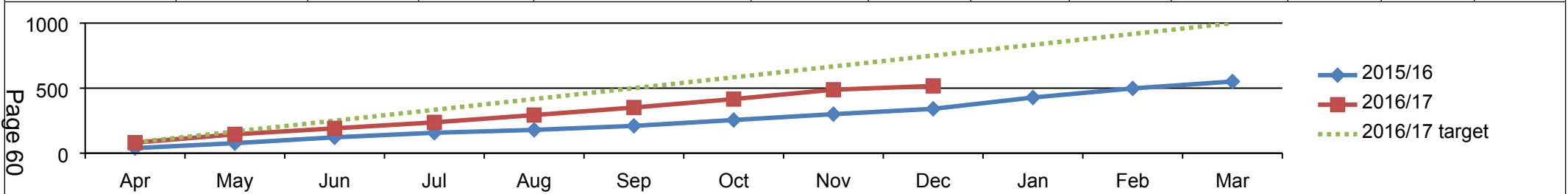
Source: ONS

Performance Overview	The 2015/16 Quarter 2 three-year average for under 18 conceptions fell slightly compared to the previous quarter, dropping by 0.1 percentage points. This is a continuation of the downward trend seen over the past five years. There were 32 conceptions to under 18s in the borough in 2015/16 Quarter 2. Performance remains RAG rated Red as LBBB continues to report a higher annual and quarterly rate of under 18 conceptions compared to national and London. LBBB is ranked 130 out of 151 Local Authorities based on the 2014 annual rate.	Further Performance comments	The gap between B&D and the national and regional averages has been widening over the last three quarters. In 2014/15 Quarter 4, B&D had a rate that was 41.8% higher than the national average. In the most recent quarterly figures (2015/16 Quarter 2), this has widened to 46.5% higher than the national average. This is due to national averages continuing to fall while B&D's have remained fairly stable in the last data periods.
RAG Rating			
Benchmarking	England – 2012/13 Quarter 3 – 2015/16 Quarter 2: 23.5 per 1,000 population aged 15-17 years London – 2012/13 Quarter 3 – 2015/16 Quarter 2: 21.1 per 1,000 population aged 15-17 years		

Indicator 10: Number of smoking quitters aged 16 and over through smoking 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. The annual target for number of quitters is 1,000.	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	<p>2012/13: 1,480 quitters</p> <p>2013/14: 1,174 quitters</p> <p>2014/15: 635 quitters</p> <p>2015/16: 551 quitters</p>	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 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	81	64	46	46	56	58	65	72	29*			



Performance Overview	<ul style="list-style-type: none"> From April to December there were 517 quitters. This is 68.9% achievement of year-to-date target. However, December figures will not be complete until 1st week in February figures due to the time lag of the smoking programme. Although the indicator is still RAG rated as Red, the figures continue to show an improvement in performance on the previous year; we are ahead by 176 quitters relative to December 15/16. 	Further Performance comments	<ul style="list-style-type: none"> Pharmacy continues to have the highest number of quits (210 quits), followed by Tier 3 (199) and then General Practice (108). Tier 3 continue to visit and support general practice and pharmacy in consultation with Public Health The Tier 3 team are currently supporting 12/13 practices, as well as making contact with 15 pharmacies. As a result of the work with GPs, 7 have increased or commenced activity, resulting in 46 people starting the programme who otherwise would not have accessed the service.
-----------------------------	--	-------------------------------------	---

Benchmarking	Between April and September 2016/17 there were 232 self-reported quitters per 100,000 population, during the same period the following boroughs within the North East London Region achieved the following number of quitters per 100,000 population: Redbridge (135), Havering (2), Newham (46), Hackney (342), City of London (863), Waltham Forest (134) and Tower Hamlets (218).
---------------------	--

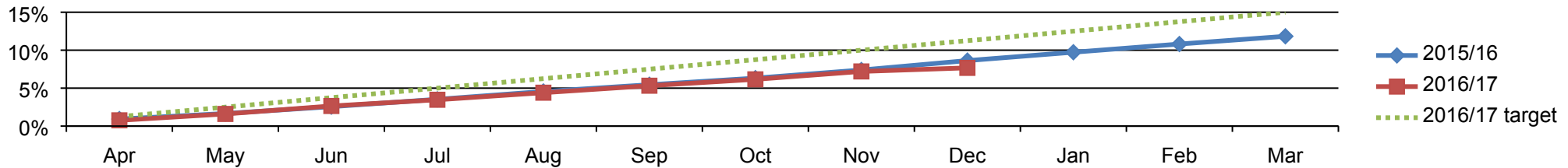
HWB Performance Indicators

Meeting date: March 2017, Data: December 2016

Indicator 12: Those aged 40-74 who receive an NHS Health Check

Source: Department of Health

<p>Definition</p>	<p>The NHS Health Check is a 5-year programme offered to people between the ages of 40 – 74yrs who have not previously been diagnosed with long term conditions, particularly - heart disease, stroke, diabetes, chronic kidney disease and certain types of dementia (eligibility criteria). Depending on the results of the risk score following the assessment, some patients may need to be referred to the relevant lifestyle programme or potentially included on a disease register. Data reporting: Performance as a percentage of the 5-year programme. Time period: April 2016 to March 2017.</p>							<p>How this indicator works</p>	<p>The programme is a 5-year rolling programme, invitations to receive a health check is sent out to 100% of its eligible population over 5 years. Number offered Health Check: 20% - of the population annually (maximum). Number received/uptake Health Check*: 75% - uptake of those offered a health check. *PHE requests that this figure should at least be better than the previous year data.</p>				
<p>What good looks like</p>	<ul style="list-style-type: none"> • Improvement on the previous year's performance. • Increased number of patients invited for a health check • Increased numbers of patients diagnosed with long term conditions. • Increased numbers of referrals made to existing lifestyle programmes. • Measured Targets: 20% invited each year; 75% uptake each year, i.e. 15%. 							<p>Why this indicator is important</p>	<p>The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, and kidney disease. It is a key approach for new patients to be identified and clinically managed with long term conditions to prevent premature deaths; also, to influence lifestyle choices of patients to improve their overall health and wellbeing.</p>				
<p>History with this indicator</p>	<p>2012/13*: 10.0%, 2013/14*: 11.4% received 2014/15*: 16.3%, 2015/16*: 11.8% received <i>*Please note this is a fraction of the 5-year programme where there is an annual target uptake of 15%.</i></p>							<p>Any issues to consider</p>	<p>There is sometimes a delay between the intervention and data capture – this means that the data is likely to increase upon refresh next month*.</p>				
<p>Age</p>	<p>Apr</p>	<p>May</p>	<p>Jun</p>	<p>Jul</p>	<p>Aug</p>	<p>Sep</p>	<p>Oct</p>	<p>Nov</p>	<p>Dec</p>	<p>Jan</p>	<p>Feb</p>	<p>Mar</p>	
<p>2015/16</p>	<p>0.93%</p>	<p>0.73%</p>	<p>0.90%</p>	<p>0.97%</p>	<p>1.03%</p>	<p>0.89%</p>	<p>0.87%</p>	<p>1.07%</p>	<p>1.24%</p>	<p>1.10%</p>	<p>1.08%</p>	<p>1.02%</p>	
<p>2016/17</p>	<p>0.76%</p>	<p>0.83%</p>	<p>1.05%</p>	<p>0.82%</p>	<p>0.93%</p>	<p>0.92%</p>	<p>0.85%</p>	<p>0.84%</p>	<p>0.49%</p>				



<p>Performance Overview</p>	<ul style="list-style-type: none"> • Quarter 3 2016/17 has seen 2.18% of the eligible population receive an NHS Health Check, lower than figures for Quarter 1 and Quarter 2. 	<p>Further Performance comments</p>	<ul style="list-style-type: none"> • Work continues earnestly to link community based programmes to the health check programme by improving the referral pathways. Data capture is poor in relation to the outcomes of this programme, this information is a priority for programme improvement. • Training continues amongst GPs and pharmacists to improve the number of health checks delivered and improve the quality of a health check.
<p>RAG Rating</p>			
<p>Benchmarking</p>	<p>In 2015/16 LBBDD completed health checks on 11.8% of the eligible population. This is above the England and London rates of 9% and 10.7% respectively.</p>		

This page is intentionally left blank

APPENDIX C

Appendix C – 2016/17 Q3 CQC Inspections							
Provider Name	Location	Weblinks	Org Type	Report Date	Inspection Date	Rating	Comments / Summary
Alexander Court Care Centre	RM10 7UU	http://www.cqc.org.uk/location/1-2258796361	Nursing Home	28/12/2016	11/03/2016	Requires Improvement	Safe: Inadequate Effective: Requires Improvement Caring: Good Responsive: Good Well Led: Requires Improvement
Harp House	IG11 9PH	http://www.cqc.org.uk/location/1-189037034	Homecare Agencies	30/11/2016	20/10/2016	Good	Safe: Good Effective: Requires Improvement Caring: Good Responsive: Good Well Led: Good
Kallar Lodge Residential Care Home	RM6 5RU	http://www.cqc.org.uk/location/1-142472420	Residential Homes	15/12/2016	10/11/2016	Good	Safe: Required Improvement Effective: Good Caring: Good Responsive: Good Well Led: Good
Valence Medical Centre	RM8 3RH	http://www.cqc.org.uk/location/1-584952137	Doctors/GPs	13/12/2016	15/09/2016	Requires Improvement	Safe: Requires Improvement Effective: Requires Improvement Caring: Requires Improvement Responsive: Requires Improvement Well Led: Requires Improvement
Dr Goyal & Associates	RM10 9RR	http://www.cqc.org.uk/location/1-537602333	Doctors/GPs	29/11/2016	05/09/2016	Good	Safe: Requires Improvement Effective: Good Caring: Good Responsive: Good Well Led: Good
Ripple Road Medical Centre	IG11 9RS	http://www.cqc.org.uk/location/1-540761669	Doctors/GPs	24/11/2016	16/08/2016	Good	Safe: Good Effective: Good Caring: Good Responsive: Good Well Led: Good
Abbey Medical Centre	IG11 8RJ	http://www.cqc.org.uk/location/1-2793694187	Doctors/GPs	24/11/2016	02/08/2016	Good	Safe: Good Effective: Good Caring: Requires Improvement Responsive: Good Well Led: Good
Sincere Care Limited	RM9 6JR	http://www.cqc.org.uk/location/1-134376322	Homecare Agencies	17/11/2016	21/09/2016	Good	Safe: Required Improvement Effective: Good Caring: Good Responsive: Good Well Led: Good
Abbey Care Home	RM5 2BH	http://www.cqc.org.uk/location/1-362678647	Residential Homes	09/11/2016	24/08/2016	Requires Improvement	Safe: Requires Improvement Effective: Requires Improvement Caring: Good Responsive: Requires Improvement Well Led: Requires Improvement
Dr UA Afser & Dr A Arif 's Practice	RM8 2AJ	http://www.cqc.org.uk/location/1-543545531	Doctors/GPs	14/10/2016	21/04/2016	Inadequate	Safe: Inadequate Effective: Requires Improvement Caring: Good Responsive: Requires Improvement Well Led: Inadequate
Shalom Care	RM10 7QT	http://www.cqc.org.uk/location/1-716658849	Homecare Agencies	14/10/2016	26/08/2016	Inspected but not rated	Safe: Inspected but not rated Effective: Inspected but not rated Caring: Inspected but not rated Responsive: Inspected but not rated Well Led: Inspected but not rated

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

14 March 2017

Title:	Future Health and Wellbeing Board Dates		
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, LBBD	Contact Details: Tel: 020 8227 5071 E-mail: Andrew.Hagger@lbbd.gov.uk		
Sponsor: Cllr Maureen Worby, Chair of the Health and Wellbeing Board, Cabinet Member for Social Care & Health Integration, London Borough of Barking and Dagenham			
Summary: This purpose of this report is to update the Health and Wellbeing Board on the proposed meeting dates for the Health and Wellbeing Board over the coming 18 months.			
Recommendation(s) The Health and Wellbeing Board is recommended to: <ul style="list-style-type: none"> • Note the proposed dates for Health and Wellbeing Board meetings. 			
Reason(s): The Health and Wellbeing is a statutory body required under the Health and Social Care Act 2012. As a partnership body, it is helpful to plan meeting dates well in advance.			

List of proposed dates for the Health and Wellbeing Board

- Tuesday 9 May 2017, 6pm to 8pm
- Wednesday 5 July 2017, 6pm to 8pm
- Wednesday 6 September 2017, 6pm to 8pm
- Wednesday 8 November 2017, 6pm to 8pm
- Tuesday 16 January 2018, 6pm to 8pm
- Tuesday 13 March 2018, 6pm to 8pm
- Tuesday 12 June 2018, 6pm to 8pm

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

14 March 2017

Title:	Integrated Care Partnership Board Update		
Report of the Integrated Care Partnership			
Open Report	For Information		
Wards Affected: ALL	Key Decision: NO		
Report Author: Andrew Hagger, Health and Social Care Integration Manager, LBBB	Contact Details: Tel: 020 8227 5071 E-mail: Andrew.Hagger@lbbd.gov.uk		
Sponsor: Cllr Maureen Worby, Cabinet Member, Social Care and Health Integration, LBBB (Chair of Integrated Care Partnership)			
Summary: This purpose of this report is to update the Health and Wellbeing Board on the work of the Integrated Care Partnership.			
Recommendation(s) The Health and Wellbeing Board is recommended to: <ul style="list-style-type: none"> • Consider the updates and their impact on Barking and Dagenham and provide comments or feedback. 			
Reason(s): There was an identified need to bring together senior leaders in health and social care to drive improvement in urgent and emergency care at pace across the system.			

1 Introduction

1.1 As noted at the meeting of the Health and Wellbeing Board on 31st January 2017, work around the ACO programme has taken stock of the significant progress that has been made in developing the basis for further partnership working. It has also identified immediate steps that can be taken in the coming months to progress the work around health devolution and further integration. This includes the establishment of the Integrated Care Partnership, based around the membership and terms of reference of the former Democratic & Clinical Oversight Group, but with the emphasis on being the new system leadership group for delivery of the programme set out in the Strategic Outline Case.

1.2 The Integrated Care Partnership Board is responsible for:

- overseeing the commissioning and delivery functions (see outline below)
 - the development of Localities in BHR
- 1.3 The Integrated Care Partnership Board is chaired by Cllr Maureen Worby and includes the most senior decision system decision makers. This is supported by an Executive Group, comprised of Executive leaders from each of the BHR partnership organisations, beneath which sits a partnership Steering Group
- 1.4 The following groups will ensure more joined up commissioning and delivery functions across the BHR system and are in the process of being established:
- System Delivery and Performance Board: a partnership group responsible for system level delivery planning and implementation. This groups work will be consistent with the NEL STP including making best use of resources, reducing duplication across the system, consulting upon and agreeing the plans that will enable the system to return to financial balance supported by a robust communications and engagement process and redesigning care and healthcare with an outcome based focus.
 - Joint Commissioning Board: A partnership group which will seek to join up the commissioning of health and care, where possible, by streamlining commissioning, ensuring best utilisation of resource (including a reduction in duplication), and ensuring an outcomes focus with KPIs and outcomes that are complimentary as opposed to contradictory.
- 1.5 A new delivery model comprised of 10 integrated place based localities based on existing GP networks has been agreed and these are each developing at pace against an agreed plan:
- Each of the three BHR Boroughs has established a local leadership group with key stakeholders from across health and care to take forward locality proposals
 - Locality profiles are being developed by Public Health to map need at a local level
 - Key priority areas of focus have been identified based on the challenges and need within each borough and locality and joint commissioning will be a key enabler for this
- 1.7 The Appendices provide action notes form the last 4 meetings of the former Democratic & Clinical Oversight Group and the now Integrated Care Partnership Board.
- 1.8 Regular updates are scheduled at future Health and Wellbeing Board meetings. This update replaces the previous update on the A&E Delivery Board meetings.

List of Appendices

Democratic and Clinical Oversight Group - 4th October 2016

Democratic and Clinical Oversight Group/Integrated Care Partnership - 16th November 2016

Integrated Care Partnership Board – 23rd January 2017

Integrated Care Partnership Board – 27th February 2017



DRAFT ACTION NOTES

Meeting: Democratic and Clinical Oversight Group

Date: Tuesday 4th October 2016

Attendees:

CLlr Darren Rodwell (chair)	DR	London Borough of Barking and Dagenham
CLlr Maureen Worby	MW	London Borough of Barking and Dagenham
CLlr Wendy Brice-Thompson	WBT	London Borough of Havering
CLlr Mark Santos	MS	London Borough of Redbridge
Steve Ryan	SR	BHR CCGs
Vincent Perry	VP	NELFT
Dr Waseem Mohi	WM	Barking and Dagenham CCG
Dr Anil Mehta	AM	Redbridge CCG
Dr Gurdev Saini	GD	Havering CCG

In attendance: Conor Burke, Cheryl Coppell, Anne Bristow, Andrew Blake-Herbert, John Brouder, Barry Jenkins

Apologies: Maureen Dalziel, CLlr Jas Athwal, Nadeem Moghal, Dr Atul Aggarwal, Dr Caroline Allum, Joe Fielder, Matthew Hopkins, Eric Sorensen, CLlr Roger Ramsey, Kash Pandya, Chris Naylor, Richard Coleman, Andy Donald

Agenda item	Summary
Welcome, introductions and	Introductions and apologies noted as above.

apologies	<p>CC outlined the current status of the ACO programme, highlighting progress made developing the SOC and a number of resulting proposals to move forward as follows:</p> <ol style="list-style-type: none"> 1) Establishment of an Integrated Care Partnership Board (ICP) and supporting governance structure. <p>The ICP would further strengthen partnership working establishing explicit joint commissioning arrangements and driving changes through a new delivery model in the form of localities.</p> <p>CC informed the group that Chief Officers had met on the 16th of September, to discuss the DCOG papers and had identified a preferred model for the ICP as set out in the attached papers. The governance paper also set out the opportunity to influence STP development and ensure that democratic leadership for BHR was embedded into STP process.</p> <ol style="list-style-type: none"> 2) Introduce and test new delivery mechanism through the development of the locality model, fast tracking a minimum of one locality in each borough 3) Agree a resource plan, to support delivery of the ACO objectives <p>CC noted that the group's original ambition for full devolution had yet to be achieved and that the system should continue to work with the London Devolution team to explore opportunities.</p> <p>DR opened up the discussion to Councillors. MS stated disappointment that the original level of ambition related to devolution has not been delivered, however MS was clear that further progress must be made, given what has been achieved so far. MS stated that he was happy with the core principle outlined in the governance paper although noted two areas for improvement 1) Health and Wellbeing boards should be incorporated into the structure 2) the current membership does not include Public Health, DCS or Finance representatives. WBT noted concern that that progress had slowed since July and there was a need to push forward with this work. The case for devolution needed to be clearly made with a focus on how devolution benefits residents. MW highlighted the need to focus on what changes will be made at a local level. In addition there was a need to explore joint commissioning opportunities, and that this could start in a small area (e.g. LD), which could be developed in phased manner. MW stated a clear desire to ensure the partnership approach succeeds and continues to progress.</p> <p>DR opened the discussion to health representatives. JB gave a clear statement that NELFT supports the proposals and will continue to work closely with partners to ensure this is delivered. JB noted that significant action was required to offset growing deficits across BHR. CB stated that it was clear that the integrated locality model was the right way to progress, and was happy to hear Councillors supported the ambition to proceed further with plans. It was noted that a locality development session had been held on the 20th of September, involving all partner organisations and GP leads. This session had been successful, displaying a groundswell of opinion amongst GPs in support of developing locality teams to drive a new way of working, this was supported by a statement from Dr Jagen John. CB reiterated the sentiment that the system would need to have ambitious plans for change to deliver</p>
-----------	--

the improved services required for the BHR population. GS highlighted concerns amongst some Havering GPs at the proposed pace and scale of change and that this would require a clear position regarding the overall governance framework and what this would mean for both GPs and the local population. With regard to the locality model; GS noted the need to collaborate closely with local partners and work in a different way, focussing on prevention.

DR noted that these concerns had been raised previously, and asked GP members how willing they would be to consolidate CCG powers into a new integrated body, and what assurance they would require. WM stated that CCG members were not at that stage, with CCG arrangements only in place for three years and that, at present, there was no appetite for significant change to commissioning arrangements. Chairs were willing to discuss new arrangements for jointly commissioning relevant secondary and community care services. WM stated the need for further clarity over the STP governance arrangements and how the BHR fed into these. AM cautioned that there was a risk of disengaging GPs if plans were not managed and communicated appropriately.

AB agreed with CB that there was a clear need for significant change and suggested that work on the locality models should continue, as locality development was not contingent on pooling commissioning arrangements. AB reflected that Boroughs were currently in different places in terms of locality development and the joint commissioning could arrangements could start on a small scale focused around a single area, to understand the implications while making progress. This would form the starting point of a journey towards joint commissioning, but require commitment from all parties. MW highlighted the potential impact that the STP could have on BHR if there was not a clear plan for engagement.

CC added that delivery of the £45M savings, detailed in the ACO SOC, were reliant on finding new ways to work across the system, and that this would need to sit within a framework, that was empowered to make commissioning decision across BHR. CC suggested that the ICP would be the forum for oversight and coordination across BHR.

ABH stated that it was clear that BHR needed to act transformatively in order to deliver improved services for BHR residents. The development of a locality model of care was key to this and needed to be progressed now. Joint commissioning arrangements could follow with a phased model of implementation. Clarity over the end point of the journey was required in order to drive engagement. CB raised the importance of having a unified BHR voice moving forward.

DR noted that London Councils has shown great interest in the progress of the BHR devolution pilot. He was keen to be able to demonstrate to London colleagues that the BHR plans supported health devolution. However, he continued to be concerned about the scale and pace and the extent to which they would achieve a shift to genuine joint decision making.

The group agreed the following:

- 1) The ICP would launch in November (taking on Board the points made in the DCOG meeting)
- 2) Development of fast track localities should proceed, in line with the roadmap.
- 3) Chief Executives should meet in October to agree the resource plan to support this next phase of work

--	--



DRAFT ACTION NOTES

Meeting: Democratic and Clinical Oversight Group/Integrated Care Partnership

Date: Wednesday 16th November 2016

Page 73

Attendees:	Cllr Maureen Worby (chair)	MW	London Borough of Barking and Dagenham
	Anne Bristow	AB	London Borough of Barking and Dagenham
	Andrew Blake-Herbert	ABH	London Borough of Havering
	Cllr Wendy Brice-Thompson	WBT	London Borough of Havering
	Cllr Roger Ramsey	RR	London Borough of Havering
	Cllr Mark Santos	MS	London Borough of Redbridge
	Vicky Hobart	VH	London Borough of Redbridge
	John Brouder	JB	NELFT
	Caroline Allum	CA	NELFT
	Joe Fielder	JF	NELFT
	Matthew Hopkins	MH	BHRUT
	Conor Burke	CB	BHR CCGs
	Dr Atul Aggarwal	AA	Chair, Havering CCG
	Dr Anil Mehta	AM	Chair, Redbridge CCG
Kash Pandya	KS	BHR CCGs	

In attendance: Jane Gateley, James Gregory

Apologies: Maureen Dalziel, Cllr Jas Athwal, Nadeem Moghal, Richard Coleman, Dr W Mohi, Steve Ryan

Agenda item	Summary
Welcome, introductions and apologies	Introductions and apologies noted as above.
Notes from the previous meeting	Notes agreed with no alterations.
Establishment of Governance Structures and development of strategies	<p>JG summarised the content of the governance paper, highlighting the following decisions that needed to be discussed and agreed by the group:</p> <ol style="list-style-type: none"> 1) Agree the governance structure and membership 2) Agree the use of a consistent naming convention 3) Agree to form a Joint Commissioning Board <p>The group discussed the proposed governance structure. ABH advised that he had agreed with the other local authority chief executives that he would take on the joint SRO role previously fulfilled by Cheryl Coppell. In this capacity he agreed to finalise the Local Authority element of the membership. He noted the need to include representation from Public Health, Adult Social Services and Children’s Social Services. It was stated that nominated leads from these areas would act to represent all BHR local authorities.</p> <p>RR noted the current representation of Councillors on the board, and stated a desire to continue to attend the board on an ongoing basis, noting the need to ensure that this aligns with the voting principles established as part of the governance proposal. CB stated the desire to ensure the board maintains strong democratic leadership. JB expressed the importance of ensuring that there is clear ownership from all parties of the decisions made by the board, as this will be crucial in order to deliver the transformation agenda. The group agreed that members would be able to name deputies, to attend board meetings in their absence, however this could not be on an ad-hoc basis. JG raised the proposal to take governance papers to relevant governing bodies. It was agreed that a paper should be prepared for Health and Wellbeing Boards for approval and a briefing paper should be provided for Boards.</p> <p>The group agreed that there should be a consistent naming convention for structures across the Accountable Care programme. JF stated that any name would need to mean something to our population and be relevant and understandable.</p> <p>JG outlined the proposal to form a Joint Commissioning Board in January. CB stated that the intention was to jointly develop the board, defining the purpose and priorities for commissioners across the BHR system. It was noted that there is a need to define what joint commissioning meant, in terms of delivering improved outcomes for the BHR population. MW highlighted the importance of the Joint Commissioning arrangements in delivering the systems ambitions. AB stated the importance of linking the Joint Commissioning Board with existing structures. VH added the need to include work</p>

	<p>carried out by Public Health to define population needs. MH queried the timeline related to the System Delivery and Performance Board, CB stated that this would be developed in the New Year, as the initial priority was to establish the Joint Commissioning Board. The group agreed the proposal to form a Joint Commissioning Board.</p>
<p>Development of fast track localities</p>	<p>JG summarised the fast track locality assessment proposal paper. The proposal outlines a two phase assessment process taking place between December and February, which would allow the board to review and support development of fast track localities. AB noted that the timeline, included in the proposal, was challenging and depending on the expected scale of change, may be difficult to deliver. CB clarified that this was an opportunity for fast track localities to define what they believed could be delivered, and the pace at which that changes happens. MW confirmed that development of fast track localities would be a phased process, which may not happen quickly, however the board should support this process and ensure that momentum is maintained. JF sought assurance that development would build on existing work already completed by the system, CB confirmed that this was the case, and added that all localities would be able to develop at their own pace. CA highlighted the benefit of learning from other organisation, using a Boston based ACO as an example that had identified key points of learning. KP asked if there were clear examples of what localities could and could not do, JG responded that locality proposals should align with the aims of the SOC. The group agreed to communicate with fast track localities, offering them the opportunity to attend the December ICP board meeting to present their vision for their fast track locality model.</p> <p>JG discussed the proposal to fund early stage locality development from the existing programme budget, with a further proposal to fund detailed financial modelling. JF asked if support for this modelling should be sought internally, JG responded that this had been raised at the Chief Executive meeting, but no capacity had been identified. MW requested that this be reviewed, to see if appropriate capacity is available within the system.</p>
<p>Sustainability Transformation Plan</p>	<p>CB updated the group on the current status of the STP. The STP had been submitted on the 21st of October, initial feedback indicates that the plan is seen as ambitious but compelling. Governance arrangements are now being discussed with Local Authority colleagues, led by Rob Whiteman. CB noted that BHR accounted for 42% of the STP population, and that this presented an opportunity to influence ongoing development of the STP, however this would require the BHR system to continue to implement the plans for transformation. MW expressed caution at the potential for delays in the implementation of the BHR plan and urged members to continue development at pace, at the local level. MH emphasised the progress the BHR system had already made in developing integrated working, which has been a priority in the area for five years.</p>
<p>Frequency/time of next meeting</p>	<p>The group agreed the proposal to meet on a monthly basis.</p>
<p>AOB</p>	<p>JF stated the importance of developing a communication plan that highlighted the work being delivered by the system. MW requested that Chief Executives review this, alongside identifying capacity including financial support, at their next meeting.</p>

This page is intentionally left blank



DRAFT ACTION NOTES

Meeting: Integrated Care Partnership Board

Date: Monday 23 January 2017

Page 77

Attendees:

Joe Fielder (Chair)	JF	NELFT
Anne Bristow	AB	London Borough of Barking and Dagenham
Cllr Wendy Brice-Thompson	WBT	London Borough of Havering
Barbara Nicholls	BN	London Borough of Havering
Vicky Hobart	VH	London Borough of Redbridge
John Brouder	JB	NELFT
Andrew Blake-Herbert	ABH	London Borough of Havering
Matthew Hopkins	MH	BHRUT
Kash Pandya	KP	BHR CCGs
Richard Coleman	RC	BHR CCGs
Steve Ryan	SR	BHR CCGs
Caroline Allum	CA	NELFT

In attendance: Jane Gateley, James Gregory, Gina Shakespeare, Jacqui Van Rossum, Tudur Williams, Dr Jagen John, Dr Ravi Goriparthi, Dr Magada Smith, Rachel Royall, Adrian Loades, Debbie Redknapp, Alan Steward, Rita Symons

Apologies: Maureen Dalziel, Cllr Jas Athwal, Cllr Darren Rodwell, , Dr W Mohi, Cllr Maureen Worby, Conor Burke, Cllr Mark Santos, Dr Nadeem Moghal, Dr Anil Mehta, Dr Atul Aggrawal

Agenda item	Summary
Welcome, introductions and apologies	Introductions and apologies noted as above.
Notes from the previous meeting	Notes agreed with no alterations.
System Delivery and Performance Board	<p>GS outlined the purpose of the System Delivery and Performance Board (SDPB), outlining the SDPB board's role in ensuring the BHR system address the underlying financial challenge through 17/18 and beyond. Members agreed the paper and agreed to receive the plan on the 27th of February.</p> <p>JB, Chair of the SDPB noted the strong current level of partnership working across the BHR system, which would be crucial in meeting the significant challenge faced by the system. MH welcomed comments by GS and MH reiterated the importance of strong partnership working, and BHRUT willingness to work with partners to remove demand from secondary care. JF stated the importance ensuring there is clear sense of urgency in delivering this work. AB noted the speed at which work had been developed and the need to review the programme of work regularly.</p>
Development of fast track localities – B&D	<p>Dr John (JJ), Jacqui Van Rossum (JVR) and Tudur Williams (TW) presented the pack (circulated to members), outlining steps taken to date by the locality, plans for further development and areas of focus.</p> <p>SR asked the B&D locality about the progress made against existing informatics issues. JJ responded that this was an ongoing piece of work, with which support was being provided by Rob Meaker (BHRCCGs). This work would include scoping the potential for data sharing agreements between primary care. JF noted the importance of ensuring interoperability between partners as being essential to facilitate more integrated care.</p> <p>MH asked if early diagnosis of Cancer was a locality focus. JJ responded that early Cancer diagnosis was part of an existing LES across all B&D practices. MH asked for what the success would look like for the locality, JJ stated that and that success would be achievement of shared outcomes as defined by the ICPB partners, which would result in improved access and outcomes for patients.</p> <p>ABH asked if a communications plan had been developed. JG noted that this had been discussed at the Chief Executives meeting in December. Rachel Royall (RR) noted that she had been tasked with developing an engagement plan with the NELFT communications Director.</p>
Development of fast track localities – Havering	BN, Alan Steward (AS), JVR and Debbie Redknapp (DR) presented the pack (circulated to members), outlining steps taken to date by the locality, plans for further development and areas of focus. BN noted the need for clarity over access to transformation funds through the STP and how these would be accessed.

	<p>JF noted the need to bring GP practices with us during implementation of the locality work. JJ and AS outlined the steps already taken through the PTI/PTE forum to ensure GPs were fully briefed. RR stated that a benchmarking exercise could take place to understand the extent of GP understanding of the proposals.</p> <p>KP asked if there was a forum for localities to share ideas and experiences. JG noted the ICP steering group which supported this.</p>
Joint Commissioning Board	<p>Adrian Loades updated the group on actions taken to date with regard to the development of the Joint Commissioning Board. It was noted that a development workshop would be held on the 13th of February to confirm the scope and benefits of the Board. A further report would be provided at the ICPB on the 27th of February.</p>
CEO update	<p>MH updated the ICPB on the discussion which took place at the Executive Group meeting. The SDPB, JCB and communications support had already been noted during the meetings.</p> <p>MH outlined discussion on the STP governance proposals, noting partners had raised issues with the STP, through a letter which had been circulated. MH stated that the financial challenge facing the NELSTP would be discussed at a meeting with NHSE on the 1st of February (Jane Milligan would represent the STP). MH stated that activity related to the STP would be ramping up over coming months.</p> <p>JF noted that some Chairs had met with Rob Whiteman and those present were fully behind efforts to meet the existing system wide challenge, and were working closely with Chief Executives to progress this work. He also called for the increased involvement of chairs and a greater clinical input to the overall governance of the programme.</p>
Time of next meeting	27 th February 2017
AOB	AOB

This page is intentionally left blank



DRAFT ACTION NOTES

Meeting:	Integrated Care Partnership Board		
Date:	Monday 27 February 2017		
Attendees:	Maureen Worby (Chair)	MW	London Borough of Barking and Dagenham
	Joe Fielder	JF	NELFT
	Anne Bristow	AB	London Borough of Barking and Dagenham
	Cllr Wendy Brice-Thompson	WBT	London Borough of Havering
	Cllr Mark Santos	MS	London Borough of Redbridge
	Vicky Hobart	VH	London Borough of Redbridge
	John Brouder	JB	NELFT
	Andrew Blake-Herbert	ABH	London Borough of Havering
	Maureen Dalziel	MD	BHRUT
	Conor Burke	CB	BHR CCGs
	Richard Coleman	RC	BHR CCGs
Dr Anil Mehta	AM	BHR CCGs	
Caroline Allum	CA	NELFT	
In attendance:	Jane Gateley, Caroline Maclean, Keith Cheesman, Jason Seez, Dr Magda Smith, Sarah See, Marie Price		
Apologies:	Cllr Jas Athwal, Cllr Darren Rodwell, Dr W Mohi, Cllr Mark Santos, Dr Nadeem Moghal, Dr Atul Aggrawal, Kash Pandya, Steve Ryan, Matthew Hopkins, Cllr Roger Ramsey, Barbara Nicholls		

Agenda item	Summary
Welcome, introductions and apologies	Introductions and apologies noted as above.
Notes from the previous meeting	Notes agreed with no alterations.
System Delivery and Performance Board	<p><u>Terms of Reference</u> JB outlined the Terms of Reference. JG advised Dr Gurdev Saini had agreed to jointly chair the SDPB with JB. Following discussion it was agreed the terms needed some further refinement to reflect a more balanced system focus (potentially with a phase 4 being added that showed the shift from May 2017) and took account of public health input. It was agreed that this could be done via email. JG agreed to recirculate the Terms of Reference to AB, CM, KC and VH for their suggested amendments ahead of the next SDPB on 15 March.</p> <p>Members approved the SDPB Terms of Reference in principal subject to the above and agreed a revised version should come back to the next meeting.</p> <p><u>System Delivery Plan</u> JB outlined the latest version of the plan and the approach taken by the SDPB. A number of issues were highlighted through the discussion:</p> <ul style="list-style-type: none"> - A need for descriptors to be added for each scheme within the plan to enable a better understanding (SDPB to action) - The potential inconsistency of the ask for this plan given the work and financial strategy outlined in the ACO SOC - The need for better alignment of the communications plan across stakeholders and strong communications to residents <p>CB advised that he and MH had had a number of discussions with regulators and had been challenged about the inconsistency of the relationship between Trust and CCGs. CB and MH suggested an independent review be carried out to support the development of the relationship particularly at Board level.</p> <p>Members agreed the System Delivery Plan for submission to NHS England and NHS Improvement on 28 February 2017 recognising the status as work in progress.</p>
Joint Commissioning Board	CB advised that he and AL had held a successful workshop in February with colleagues. There was agreement to establish a Joint Commissioning Board from April and a number of areas had been identified for initial priority focus.
CEO update	ABH advised the CEOs had met last week. Discussion had focused on items covered elsewhere on this agenda.
London Devolution	ABH fed back on the last Programme Board meeting in February. He highlighted the discussions focussed on the sugar levy (due to go the Treasury in year 1 and thereafter potentially London) and the London estates programme which aimed to secure the ring fencing of London capital receipts for

Programme Board	London. Since the meeting the London Devo team have advised the public announcement is likely to take place the week beginning 13 March. CEOs at their meeting on 1 March will agree attendance.
Sustainability and Transformation Plan	CB advised the STP governance architecture was continuing to be established and the STP mechanism remained as the only route to secure transformation funding. MW asked ABH as the BHR Local Authority representative on the STP Board to request a response from Rob Whiteman to the letter sent to him from the three council leaders.
Time of next meeting	27 th March 2017 – 5pm - Committee Room 2, Town Hall, 1 Town Square, Barking, IG11 7LU
AOB	None

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

14 March 2017

Title:	Sub-Group Reports	
Report of the Chair of the Health and Wellbeing Board		
Open Report	For Information	
Wards Affected: NONE	Key Decision: NO	
Report Authors: Andrew Hagger, Health and Social Care Integration Manager, LBBD	Contact Details: Telephone: 020 8227 5071 E-mail: Andrew.Hagger@lbbd.gov.uk	
Sponsor: Councillor Maureen Worby, Chair of the Health and Wellbeing Board		
Summary: At each meeting of the Health and Wellbeing Board each sub-group, excluding the Executive Planning Group, report on their progress and performance since the last meeting of the Board. Please note that there have been no meetings of the Learning Disabilities Partnership Board or Public Health Programmes Board since the last meeting of the Health and Wellbeing Board so there are no updates for these groups.		
Recommendations: The Health and Wellbeing Board is asked to: Note the contents of sub-group reports set out in the appendices and comment on the items that have been escalated to the Board by the sub-groups.		

List of Appendices

Appendix 1: Integrated Care Sub-Group report and appendices

Appendix 2: Mental Health Sub-Group report

Appendix 3: Children & Maternity Sub-Group report

This page is intentionally left blank

Barking and Dagenham Integrated Care Health and Wellbeing Sub Group

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

<p>Items to be escalated to the Health & Wellbeing Board</p> <p>None at this stage</p>
<p>Performance</p> <p>N/A</p>
<p>Meeting Attendance</p> <p>Members:</p> <ul style="list-style-type: none"> ▪ Sharon Morrow, B&D CCG ▪ Dr J. John, B&D CCG Clinical Director ▪ Mark Tyson, LBBB ▪ Melody Williams, NELFT ▪ Tudur Williams, LBBB Adult Social Care ▪ Susan Lloyd, Public Health, LBBB ▪ Sarah D'Souza, B&D CCG ▪ Bas Sadiq, BHRUT ▪ Ann Graham, LBBB ▪ Dr Goriparthi, B&D CCG ▪ Sandeep Prashar, Public Health, LBBB <p>Attendees:</p> <ul style="list-style-type: none"> ▪ Jane Gateley, BHR CCGs ▪ Rita Symons, NELFT ▪ Sarah Perman, BHR CCGs ▪ Monga Mafu, B&D CCG ▪ Emily Plane, BHR CCGs
<p>Action(s) since last report to the Health and Wellbeing Board</p> <p>Since the last report to the health and wellbeing board, three meetings of the Integrated Care Health and Wellbeing Board sub group have taken place including an extended meeting in workshop format. The primary focus of these meetings has been the development of proposals to take forward the establishment of the locality model of care in Barking and Dagenham. This model will aim to deliver more seamless health and care to the people of B&D, with the primary aim of improving health and wellbeing, as well as helping to address some of the system challenges identified in the BHR Devolution Strategic Outline Case.</p>
<p>Action and Priorities for the coming period</p> <p>We have received updates through the ICSG meetings on the progress which individual organisations (primarily NELFT and LBBB Adult social care as well as General Practice- through the development of GP networks which are coterminous with the locality</p>

footprints) have made towards reconfiguring their services around the three Barking and Dagenham localities. Going forward, meetings will focus on how we can build on this progress to create a more integrated model of care which will include wider links with the community and voluntary sector. Public health are in the process of developing profiles at Locality level to enable the reconfigured teams to weight their service provision based on need, and this process will also enable more informed discussion about the types and level of service required within each locality to meet the needs of the people living there. By working together we will aim to use the resources available to us more intelligently to deliver high quality care and support in a time of constrained finances.

Key next steps on the agenda for the ICSG include:

- Development of health and care profiles at locality level
- Development of a prevention strategy around the locality model which will seek to describe how the locality model will be the delivery mechanism through which the B&D health and wellbeing strategy prevention agenda is delivered
- Working with health and care staff as well as wider groups with influence over the wider determinants of health to develop proposals to take forward/ establish the locality model
- A strong programme of engagement will be required/ developed to ensure that the model can be truly co-designed with staff, our population and other key stakeholders

NOTE: the locality model of care has been developed by BHR partners through the Integrated Care Partnership group's Devolution agenda and forms the BHR element of the north east London Sustainability and Transformation plan.

Action notes for the following ICSG meetings are attached for information:

- Attachment 1 - Action notes_ICSG_28 11 16
- Attachment 2 - 12.12.16 Workshop Write up
- Attachment 3 – BD Locality Development ICP_23 01 17 2 (*meeting with a focus on developing the presentation for the Integrated Care Partnership Group on 20.01.17*)

The next meeting will take place on 13.03.17 with a focus on; feedback from the presentation to the Integrated Care Partnership meeting on 20.01.17 and next steps for locality development in Barking and Dagenham

Contact:

Emily Plane, Project Manager, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

Tel: 0203 182 2965; **Email:** e.plane@nhs.net

DRAFT ACTION NOTES

Meeting:	Barking and Dagenham Integrated Care Health and Wellbeing Sub Group (ICSG)
Date:	28 November 2016
Attendees:	Dr J. John, Sharon Morrow, Melody Williams, Tudur Williams, Susan Lloyd
In attendance:	Jane Gateley, Rita Symons, Sarah Perman, Monga Mafu, Emily Plane
Apologies:	Sarah See, Toby Young, Ann Graham

Page 89

Agenda item	Summary
Welcome, introductions and apologies	Introductions and apologies noted as above.
Action notes from the previous meeting	<p>The group reviewed the action notes from the previous meeting. The notes were recorded as an accurate reflection of the discussion.</p> <ul style="list-style-type: none"> ▪ Action log number 4: TW updated that he will liaise with LBBB colleagues to ensure that the correct mix of commissioning and provider leaders from LBBB are around the table of this group (TW will test attendance of Chris Bush and Mark Tyson)
Accountable Care System / Devolution	<p>Update on locality development: SM recapped on the locality development progress to date in B&D including that locality 3 has been identified as the locality which will 'go live' slightly ahead of the other localities in B&D and share the learning from establishment of the model. There is a need to ensure consistent naming of localities with GP networks; Action: Sarah Perman to feed this back to Sarah See to ensure that there is consistent naming to prevent confusion. Drs Kalkat and John will be the CCG GP clinical leads for this locality, with NELFT and Social Care clinical leads to be confirmed.</p> <p>Next steps and support for development: Jane Gateley provided an overview of the emerging system governance structure under the leadership of the Integrated Care Partnership (previously known as the Integrated Care Coalition and then the Democratic and Clinical Oversight Group). Development of the Strategic Outline Case has made a clear case for the benefits of the locality model of care from both national and international best</p>

practice alongside clear feedback from our population and those that work in health and care in BHR who have reported that they find artificial organisational barriers and sometimes conflicting priorities can make it more difficult to deliver high quality care. A Joint Commissioning Board is being developed to bring together health and care commissioners at a more strategic level to try to address some of the issues around conflicting priorities and duplication of commissioning. One of the future responsibilities of this Board could be to commission new models of care such as localities.

Integrated Care Partnership leaders from across BHR which includes both clinical and democratic leadership from all eight of the partner organisations have, based on the evidence and feedback from the engagement work, agreed in principle to support the fast track localities as much as possible to respond to the issues highlighted through the SOC engagement work and to address some of the key health and wellbeing, care and quality and efficiency challenges facing the BHR system. As such ICP members have extended an invitation to locality Leadership teams to attend the ICP meeting in either December or January to discuss in more detail; the high level vision, commitment of local leaders to the establishment of the model, and resource required to do this.

Jane was clear that the process is not set in stone and localities are free to progress at the pace at which they feel is achievable to ensure the success of the roll out of the model.

As part of the discussion around locality development, Dr John noted that consideration will be given to support for nursing homes along with the implications of the new model and workforce arrangements for Integrated Case Management.

The group discussed the progress that each individual organisation/group has made to prepare for locality working; as part of this discussion Dr John confirmed that GPs are now part of developing networks of practices, aligned to the locality model (three networks geographically aligned to the localities). NELFT are reviewing their current service provision to identify which services could be provided at locality, borough and BHR level to ensure economies of scale; this work will provide a clear core service offer for each level. MW was clear that NELFT will require access to dedicated resource to support any reconfiguration. The group feel that by April 2017 based on the work already underway, Primary Care, NELFT and LBBB will be reconfigured into a model that will support the delivery of health and care in the three localities in B&D.

The group discussed the PTI in December which could potentially be used to discuss the development of networks and the locality model. MW was asked to attend the meeting to discuss the way in which NELFT are reconfiguring their workforce to support the locality model and what the core service offer at locality, borough and BHR level could potentially be.

The group discussed the offer of attending the ICP and agreed that the next key step for B&D locality development is a workshop which will take place on 12 December (using the time previously held for the next ICSG meeting) which Rita Symons offered to facilitate. The group therefore agreed that it will be appropriate for leaders from the B&D locality development team to attend the ICP in January 2017.

Actions agreed regarding the workshop on 12/12:

- EP to extend the length of the next ICSG meeting to enable time for a locality workshop to take place

	<ul style="list-style-type: none"> - EP to invite additional leads including Jacqui Van Rossum (NELFT), Bas Sadiq (BHRUT), Anne Bristow and Mark Tyson (LBBD), Drs Hara, Goriparthi and Kalkat - EP to work with RS to develop a draft agenda and supporting information pack
Identifying locality priorities <ul style="list-style-type: none"> ▪ Locality profiles <ul style="list-style-type: none"> ○ Impact of merged practices ○ Locality maps ○ Locality profile outline ▪ Right Care opportunities 	<p>The group touched on the impact of merged practices and Dr John updated that some practices along locality borders have moved to ensure that the size of the localities is more equitable. Action: Dr John agreed to share the updated practice list within each locality with Melody, Sue Lloyd and Emily within the next two days.</p> <p>Action: Sue Lloyd agreed to try to incorporate the right care opportunity information in the locality profiles.</p> <p>Due to time constraints as a result of the focus given to a frank discussion about locality development during the meeting, full discussion of this agenda item will be deferred to the next meeting.</p>
Update on LBBD configuration	Deferred to the next meeting
Healthy New Towns/ Barking Riverside update	No new updates noted; item will be discussed at the next meeting
Any other business	None noted

ICSG Action Log				
Meeting Date: 10 October 2016		Lead	Due	Done
1	EP to share the slides from the 20 September workshop	EP	10/10	Complete
2	SL to review timelines for completing this - probably by end of November	SL	Nov	Complete
3	SL to share the first cut of the draft locality profiles as soon as possible	SL	Nov	Complete
4	TW to test this approach with LBBD colleagues <i>Update 28/11: TW updated that he will liaise with LBBD colleagues to ensure that the correct mix of commissioning and provider leaders from LBBD are around the table of this group (TW will test attendance of Chris Bush and Mark Tyson)</i>	TW	12/12	In progress
5	TW to share an impact assessment that has been completed. Will share various documents next week	TW	17/10	In progress
6	Barking Riverside to be a standing item at the ICSG meetings going forward	SM/EP	Nov	Complete
Meeting Date: 28 November 2016		Lead	Due	Done
7	Sarah Perman to feed back to Sarah See the need to ensure that the naming of networks and localities is consistent to avoid confusion e.g. 'locality 1' should also be 'GP network 1'	Sarah Perman	12/12	
8	EP to extend the length of the next ICSG meeting to enable time for a locality workshop to take place	EP	29/11	Complete
9	EP to invite additional leads including Jacqui Van Rossum (NELFT), Bas Sadiq (BHRUT), Anne Bristow and Mark Tyson (LBBD), Drs Haha, Goripathi and Kalkat	EP	29/11	Complete
10	EP to work with RS to develop a draft agenda and supporting information pack	EP/RS	12/12	In progress
11	Dr John agreed to share the updated practice list within each locality with Melody, Sue Lloyd and Emily within the next two days	Dr John	30/11	
12	Sue Lloyd to incorporate the right care opportunity information in the locality profiles	SL	12/12	In progress



Barking and Dagenham Locality Development Workshop

SUMMARY OF DISCUSSION

12 December 2016



Background and attendees

At the Integrated Care Health and Wellbeing Board Sub Group meeting on 28th November the group agreed to extend the next meeting of the group, planned for Monday 12th November to take place in workshop style to enable in depth discussion around;

- ✓ Setting the scene
- ✓ Vision
- ✓ Reality
- ✓ Commitment to developing the new model and resource requirements
- ✓ Next steps

Invitations to the group were extended to Jacqui Van Rossum (NELFT), Bas Sadiq (BHRUT), Anne Bristow and Mark Tyson (LBBD), Drs Hara, Goriparthi and Kalkat.

The workshop was facilitated by Rita Symons, NELFT.

Workshop attendees (12/12/2016) included:

- | | |
|---------------------------|-----------------------------------|
| ▪ Sarah D'Souza (B&D CCG) | ▪ Dr J John (B&D CCG) |
| ▪ Mark Tyson (LBBD) | ▪ Dr Goriparthi (B&D CCG) |
| ▪ Tudur Williams (LBBD) | ▪ Sharon Morrow (B&D CCG) |
| ▪ Melody Williams (NELFT) | ▪ Sue Lloyd (Public Health) |
| ▪ Jane Gateley (BHR CCGs) | ▪ Sandeep Prashar (Public Health) |
| ▪ Bas Sadiq (BHRUT) | ▪ Monga Mafu (B&D CCG) |
| ▪ Ann Graham (LBBD) | ▪ Emily Plane (BHR CCGs) |

The following pages reflect the discussion at the workshop and agreed next steps to take forward locality development

Setting the scene

Mark Tyson provided an update on the background to locality development including development of the Strategic Outline Case for BHR to test the benefits of devolution.

A lead from each organisation then provided an update on thinking and progress to date to align workforce to localities as follows:

Melody Williams; NELFT

- Clinical leads and operational staff within NELFT have come together to undertake a review of the service provision in B&D including which services could be provided at **locality, borough and system** (BHR) level to ensure economies of scale; this work will eventually provide a clear core service offer for each level. They have begun to scope how this could work operationally within the current contractual framework
- NELFT will require access to dedicated resource to support any reconfiguration and may have to undertake a staff consultation (between 30 – 90 days) due to the subsequent changes to working locations (with the move from 6 clusters to 3 localities) and caseloads. Any changes would have to be phased rather than big bang
- NELFT's preference is a 'cradle to grave' approach which will ensure the delivery of more seamless care
- Through these discussions NELFT have identified a number of key benefits of the new way of working including increased clinical time with patients, better use of resources and providers working together to address the needs of a defined population. Trusted assessor agreements may begin to develop through relationships born of co-location and recruitment and retention may also be improved
- The next step will be reviewing 'need' by locality through the locality profiles and weighting services in each locality based on the level of need
- The below diagram shows *current thinking* (which may be subject to change) around which services could be provided at each level:

Locality level services (current thinking);

- Community Health and Social Care Service
- Universal children's' functions (school nursing / health visiting etc.)
- Talking therapies (IAPT)
- Community recovery services (mental health)
- Some therapy services in the future (e.g. SALT)

Borough level services (current thinking);

- Access and brief intervention team (mental health); as the locality develops there is the possibility of this moving to localities
- Adult and memory services
- Perinatal infant mental health
- Eating disorder services

System level services (current thinking);

- Walk in Centre
- Community Treatment Team
- Intensive Rehab Service
- Community Rehab Beds

Tudur Williams; LBBD

- LBBD are in the process of reconfiguring their social care services and have just completed a staff consultation and are in the process of responding to the comments received through this process
- This will include a degree of centralisation of some services e.g. central business unit/ information to ensure greatest efficiency
- Focus on ensuring that social workers on the ground have a greater proportion of clinical/face to face time with service users. It has become apparent that social workers have been picking up a lot of work that does not necessarily need to be undertaken by a qualified social worker; to ensure that best use is made of qualified social workers' time, Care Navigator roles are being created, this will strengthen the role of social workers to focus on longer term, complex case management
- The OT service needs some reorganisation as not currently as efficient as it could be

Locality level services (current thinking);

- 4 social workers
- Locality manager
- Consultant social worker role

Borough level services (current thinking);

- Central business unit
- Assessment team

Dr John; GP Networks

- Dr John confirmed that GPs are now part of developing networks of practices, aligned to the locality model (three networks geographically aligned to the localities)
- As well as Dr John, Drs Kalkat, Hara and Goriparthi are GP Network leads for the 3 networks in B&D
- An extraordinary PTI meeting will be taking place tomorrow (13/12) to explore the development of networks and localities in greater detail
- Dr John noted that there are two GP Federations in B&D which are essentially provider networks design to enable the delivery of primary care at scale
- GPs on the ground are aware of the developments around localities and networks but not necessarily how this will work in practice e.g. the impact on ICM

Bas Sadiq; BHRUT

- Clinicians aware of developments in the community but not of the detail
- Need to be sure to communicate information at the right time in the right way; JG noted ICP meeting this pm will discuss Comms support from January 2017

The group feel that by April 2017 based on the work already underway, Primary Care, NELFT and LBBD will be reconfigured into a model that will support the delivery of health and care in the three localities in B&D.

Group discussion; the locality vision for B&D



The group considered their 'dream' vision and aspirations for B&D responding to;

- What do I want
- What is my vision
- What are the benefits

The Dream; key themes

- **Whole system should be joined up** and consider health in its broadest terms (everyone should refer to 'our patients' and 'our targets'), with a strong **focus on outcomes** for our population. There should be no bouncing people around the system, everyone who works in health and care and the third sector should feel responsible for each person using our services/living in B&D
- **Integrated care organisation** to remove all issues that arise from multiple organisations delivering care to the same people; this would also increase productivity and efficiency and remove duplication
- People should be supported to be as happy as possible, be **proud to live and work in B&D** and want to work here (recruitment and retention issues solved). This would include GPs who don't want to retire early due to workload pressure and a reduction in pressure on all staff
- People in B&D should **live longer and be healthier** for longer (longer life and healthy life expectancy)
- **Work much more closely with the community and voluntary sector and wider community** to enrich peoples lives and ensure that they are fully supported and that everyone has a say in the design of services
- **Simple and easy to use system** so that both our population and staff know the right service to access, first time
- Support people to be **independent** as much as possible
- Embed **prevention** in all services
- Patients/service users feel **empowered**
- **Address poverty** and improve the number of those with **qualifications**, going into well paid work with high aspirations
- Develop a **strong and joined up IT platform** so that all services (subject to the right controls) can access a persons information when needed to greatly improve the care and treatment of that person
- Have **access courses** and **training locally** to enable people to go into nursing or social care etc.
- Support the people of B&D to reach their **full potential**
- **Reduce workloads** of clinical staff (burden of bureaucracy)
- **Freedom and time to think/innovate and effect change**, especially for front line and operational staff, as well as patients/community and voluntary sector
- **Parity of esteem for both physical and mental health** through the locality model
- Utilise **new technologies**
- **Improving the culture** of those working in B&D; people to have positive attitudes and believe that they can make a difference
- **Make best use of estate**

Group discussion; the locality vision for B&D



The group considered the 'reality' of the current situation in B&D, responding to;

- How long will the dream take
- Who needs to be involved
- What steps do I need to take this forward
- How far away are we

Reality; key themes

- Need to develop clear milestones for the next 5 years and then longer term; will need plans with timeframes from each organisation and bring these together into a master plan for B&D
- Frontline/operational staff along with the community and voluntary sector and the public need to be involved in the development of the model
- If we are talking about radical change, need to create the space for people to think about this and make it happen
- There is a Borough Manifesto which has been developed by the local authority with partners from across BHR; should we use this opportunity to feed the locality vision into this document that will then be shared with all partners to seek ownership
- Will need to bring locality teams together on an ongoing basis to develop the proposals / design how the locality will operate in practice and support establishment of the model
- Page 97 Noted that we do trust our partners but the way that we work is different and we each have different (and sometimes competing) priorities and rules governing us which makes full cooperation difficult at times; noted therefore that to establish successful localities based upon trust, would need one form of regulation for the locality as a whole. JG noted that the joint commissioning in board in development under the BHR Integrated Care Partnership may go some way to address this
- Need to take this opportunity to propose local leadership to take forward the locality model in B&D; need strong local leadership to ensure that there is a strong link and dialogue between leadership and operational staff
- Important that time and resource is dedicated to developing local leadership
- Need to discuss and agree how to engage with the community and voluntary sector going forward and include them in locality development discussion. EP noted that the ICP initiated a programme of engagement with the community and voluntary sector through the development of the Strategic Outline Case which was well received and created some positive momentum to support closer and better ways of working; another workshop in the series is planned to take place around February 2017. The group agreed that they need to give some thought to the inclusion of a community and voluntary sector voice in the discussion around locality model development in B&D. In addition LBBDD have commissioned Locality Matters to map community assets in the Gascoigne area and to explore how to mobilise these assets to support the locality model of care
- Dr John noted that Health 1000 did develop a joint care plan so there is some learning to be taken from this. The group also noted that there is a lot of care plan sharing for the most vulnerable across the patch, but we need to develop a solution that works to improve the delivery of care for the whole population; a joined up IT solution for everyone. Noted that the local authority are about to go out to procurement for a new IT system, NELFT have just procured an updated IT system and GPs work on three different systems but EMIS seems to be the most prevalent. One of the key barriers to information seems to be information governance rules rather than technology. Locality model development is a chance to see if we can work together to address this and test a joined up care plan in B&D providing that the relevant safeguards are in place.

Group discussion; Resourcing Requirements



The group discussed the resourcing required to take forward further development of the vision, along with development of the plan and establishment of the model.

The group will be required to update the Integrated Care Partnership on the resources required to take this forward when attending their meeting (possibly 23 January) to update on progress in B&D.

Resourcing discussion key points

- Acknowledge that more likely to receive support in the form of people rather than money although noted that there will be a requirement to backfill clinical time for GPs
- Commissioning; discussion is underway to develop a Joint Commissioning Board
- Project support (half of EP's time offered to B&D to support development of the model)
- Service manager – NELFT
- Social Care manager – LA (adults and children)
- BHRUT; FD to provide support
- Support for primary care development from CCG to be reviewed
- Intelligence which needs to be aligned to the intelligence being produced for the other boroughs and feeding up into the BHR system and the wider STP
- Communications support required; JG noted that the Integrated Care Partnership are going to discuss the Communications support for the programme in January 2017
- Noted that although LBBD adult services are in the process of reconfiguring, children's services are yet to take this step which will need to take place to allow alignment with the locality model

Agreed actions / next steps

Key messages:

- ✓ Big dreams
- ✓ Collective leadership
- ✓ Consensus Re localities and the benefits of coterminous working
- ✓ Borough Manifesto as the route to develop and share the locality vision
- ✓ Localities agreed / good progress on plan
- ✓ Willingness to resolve IG issues and test joined up information/IT systems
- ✓ Clear confidence between partners that this model is the right direction of travel and is deliverable

Actions/next steps agreed:

13	B&D localities need names, not numbers to avoid confusion and need to work together on a shared language; 'ours' not 'my' etc.	All	23/01	
Page 99	Once locality profiles are completed, NELFT will review the level of need within each locality and weight service provision in each locality accordingly	All	Subject to completion of locality profiles	
	Tudur Williams and Melody Williams to meet to discuss how to align the NELFT and Social Care reconfiguration processes; there are clear plans for each organisation/partner at the moment in terms of re-aligning to the three localities; we need to bring these plans together	TW/MW	23/01	
16	Need to develop a prevention strategy to be embedded in the locality model	All	23/01	
17	Need to consider how to engage with the community and voluntary sector in the development of the locality model at a B&D level	All	23/01	
18	EP to share the realising the value' document with the group	EP	13/12	Complete
19	Seek to include the locality vision in the B&D borough manifesto document which can then be used to communication the vision going forward	All	23/01	
20	Establish a plan for Leadership development	All	23/01	
21	Need to prepare for the B&D update to the Integrated Care Partnership Group meeting in January 2017	All	23/01	
22	Bas to check with BHRUT RE who can support development of the locality model in B&D from their organisation	BS	02/01	
23	JG to share how the Redbridge discussion on locality development goes at the Integrated Care Partnership meeting this evening	JG	20/12	

This page is intentionally left blank



Barking and Dagenham Locality Development

23 January 2017



Barking and Dagenham has a well established partnership group which is driving and overseeing development of the locality model; the Integrated Care Health and Wellbeing Board Sub Group.

This group has well established links with the B&D Health and Wellbeing Board and provides regular updates on progress.

Membership of the group includes:

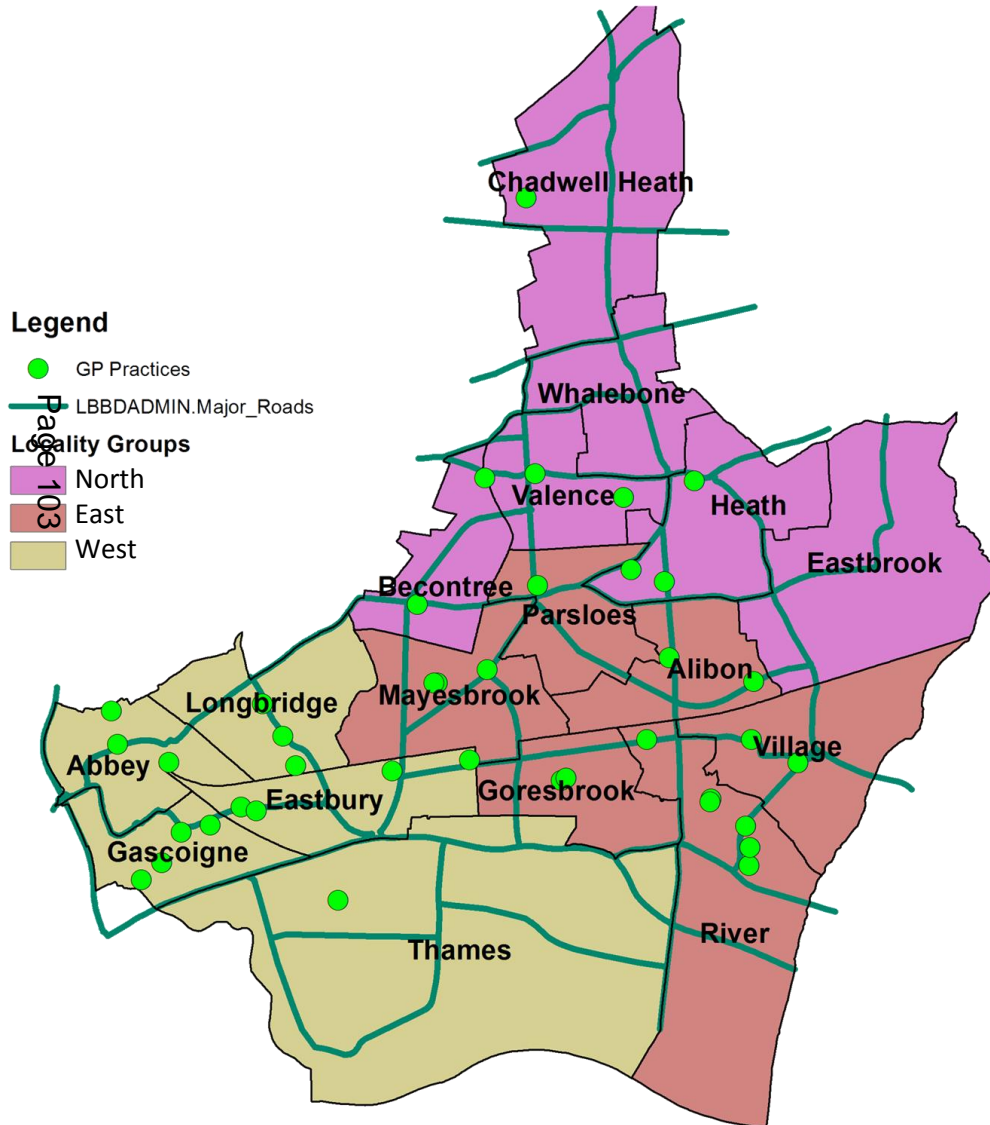
- Dr Jay John, B&D CCG
- Dr Kalkat, B&D CCG
- Melody Williams, NELFT
- Tudur Williams, LBBD Adult Social Care
- Ann Graham, LBBD Childrens Social Care
- Susan Lloyd, LBBD Public Health
- Sharon Morrow, B&D CCG
- Sarah See, BHR CCGs

Basirat Sadique from BHRUT is also involved in locality development in B&D and joined the workshop held on 12/12

The CCGs have identified a project manager (0.5 WTE) to support locality development in B&D

Barking and Dagenham localities – Dr John

The below map shows the Barking and Dagenham localities which partners are re-aligning to. These have also taken into account future population growth. It is anticipated that a fourth locality the support the Barking Riverside development will emerge in around 2021.



Network Population	Network (post Jan 17 Inf CDs)
West	77,101
East	75,239
North	61,469
Not Applicable	340
Total	214,149

Agreement has been reached to refer to the localities as north, east and west

At the Integrated Care Health and Wellbeing Board Sub Group meeting on 28th November the group agreed to extend the next meeting of the group, planned for Monday 12th November to take place in workshop style to enable in depth discussion around;

- ✓ Setting the scene
- ✓ Vision
- ✓ Reality
- ✓ Commitment to developing the new model and resource requirements
- ✓ Next steps

Key messages from the workshop:

- ✓ Big dreams
- ✓ High level of trust
- ✓ Collective leadership
- ✓ Consensus re: localities, focus on community asset and the benefits of coterminous working
- ✓ Borough Manifesto as the route to further develop and share the locality vision
- ✓ Localities agreed / good progress on plan
- ✓ Willingness to resolve IG issues and test joined up information/IT systems
- ✓ Clear confidence between partners that this model is the right direction of travel and is deliverable
- ✓ Next steps to take forward locality development together agreed

What are our priorities?

We have identified some key priority areas through which we are proposing to test the locality model. These are based on the evidence available in the commissioning for value packs as well as clinical experience including input from Public Health;

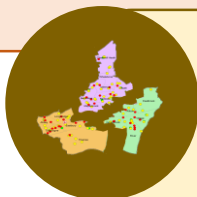
- Diabetes
- Social prescribing
- Crisis management
- Core locality team
- Childrens services; Childrens Social Care is currently working to realign their services to the locality model and are under consultation. This is not quite in as advanced a stage as adults services but further work will take place to see how Childrens services can work with the locality model in the future

Each of these areas has its own challenges within Barking and Dagenham and improvements to these areas will contribute towards closing the key health and wellbeing, care and quality and finance and productivity gaps at both a borough, and Barking and Dagenham, Havering and Redbridge system level.

The group have considered some of the benefits of locality working which include; better risk and crisis management born of improved joint working which will result in visibility and accessibility between services and embedding prevention; As confidence in the locality model grows and joint working embeds, it is possible that more services in the future could be delivered at locality level.

Jacqui Van Rossum; NELFT

- Clinical leads, operational staff and managers within NELFT have come together to undertake a review of the service provision in B&D including which services could be provided at a **locality (x3)**, **borough (whole)** and **system (BHR)** level to ensure economies of scale. Scoping how this could operationally and managerially work within the current contractual framework has begun
- NELFT will require access to dedicated resource to support any reconfiguration and will have to undertake a staff consultation due to the subsequent changes to working locations, managerial changes (with the move from 6 clusters to 3 localities) and caseload reallocation. Any changes would have to be phased rather than big bang
- NELFT's preference is an 'all age' coterminous approach which will ensure the delivery of more seamless care
- Through these discussions NELFT have identified a number of key benefits of the new way of working including: increased clinical time with patients, better use of resources and providers working together to address the needs of a defined population. Trusted assessment developing through relationships born of co-location and positive impact to recruitment and retention
- The next step will be confirming 'need' by locality through the locality profiles and subsequently weighting service capacity in each locality and then actively consulting with staff to embed the new model
- The below diagram shows *current thinking* (subject to consultation) around which services could be provided at each level:



Locality level services (current thinking);

- Community Health and Social Care Service (CHSCS)
- Universal children's' functions (school nursing / health visiting)
- Talking therapies (IAPT)
- Community recovery services (mental health - CRT)



Borough level services (current thinking);

- BDAABIT (Access and brief intervention team -mental health)
- Older Adult Mental Health and memory services
- Childrens Targeted services (CAMHS, Paediatricians , Therapy Services)
- Long Term Condition Services



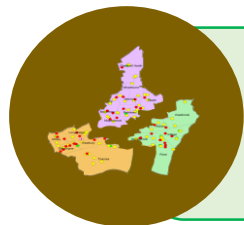
System level services (current thinking);

- Walk in Centre
- Community Treatment Team/Intensive Rehab Service
- Perinatal infant mental health
- Eating disorder services
- Clinical Health Psychology Services

Where we are now; Tudur Williams - LBB

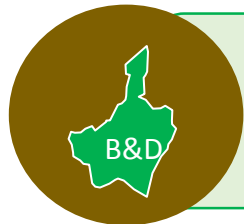
Tudur Williams; LBB

- LBB are in the process of reconfiguring their social care services and have just completed a staff consultation and are in the process of responding to the comments received through this process
- This will include a degree of centralisation of some services e.g. central business unit/ information to ensure greatest efficiency
- Focus on ensuring that social workers on the ground have a greater proportion of clinical/face to face time with service users. It has become apparent that social workers have been picking up a lot of work that does not necessarily need to be undertaken by a qualified social worker; to ensure that best use is made of qualified social workers' time, Care Navigator roles are being created, this will strengthen the role of social workers to focus on longer term, complex case management
- The OT service needs some reorganisation as not currently as efficient as it could be
- The below diagram shows *current thinking* (which may be subject to change) around which services could be provided at each level:



Locality level services (current thinking);

- 4 social workers
- Locality manager
- Consultant social worker role



Borough level services (current thinking);

- Central business unit
- Assessment team

Where we are now; Dr John – GP Networks

Dr John; GP Networks

- GPs are now part of developing networks of practices, aligned to the locality model (three networks geographically aligned to the localities)
- As well as Dr John, Drs Kalkat, Hara and Goriparthi there are GP Network leads for the 3 networks in B&D
- An extraordinary PTI meeting took place in December to explore the development of networks and localities in greater detail
- There are two GP Federations in B&D which are essentially provider networks design to enable the delivery of primary care at scale
- GPs on the ground are aware of the developments around localities and networks but not necessarily how this will work in practice e.g. the impact on ICM but this will be explored through engagement around locality development

Page 10

BHRUT

- Clinicians aware of developments in the community but not of the detail at this stage
- Key need to communicate information at the right time in the right way

Where are we now; summary

Page 109

- **Localities and supporting information:** Locality boundaries have been agreed and partners are working to develop a key suite of supporting information to enable key decisions around workforce requirements in line with need to be made alongside informing the operational model. This information will include a map of the services currently provided across the system and 'locality profiles' being developed by Public Health.
- **Progress to date:** A lot of work has already taken place in B&D to begin to realign services from the 6 ICM clusters to the three localities model (with a fourth locality coming online in 2021 to support the Barking Riverside development). LBBD are in the process of reconfiguring their social care services and have just completed a staff consultation which will include a degree of centralisation of some services e.g. central business unit/ information to ensure greatest efficiency and will have a focus on ensuring that social workers on the ground have a greater proportion of clinical/face to face time with service users. NELFT are in the process of scoping a similar approach to realign their services to the three localities.
- **Leadership to take this forward:** The existing Integrated Care Health and Wellbeing Sub Group (ICSG) is overseeing locality development. This group includes leads from; B&D Local Authority, B&D Clinical Commissioning Group, NELFT, B&D Public Health and BHRUT.
- **Current thinking around locality development:** Thought has already been given to the different services that could be provided at locality, borough and system level to ensure economies of scale and improve service delivery.
- **Strong partnership working to ensure delivery:** The ICSG, at their workshop in December discussed their commitment to develop the locality model and feel that by April 2017 based on the work already underway, Primary Care, NELFT and LBBD will be reconfigured into a model that will support the delivery of health and care in the three localities in B&D.

B&D locality develop next steps

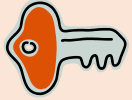
Key next steps:

- ✓ Public Health to develop locality profiles (in progress)
- ✓ Once locality profiles are completed, NELFT will review the level of need within each locality and weight service provision/the 'core' service offer in each locality accordingly
- ✓ Tudur Williams (LBBD) and Melody Williams (NELFT) to meet to discuss how to align the NELFT and Social Care reconfiguration processes; there are clear plans for each organisation/partner at the moment in terms of re-aligning to the three localities; we are in the process of bringing these plans together
- ✓ ICSG meetings will continue to further develop locality proposals and oversee establishment of the model
- ✓ NELFT, LBBD, primary care and other partners to work on development of the locality operational model
- ✓ ICSG to consider how to engage with the community and voluntary sector in the development of the locality model at a B&D level

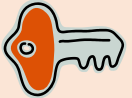
The £8,000 supporting funding for locality development will be used towards:

- **GP backfill** to enable non clinical directors to lead on development of the locality model
- Resources to access **data** / CSU support
- Support **engagement** as required as the programme progresses

Requirements of the ICP



Dedicated project support to develop the plans/project documentation and develop the prevention strategy



Support to enable backfill for staff including NELFT and independent GPs to develop the locality model



Business intelligence support that will regularly provide borough and locality information so that we can be responsive to the needs within the system and weight services according to need in each locality (from a core service offer)



Connected data/information sharing which will greatly improve outcomes for our population and improve the effectiveness of interventions



Strong, well established relationships



Shared vision



Joined up planning



A commitment to make this happen

This page is intentionally left blank

Mental Health Sub Group

Chair: Kevin Sole on behalf of Melody Williams (NELFT)

Items to be escalated to the Health & Wellbeing Board

Feedback from MH service Users Group & Carers forum – Discussed the recent closure to admission for Goodmayes Hospital. Updated on the review of the acute care pathway which has been undertaken since this incident and the three work-streams which have been created to look at:

- Inter-team working between Acute and Community Teams.
- Service workload and capacity
- Effective use of RiO (Electronic Patient Record system)

There has also been a complete revamp of the bed management policy and escalation process to ensure that people do not stay in hospital longer than required.

Training and Development – National CQUIN to improve the physical healthcare and reduce premature mortality in people with severe mental illness. This CQUIN builds on the developments made across England on improving physical health care for people with severe mental illness in order to reduce premature mortality in this patient group. It gives providers an opportunity to continue building on progress made over the past two years and ensure systems are in place to embed learning and sustain good practice.

The aim is to ensure that patients with severe mental illness have comprehensive cardio metabolic risk assessments, have access to the necessary treatments/interventions and the results are recorded in the patient's record and shared appropriately with the patient and the treating clinical teams.

Patients with severe mental illness for the purpose of this CQUIN are all patients with psychoses, including schizophrenia and bi-polar disorder in inpatient units and community mental health services.

The cardio metabolic parameters based are based upon the evidenced based Lester Tool and require mental health services to look at the following in the this cohort of patients

- Smoking status
- Lifestyle (including exercise, diet alcohol and drugs)
- Body Mass Index
- Blood pressure
- Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate)
- Blood lipids.

Training to screen for these six areas has been undertaken to increase the number of frontline clinicians and practitioners able to accurately assess, identify and support people into programmes to make lifestyle changes.

Performance

Performance remains in line with national indicators. Barking and Dagenham has seen a

reduction in the number of people with delayed discharge as a result of the work undertaken to improve discharge planning.
<p>Meeting Attendance</p> <p>Date of last meeting – 23rd January 2017</p>
<p>Action(s) since last report to the Health and Wellbeing Board</p> <ul style="list-style-type: none"> (a) Review of the mental health strategy for implementation (b) Development of Community Pharmacy project to support physical health screening of people with mental health problems
<p>Action and Priorities for the coming period</p> <ul style="list-style-type: none"> (a) Support from the sub group for the suicide prevention plan workshop on 21st March 2017. (b) Implementation of the NELFT CQC Action Plan (c) Consideration for the development of a Peer Support Service. (d) Review of the ACO and three locality changes required across the care community.

Contact: Kevin Sole, Assistant Integrated Care Director

Tel: 0300 555 1201 **Email:** kevin.sole@nelft.nhs.uk

Children and Maternity Sub-Group

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

Items to be escalated to the Health & Wellbeing Board

- (a) Note that the Children and Maternity Group has been disbanded and will be replaced by a new Children's Partnership Board which includes the responsibilities of the Children's Trust

Performance/Update

Barking and Dagenham's Children's Trust was established in 2006 as set out in the Children's Act 2004. The Trust is a partnership of organisations with the overall strategic responsibility for improving outcomes for children, young people, and their families. The Children's Trust is chaired by the Strategic Director of Service Integration and Development (who is the DCS) and Deputy Chief Executive of the Council. The Trust has partner agency representation from Health, Schools, Police, Voluntary Community Sector and Job Centre Plus, and comprises of 18 members and 12 advisers.

The Children's Trust forms one of several strategic partnerships that review key children's priorities; the Local Safeguarding Children Board, Health and Wellbeing Board and the Community Safety Partnership. There are also various sub-groups that cover the current CYPP priority areas and objectives, including the local Children and Maternity Group (CMG), a sub group of the HWBB.

During 2016/17 (between November and February), the Children's Trust has undergone a strategic review focusing on (i) effectiveness of current arrangements and (ii) preferred options for the future children's partnership commencing April 2017. The CMG was also a part of this strategic review of partnerships.

The review concluded that partners felt that future arrangements should involve streamlining membership, having a solution focused approach, being more strategic and that the new Children's Partnership Board should have a clear and effective link to the Health and Wellbeing Board. A workshop was held, feedback from which showed that the most popular option was to have a Children's Partnership sub-board, reporting to the Health and Wellbeing Board with an established governance framework in place.

The members of the Children's Trust have formally agreed to disband both the Children's Trust and CMG, replacing them with a new Children's Partnership Board. This new board will formally report into the HWBB as a sub-group and lead on a smaller number of agreed priority areas to ensure that the approach is solution focused and problem solving i.e. using partner agencies to unblock problems and issues.

Work is underway to set up the new Children's Partnership Board commencing May 2017/18.

Meeting Attendance

N/A

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

- (a) Children's Trust / Children and Maternity Group review workshop held

Action and Priorities for the coming period

- (a) Set up the new Children's Partnership Board commencing May 2017, reporting to the HWBB

Contact: Vikki Rix, Policy and Strategic Commissioning Manager, LBBD

Tel: 020 8227 2564 **Email:** Vikki.Rix@lbbd.gov.uk

HEALTH AND WELLBEING BOARD

14 March 2017

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.			

This page is intentionally left blank



In this edition of my Chair's Report, I talk about Breast Screening, Community Pharmacy and the Adult Social Care Survey. 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*

Healthy Workplace Charter

Organisations with a healthy workforce perform better than those that do not. There are clear benefits for workplace wellbeing programmes, as better health and wellbeing in employees will lead to improved business outcomes. Given that a significant proportion of an individual's life is spent at work, the workplace offers the opportunity to influence the behaviour of large numbers of people.

Sickness absence costs an average London firm of 250 employees £250,000 per annum. The cost to the Council is (on average) £3.7 million a year.

Demonstrating that we are serious about the health of our workforce can also improve our recruitment and retention rates as an employer. In addition, as approximately 50% of employees are residents of the Barking and Dagenham, improving the health of our employees also meets our objective of improving the health and wellbeing of the local population.

The London Healthy Workplace Charter acts an organised employer sponsored program that supports employees as they adopt behavioural changes that reduces risk, improves quality of life and enhances personal effectiveness. Further detail about the charter can be found [here](#).

After gaining the London Healthy Workplace Charter at Commitment level, the Council are currently working towards accreditation at the higher levels. Judges of the Charter were particularly pleased with our excellent Corporate Support in particular from senior management, a health, safety and wellbeing committee, wellbeing survey, evolving action plans and good communications and the programme of training and support for managers on absence management.

So far, we have done a lot of work to assess what actions are required to meet the standards at Achievement and Excellence levels. Whilst much of this is now in place for Achievement level, there are gaps in Excellence level which are around mental health and its link with alcohol and substance misuse training for managers and employees as well as healthy eating. Accreditation at Achievement level is being worked towards against verification in May and a plan for meeting the highlighted gaps at Excellence level is being further worked up.

I would like to call on partners at the Health and Wellbeing Board to work towards achieving the Charter as a way of improving the health of the community and our workforce and to send a positive message to other organisations and businesses about living healthy lifestyles.

Healthy Schools Survey

As we know, Barking & Dagenham faces significant challenges around positive health outcomes for children and young people in the borough. Failure to meet the health needs of children and young people stores up problems for the future, so we need to ensure that we are taking the most effective measures to prevent the development of these habit-forming lifestyle behaviours in children and young people.

A good direct knowledge from the perspective of young people of the peer group, family and societal pressures they face and of the attitudes and engagement they have with various harmful behaviours is essential in formulating an effective prevention strategy. Therefore the Council will be undertaking an in-depth school based survey. This will provide commissioners, schools and other stakeholders with relevant up to date information on which to base a range of preventative interventions.

Once the findings are completed an update will come to the Health and Wellbeing Board.

Mayesbrook Park Lifestyle Hub

A pilot project is currently taking place in Mayesbrook Park which is looking at developing lifestyle hubs utilising parks and open spaces. It aims to demonstrate that by focusing on a locality approach using community assets, the health of local people can be improved. The pilot hopes to increase customer satisfaction, increase local participation in health-related activities and be financially viable at a time of reduced public expenditure.

The objectives of the pilot are:

- To put in place lifestyle activities in parks in the borough
- To offer a co-ordinated lifestyle service focusing primarily on healthy weight
- To involve the whole community in providing and participating in these activities

The approach currently being taken is to improve access/take up of healthy lifestyle services already based in and around Mayesbrook Park as well as establish new healthy lifestyles services initiatives. It is then anticipated to establish new healthy lifestyles services for residents in the wider locality serving residents in the Mayesbrook ward.

The work of the pilot is being evaluated and more information, as well as recommendations to support future work, available in April.

Health and Wellbeing Board Meeting Dates

Tuesday 9 May 2017, Wednesday 5 July 2017, Wednesday 6 September 2017, Wednesday 8 November 2017, Tuesday 16 January 2018, Tuesday 13 March 2018, Tuesday 12 June 2018.

All meetings start at 6pm and are held in the conference room of the Barking Learning Centre.

January Integration Workshop

On 26th January, leaders from the Health and Wellbeing Board took part in a workshop on progressing our ambitions for integration. The workshop, facilitated by the LGA, helped assess the capacity and capabilities of our system so that we can further refine and deliver our shared vision for integration. It also provided an opportunity to reflect on the journey so far, what has gone well and what could improve, and to plan next steps. We reflected on our local context to integration, with the majority of the session focusing on identifying and addressing the challenges and opportunities in Barking and Dagenham.

Coming out from the session were 3 key actions which we would like to take forward:

- Refresh the commitment to integration across the partnership, including ensuring partners create the space for strategic and honest conversations about stepping beyond organisational roles into system leadership positions
- Agree three to five priorities to jointly work on, including agreeing the actions each will take, ensuring the priorities are achievable and that there is a governance space to hold each other to account for those actions
- Consider how to develop an integrated programme management function, such as mapping what resources exist across partners and how these might be diverted to support the strategic intent

The next Health and Wellbeing Board meeting in May will provide an opportunity for the whole of the Board to explore these actions and how we will put these into place.

News from NHS England

How effective is the NHS Health Check?

Public Health England's Expert Scientific and Clinical Advisory Panel published a report summarising the emerging evidence on the NHS Health Check programme. Evidence summarised in the report is encouraging, showing that undiagnosed high-risk conditions such as cardiovascular disease, type 2 diabetes and chronic kidney disease are being identified by the health check. There is robust evidence that early diagnosis and medical treatment substantially reduces the risk of life changing events such as heart attack, stroke and dementia. The programme is achieving its objective of tackling health inequalities, as people from the most deprived populations are at least as likely to have the check as people in affluent communities.

The report also shows where improvement is needed. Currently only half of all people invited for the NHS Health Check take up the offer and the report highlights that increasing uptake must be a priority to maximise the programme's potential for preventing premature death and disability.

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

14 March 2017

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 10 April 2017. Any changes or additions to the next issue should be provided before 2.00 p.m. on 5 April 2017.	

Public Background Papers Used in the Preparation of the Report:

None

List of Appendices

Appendix A – Draft Forward Plan

This page is intentionally left blank



HEALTH and WELLBEING BOARD FORWARD PLAN

DRAFT May 2017 Edition

Publication Date: Due on 10 April 2017

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://modern.gov.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
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://modern.gov.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: 9.5.17	<p>Older People's Housing Strategy - Discussion</p> <p>The Board will be asked to consider and discuss the Older People's Housing Strategy.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)
---	--	------	--

Health and Wellbeing Board: 9.5.17	<p>Contract: Integrated Sexual Health Service - Tri-borough Procurement Strategy : <i>Financial</i></p> <p>The contract for Integrated Sexual Health services will expire on 30 September 2018.</p> <p>The Board will be asked to approve the procurement strategy for the joint competitive procurement of this service with the London Boroughs of Havering and Redbridge from 1 October 2018 to 30 September 2021, with the option for the Council to extend the contract for a further two-year period, and to the delegation of the award of the contact.</p> <ul style="list-style-type: none"> • 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: 9.5.17	<p>Contract: Integrated Substance Misuse Service - Procurement Strategy : <i>Financial</i></p> <p>The current contract for the Substance Misuse (Drug and Alcohol) services will expire on 31 March 2018.</p> <p>The Board will be asked to approve the procurement strategy for the competitive procurement of this service from 1 April 2018 to 31 March 2021, with the option for the Council to extend the contract for a further two-year period, and to the delegation of the award of the contact.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)
Health and Wellbeing Board: 9.5.17	<p>Contract: Mental Health Support Procurement Strategy : <i>Financial</i></p> <p>The Board will be asked to approve the proposed strategy to procure mental health support for residents of the Borough.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Fully Exempt It will include information relating to the accommodation of individual residents.	Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)
Health and Wellbeing Board: 9.5.17	<p>Stepping Up - The Future of Health and Wellbeing Board (H&WB) Integration</p> <p>A workshop was held on 26 January at which members of the Board and associated individuals from partner organisations considered the progress made in Barking and Dagenham around the integration of health and social care and what was required for the future.</p> <p>The Board will be presented with some of the key findings and have a chance to discuss and agree ways forward in terms of health and social care integration at a Barking and Dagenham level.</p> <ul style="list-style-type: none"> • Wards Directly Affected: Not Applicable 	Open	Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)

Health and Wellbeing Board: 9.5.17	<p>Sustainability and Transformation Plan Update</p> <p>The Board will be provided with an update on the progress made in the development and delivery of the North East London Sustainability and Transformation Plan (NEL STP).</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)</p>
Health and Wellbeing Board: 9.5.17	<p>Barking, Havering and Redbridge Transformation Programmes and Governance</p> <p>The Board will be provided with an update on the various BHR wide transformation programmes that are ongoing across social care and health, including work related to health devolution and localities as well as other health related work.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)</p>
Health and Wellbeing Board: 9.5.17	<p>Better Care Fund Plan 2017/19 : <i>Financial</i></p> <p>The Better Care Fund will continue across a two-year period from 2017 to 2019.</p> <p>The Board will be presented with plans for 2017/19 and be asked to approve the plans for submission to NHS England and to delegate authority to enter into a Section 75 agreement for a polled BCF fund between LBBD and B&D CCG.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)</p>

Health and Wellbeing Board: 5.7.17	<p>Domestic and Sexual Abuse Strategy : <i>Community</i></p> <p>The report will present the Board with the draft Domestic and Sexual Abuse Strategy.</p> <p>The Board will be asked to discuss and approve the Domestic and Sexual Abuse Strategy.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)</p>
Health and Wellbeing Board: 5.7.17	<p>Contract: Public Health Primary Care Service - Procurement Strategy : <i>Financial</i></p> <p>The current contract for the Public Health Primary Care service will expire on 31 March 2018.</p> <p>The Board will be asked to approve the procurement strategy for the competitive procurement of this service from 1 April 2018 to 31 March 2020, with the option for the Council to extend the contract for a further two-year period, and to the delegation of the award of the contact.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>

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
Councillor 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)

This page is intentionally left blank