AGENDA

1. Apologies for Absence

2. Declaration of Members' Interests
   
   In accordance with the Council’s Constitution, Members 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 2 November 2016 (Pages 3 - 7)

4. Review of Continuing Healthcare Packages (Pages 9 - 14)

5. Localising Healthy Lifestyle Services (Pages 15 - 21)

6. Update on System Wide Health Integration: the Sustainability and Transformation Plan and the Accountable Care Organisation Devolution Pilot (Pages 23 - 33)

7. Work Programme (Pages 35 - 36)
   
   The Committee will be asked to agree the latest version of the Work Programme.
8. Any other public items which the Chair decides are urgent

9. 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 Adult Services Select Committee, 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.**

10. Any other confidential or exempt items which the Chair decides are urgent
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
20. Minutes - To confirm as correct the minutes of the meeting held on 7 September 2016

The minutes of the meeting held on 7 September 2016 were confirmed as correct.

21. North East London NHS Foundation Trust's Response to the Care Quality Commission's Inspection Findings

The Executive Director for Integrated Care (London) and Corporate Communications (the ED) for North East London Foundation Trust (NELFT) delivered a presentation to update the Committee on the Care Quality Commission’s (CQC) inspection of the Trust in April 2016 that had resulted in the Trust receiving an overall rating of ‘requires improvement. Members noted that NELFT provides community health and mental health services across Outer North East London and Essex.

The presentation briefly covered the inspection timeline, the process, and the following areas of the CQC’s findings:

- Some concerns in community health services;
- Some concerns in mental health services;
- Positive findings;
  - Good practice - community services;
  - Good practice - mental health services;
  - Good practice at provider level;
- Ratings for community health services;
- Ratings for mental health services; and
- Overall summary.

Members noted that the CQC had visited 62 NELFT wards, teams and clinics and spoken with a total of 265 patients and service users and that all boroughs covered by NELFT were inspected.

The ED explained that prior to publication, the CQC’s inspection report of the Trust had been shared with the Trust, who, in response, had given them considerable information around the factual accuracy of the report. However, the CQC decided not to amend the final report and NELFT chose to accept this decision and put its
efforts into moving the Trust forward, rather than legally challenge it.

Following this, NELFT’s Integrated Care Director (ICD), delivered a presentation to outline the Trust’s response to the inspection findings, which covered the following areas:

- NELFT’s vision remains unchanged;
- What NELFT expects;
- Quality Improvement Plans for each of the following of the CQC’s inspection domains: safety, caring, responsive, clinical effectiveness and well-led, and
- Successes.

Members asked whether the situation around the shortage of nurses had been addressed and whether the shortage had had an impact on referral to treatment times. The ICD stated that the Trust had invested in its resourcing team, who are working hard to address staff shortage, for example, by working with partners on localised recruitment campaigns. The Trust is currently meeting the 18-week referral target as it uses locum or temporary staff to fill vacancies and meet demand. However, there are several challenges around the use of such staff, such as the quality of supervision and staff development, which the Trust is also working to address. The Trust has arrangements in place for the senior oversight of risk assessments completed by staff and to triangulate these with risk incidents. Furthermore, better systems are being developed to measure staff against a range of competencies.

The ED stated that the resourcing team had undertaken significant work to reduce the Trust’s spend on temporary and agency staff. It is also making changes to ensure, where possible, equality between agency and permanent staff, such as paying permanent staff their remuneration every week, rather than every month, to bring them in line with agency staff. In addition, the Trust has worked with universities to help increase its recruitment.

A member of the Barking and Dagenham Clinical Commissioning Group’s Patient Engagement Forum asked what the Trust was doing to make it a more attractive place to work. The ED accepted that the Trust’s previous recruitment process had been too long and bureaucratic but stated that this is now being improved. The Trust offers good training, development and educational opportunities, apprenticeships, and rotations and works with innovative organisations such as Care City, all of which help the Trust with recruitment. There is a renewed focus on retention too; exit interviews are now held to determine the reasons people were leaving. However, the Trust does not offer ‘golden handshakes’ and only recruits the highest calibre staff who care about their role and share the Trust’s values. The ICD stated that it is important to note that there are pockets in NEFLT which do not have recruitment challenges. However, it is a challenge to overcome Barking and Dagenham’s image as a deprived area and the vast majority of recruitment is still based on word of mouth. Furthermore, NELFT is trying to implement changes to reflect staff feedback, for example, it is looking at making incentive payments for referrals.

Members asked whether the findings that the ‘fit and proper person’ requirements for directors was not being met, and that there was the lack of robust training for governors, had been addressed. The ED stated that the finding in relation to the fit
and proper person requirements was down to some easily resolvable issues such as a lack of two references and a small number of out of date Disclosure and Barring service checks, which are being addressed. In relation to training for governors, the ED stated that governors had received robust training in six of their meetings throughout the year; however, it may have been the case that the governors did not recognise these meetings as part of their formal training. The Trust had asked the governors what further training they would like and will be providing it where possible.

Members asked whether local representatives, such as local councillors, had been a part of the CQC’s inspection team. The ED stated that the CQC selected its inspection team; it did not include a local representative but did include a lay person. The team was smaller than what was expected, considering the size of the Trust. The inspection was carried out under the Mental Health framework so it was also surprising that there was only one psychiatrist in the inspection team.

Members referred to the CQC’s finding that “there was a lack of consistent recording of patient risk across the services to ensure these were captured and plans made to minimise risks” and asked why the Trust had allowed this happen. The ED explained that this finding was mainly in relation to ligature risks, which not all staff could identify within the ward and which were not consistently recorded in individuals’ risk assessments. The Trust had arranged bespoke training for staff to address this finding. The ICD stated that whether any trust could achieve a 100 percent rate of recording all risks was questionable but the Trust will make every effort to send a clear message to staff.

A local GP, Dr Rai, stated that as the Trust has a high turn-over rate of agency staff, it is vital that the Trust establishes an effective method of communicating the importance of recording risks in line with its protocols with all staff. Recording risks for patients who are at risk of self-harm and suicide should be mandatory and nothing less than 100 percent compliance should be acceptable. The Committee strongly agreed with Dr Rai’s comments and the NELFT officers accepted them but emphasised that the Trust was doing it all it could to address this point.

The Chair thanked the ED and the ICD for their attendance and asked that the Trust’s Action Plan in response to the CQC’s inspection be circulated to the Committee.

22. Cancer Awareness and its Barriers - what can be done Locally to Improve Cancer Outcomes?

The Council’s Public Health Consultant (PHC) introduced the following people:

- Jane Burt, Cancer Research Facilitator for Cancer Research UK (CRUK);
- Kate Kavanagh, the Commissioning Manager for the Barking, Havering and Redbridge Commissioning Support Unit; and
- Dr Rai, a local Macmillan GP with a special interest in cancer.

The PHC delivered a presentation that related to the Committee’s scrutiny review on Cancer Prevention, Awareness and Early Detection, which covered the following:
The national picture;
Barking and Dagenham Cancer numbers;
Incidence of cancer in Barking and Dagenham;
1 year survival from cancer in Barking and Dagenham;
Lifestyle influences;
Screening for cancer;
Emergency Presentation;
Most common barriers;
What is happening locally;
How can we increase awareness and early diagnosis in Barking and Dagenham based on the evidence; and
Supporting evidence.

The PHC, Dr Rai, Ms Burt and Ms Kavanagh described the positive work currently taking place to improve cancer outcomes from their own perspectives, such as collaborative work between GPs to share good practice and the development of local lifestyle hubs, which would have a key role to play going forward in raising awareness about reducing risk. However, they all agreed that there are significant challenges around raising awareness, primary care and the late presentation of cancer symptoms at A&E.

Dr Rai stated that the borough has seen an increase in the bowel cancer screening rate since GPs had been charged with contacting patients when they were due for screening.

Ms Burt stated that she welcomes members’ suggestions on how to increase attendance at roadshows arranged by Cancer UK and other organisations aimed at raising awareness about general health and diseases such as cancer. Members suggested that it may be possible to attract more people by offering small give-aways, and that as there is a very diverse community in the borough, the roadshows may take place nearer to community hubs such as mosques, churches and gurdwaras, if possible.

Members asked whether e-cigarettes could be more harmful than tobacco cigarettes. The PHC stated that the advice from Public Health England is that e-cigarettes are less harmful; however, the evidence is still developing so this is not conclusive. She stated also that the evidence so far indicates that there is not a link between young people vaping and smoking tobacco. The Council’s Director for Public Health (DPH) stated that in most cases, e-cigarettes will not suffice in helping the person to stop smoking and they will need to be given some form of nicotine replacement. E-cigarettes contain differing levels of nicotine and are popular amongst young people. He added that smoking shisha is also very dangerous as the substance contains nicotine as well as carbon monoxide, which means that authorities must check shisha cafes for compliance with the law.

In response to a question, Ms Kavanagh stated that currently the Barking, Havering and Redbridge University Hospitals Trust is not meeting all referral to treatment times for cancer and that she can circulate more detailed data around this after the meeting. Dr Rai stated that the Trust is currently meeting the initial two-week target. However, more referrals were now being generated as a result of NICE guidance, which had lowered the threshold for cancer referrals, and whilst this is a positive thing as it potentially means more people will be diagnosed; the
pressure being created by the increase means that, with the same amount of resources, the Trust may find it difficult to reach the referral targets going forward.

The local Healthwatch representative asked how GPs would identify women who had moved to the borough recently, who need screening for breast cancer. The PHC stated that there was a national breast cancer screening register and the patients would be notified via their GP when they are due for screening. In response to her second question, the DPH stated that women who were diagnosed with cancer in another area and then moved to the borough would be treated locally.

The Chair thanked the PHC for her presentation and the guests for their contributions.

23. Update and Feedback from Talk Cancer Session on 12 October 2016

Councillors Fergus, Jones and Rai provided feedback on a ‘Talk Cancer’ session they attended on 12 October 2016 as part of the Committee’s Scrutiny Review. The session was delivered by CRUK nurses and designed to help people feel confident to talk to people about ways to reduce the risk of cancer, spotting cancer early, and screening. Members were very positive about the session, which taught them that people did have control over their risk of cancer and that seeing your GP early on about changes that were not normal for you, was very important because early diagnosis meant better survival rates. All members strongly felt that the style of the session and its messages should be used in other services and programmes designed to raise awareness about cancer.

24. Results of inspections undertaken by the Care Quality Commission on Local Adult Social Care Services in Quarter 2

The Council’s Operational Director for Adults’ Care and Support (ODACS) summarised the report on the results of inspections undertaken by the CQC on local adult social care services in quarter two.

Members noted that two of the providers had issues around equalities and diversity and the ODACS stated that he would take this back for further consideration with staff who supported providers.

25. Joint Health Overview & Scrutiny Committee - update

The report was noted.

26. Work Programme

At the request of the Chair, members agreed to remove the session, ‘the views of residents’ which related to the Scrutiny Review, from the work programme as they felt it would be more appropriate to undertake this session as a smaller group and during a closed meeting.

Subject to this change, the work programme was agreed.
This page is intentionally left blank
## Title: Continuing Healthcare for People with Learning Disabilities

### Report of Scrutiny, Democratic Services

<table>
<thead>
<tr>
<th>Open Report</th>
<th>For Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Author:</strong> Masuma Ahmed, Democratic Services, Scrutiny, Law and Governance</td>
<td><strong>Contact Details:</strong> Tel: 020 8227 2756 E-mail: <a href="mailto:masuma.ahmed@lbbd.gov.uk">masuma.ahmed@lbbd.gov.uk</a></td>
</tr>
</tbody>
</table>

**Accountable Director:** Fiona Taylor, Head of Law and Governance

**Accountable Strategic Director:** Chris Naylor, Chief Executive

### Summary:

On 7 September 2016, the Health and Adult Services Select Committee (HASSC) accepted a suggestion to include the issue of Continuing Healthcare packages for people with learning disabilities on the agenda for this meeting. Members noted that Continuing Healthcare was an NHS package of healthcare offered to individuals with a primary health need, which could be offered within the person’s home or at a provider care home and that the Clinical Commissioning Groups (CCG) intended to carry out a review of some of these care packages for people with learning difficulties.

Rob Meaker, Director of Innovation for the BHR CCGs, will deliver the presentation at Appendix 1 of this report to the HASSC. Members will have the opportunity to ask questions to obtain further detail around the processes this review will entail as well as the potential negative impact it will have on the borough’s residents with learning difficulties who currently receive a continuing healthcare package.

### Recommendation(s)

The HASSC is recommended to:

1. Note the information at Appendix 1 and
2. Ask questions of the BHR CCG’s Director of Innovation to obtain further detail around the processes this review will entail as well as the potential negative impact it will have on the borough’s residents with learning difficulties who currently receive a Continuing Healthcare package.

### Reason(s)

This item relates to the Council’s priority to enabling social responsibility and under it, the objectives to protect the most vulnerable, keeping adults and children healthy and safe and ensure everyone can access good quality healthcare when they need it.
Background Papers Used in the Preparation of the Report:

Minutes of the HASSC meeting on 7 September 2016.

List of appendices:

Appendix 1  Continuing Healthcare for People with Learning Disabilities
Continuing healthcare for people with learning disabilities

Health and Adult Services Select Committee
11 January 2017
Rob Meaker, Director of Innovation

Barkingdagenhamccg.nhs.uk
@BD_CCG
Reviewing healthcare packages

• As part of a wider review of the services we commission, we will be reviewing all continuing healthcare packages over £1,000 for people with learning disabilities.

• The purpose of the review is to ensure the packages are appropriate for the patient’s needs, which may have changed since they first received continuing healthcare.
Current situation

• Around 200 people who receive continuing healthcare in BHR are being reviewed to assess their continuing healthcare needs

• Historically, once a package was provided a reassessment may not have been carried out for some time (sometimes years) even though the initial assessment may have covered short-term care measures

• The needs of people often change as they get older or if they change medication so the package may no longer be best suited to them.
Review process

1. The CCG has employed a nurse assessor who is visiting everyone with a continuing healthcare package of over £1,000.

2. The nurse will review the patient’s needs, and whether their current package best meets their needs.

3. Once all patients have been assessed anyone who has been identified as potentially needing a different package will have a full assessment by the CCG and the community learning disability team to assess the patient’s needs.

4. Together they will use the ‘decision support tool’ to identify the most appropriate care package.
**Title:** Localising Healthy Lifestyle Services: Project Development and Mayesbrook Park Pilot

**Report of the Strategic Director, Service Development and Integration**

<table>
<thead>
<tr>
<th>Open Report</th>
<th>For Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Author:</strong></td>
<td><strong>Contact Details:</strong></td>
</tr>
<tr>
<td>Susan Lloyd: Consultant in Public Health</td>
<td>Tel: 020 8227 2799</td>
</tr>
<tr>
<td>Angela Birch: Project Manager – Healthy Lifestyle Service</td>
<td>E-mail: <a href="mailto:sue.lloyd@lbbd.gov.uk">sue.lloyd@lbbd.gov.uk</a></td>
</tr>
</tbody>
</table>

**Accountable Director:** Anne Bristow, Strategic Director, Service Development and Integration

**Accountable Strategic Director:** Matthew Cole, Director of Public Health

**Summary:**

This is a report on a community-focused model that has been developed and is currently being piloted in and around Mayesbrook Park. The purpose of the Healthy Lifestyle Service is to make healthier living the easiest choice across all stages of life, so that residents Start Well, Live Well and Age Well by:

- Providing a more cost effective service for smoking, obesity, physical activity and others, for example, by working with volunteers and exploiting potential economies of scale within the model
- Improving access and support to healthy lifestyle services and developing integrated pathways across NCMP, child weight management, adult weight management, physical activity and healthy eating programmes
- Building resilience by helping people to increase self-care and social responsibility so that individuals have control over their lifestyle behaviours
- Working more efficiently and using resources more effectively so that services become sustainable
- Focussing services to address health inequalities

The Mayesbrook Park pilot brings together healthy lifestyle services, primary care and our voluntary sector in the borough to provide a holistic approach to healthy lifestyle and behaviour change. The service is facilitated through health champions and health trainers. This paper describes the approach.

**Recommendation(s)**

The Health and Adult Services Select Committee is recommended to:

(i) Note the content of the report and

(ii) To advise that supporting healthy lifestyle is a positive approach to cancer prevention and that a recommendation to link residents with the healthy lifestyle service through the Mayesbrook Park model (and other park models as they develop) should be included in the review.
The evidence base proves that healthy lifestyle behaviours are beneficial in preventing the development of some cancers, particularly, lung, breast and colorectal.

Linking residents with lifestyle services increases the likelihood of behaviour change in residents who have unhealthy behaviours.

1. Introduction and Background

1.1 This is a report on a community-focused model that has been developed and is currently being piloted in and around Mayesbrook Park.

1.2 The purpose of the Healthy Lifestyle Service is to make healthier living the easiest choice across all stages of life, so that residents Start Well, Live Well and Age Well by:

- Providing a more cost effective service for smoking, obesity, physical activity and others, for example, by working with volunteers and exploiting potential economies of scale within the model
- Improving access and support to healthy lifestyle services and developing integrated pathways across NCMP, child weight management, adult weight management, physical activity and healthy eating programmes
- Building resilience by helping people to increase self-care and social responsibility so that individuals have control over their lifestyle behaviours
- Working more efficiently and using resources more effectively so that services become sustainable
- Focussing services to address health inequalities

1.3 The HLS core offer will continue to focus on the biggest contributors to most preventable diseases - smoking cessation, physical activity, healthy weight, diet etc., (public health priorities).

1.4 The service model is an Integrated Health Improvement and Stop Smoking Service across all stages of life – using parks as the hubs for delivering activities

1.5 There will be greater development of cross-cutting skills across the HLS, for example Stop Smoking Advisers will be trained in Health Improvement (Level 2 Understanding Health Improvement) and Health Trainers will also be trained as Level 2 Stop Smoking Advisors.

1.6 Delivery will be structured around a progressive change model for residents to support the achievement of health outcomes at all stages of behavioural change:

- Level 1: Taking Care of Yourself - The level at which interventions are targeted universally at the whole community, but with a focus on targeting those sections of the community at increased risk and hardest to reach.
- Level 2: Supporting Change - Behaviour change interventions
- Level 3: Specialist Help - these interventions can help clients to manage existing conditions, or high risk factors. They are designed to reduce risk, improve self–management and/or to improve independence
**1.7** The **Community Health Champions & Health Trainer Service** will also be based within the central office and has 4 key objectives:

- To recruit and train from the wider community individuals as Community Health Champions to inspire and help their friends, families, neighbours and work colleagues to lead more healthy lives.
- To manage the new Healthy Lifestyle Accreditation. This is awarded to partners and stakeholders who share and demonstrate a commitment to improving health. With this accreditation partner organisations have access to free RSPH Training ensuring there is standardisation of delivery and dissemination of agreed key health messages. In return partners, will also promote the recruitment of Community Health Champions within their own organisations.
- To deliver Healthy Lifestyle Events with partners and stakeholders in each of the localities.
- To undertake community mapping.

**1.8** The team structure includes 10 Health Trainers (Healthy Lifestyle Coaches) made up of 5 whole time equivalents and up to 20 Community Health Champions (CHC’s) for each of the 3 localities (60 total) supported by providers from the community voluntary, sector, primary care or specialists provision in the locality or within the borough.

**1.9** Community Health Champions and Health Trainers will be responsible for Level 1 and 2 activities and will operate flexibly from community bases within the locality.

- Community Health Champions will be recruited from the wider community and through community voluntary groups. This will ensure that the service is culturally diverse and through the variety of languages spoken, increase access to services.
- The Royal Society of Public Health (RSPH) Accredited Centre will provide training and development opportunities to support Community Health Champions, voluntary and faith communities, front line staff in primary care, partner organisations and individuals, so they can confidently deliver key health messages.
- Level 3 training will be targeted at Community and Faith Leaders so they can empower and build the capacity of their organisations and lead to the establishment of a ‘competent’ community infrastructure that can design and deliver interventions for their needs.
- The RSPH Centre will also implement the Prevention and Lifestyle Behaviour Change Competence Framework: Making Every Contact Count and other training i.e. Walks Leader, Mental Health First Aid and Cancer Awareness.

**2. ** **Stage 1. Initial Design**

**2.1** The outline model for the pilot for the Mayesbrook Park Locality is based on the model for the HLS.
2.2 For ease of reference the Mayesbrook Park pilot is listed as Locality 1 within the above model. Other parks will be listed as the other Localities when they come online.

2.3 The objectives of the pilot were to:

- To put in place lifestyle activities in parks in the borough
- To offer co-ordinated lifestyle service
- To involve the whole community in providing and participating in these activities
- To evaluate the services offered.

2.4 To support this approach the following has been put in place:

- Establish the Community Health Champions & Health Trainer Service
- Establish the RSPH Accredited Training Centre
- Implement the MECC Prevention & Lifestyle Behaviour Change Competence Framework
- Establish locality working utilising community assets
- Implement integrated working
- Implement the Progressive Behaviour Change model across Starting Well, Living Well and Ageing Well addressing gaps in provision
- Demonstrate increased partnership working and increased health outcomes.
3. **Stage 1. Mayesbrook Park Pilot**

3.1 Community profile - benefits of delivering the pilot in Mayesbrook Park ward

The population of Mayesbrook ward is estimated to be around 10,773 (Public Health England Mayesbrook Local Health Report 2015). This comprises:

<table>
<thead>
<tr>
<th>Mayesbrook population breakdown</th>
<th>Life-course stages</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,045 - under 16 years</td>
<td>Starting Well - reach figures: 3,045</td>
</tr>
<tr>
<td>1,249 - 16 – 24 years</td>
<td>Living Well - reach figures: 6,583</td>
</tr>
<tr>
<td>5,334 – 25 – 64 years</td>
<td></td>
</tr>
<tr>
<td>967 – 65 – 84 years</td>
<td>Ageing Well – reach figures 1,145</td>
</tr>
<tr>
<td>178 – 85 years +</td>
<td></td>
</tr>
</tbody>
</table>

3.2 The black and minority ethnic (BME) and ‘not white’ population of the ward is lower than the rest of Barking and Dagenham; however, deprivation levels of 39.2 are higher than the LBBD average of 34.6. This is also true for income deprivation (Mayesbrook 25.7, LBBD 24.2), child poverty (Mayesbrook 32.3, LBBD 31.9) and older people in deprivation (Mayesbrook 29, LBBD 27.9).

3.3 The number of people in the ward who provide 50 hours or more of unpaid care per week and the number of pensioners who live alone in the ward are both above the borough and England average.

3.4 Obese Children (Reception Year), Children with excess weight (Reception Year), Obese Children (Year 6) and Children with excess weight (Year 6) although not quite as high as the borough average are still significantly higher than the England average.

3.5 There are 2,079 obese adults in the ward (approximately 27% of adults aged over 16 years) and only 1,554 healthy weight adults (approximately 20%) in the ward.

3.6 Whilst deaths from all cancers are high, with regard to individual cancers deaths from lung cancer is significantly higher than the LBBD and the England average. Life expectancy for males at birth is significantly worse for males in the ward.

3.7 Parks and green spaces provide free access to nature, relaxation, play, exercise, sports, education and social cohesion and contribute significantly towards wellbeing. Mayesbrook Park which is based on the ward offers a great opportunity to base future health improvement initiatives.

3.8 The facilities on offer in the park are:

- A toddler’s playground
- Adventure playground
- Outdoor gym with basketball court
- Trim Trail
- Six football pitches
- One cricket pitch
- Two basketball courts
- Local Nature Reserve with two lakes and woodland
• Athletics arena
• Sport House indoor sports centre.

All these assets were piloted to deliver health improvements for local residents.

3.9 The aim of the pilot was to demonstrate:

• Improved service performance (health outcomes) and customer satisfaction
• Increased local participation in health-related activities
• Financial viability in the context of reduced public expenditure

4. Update: Mid-stage Progress

4.1 A lot of work has been completed to address the structural changes required to enable the team to do the operational work required. The following has already been achieved overall:

• Healthy Lifestyle Community Event 28.10.16 – raising awareness of the service
• Guided walks training has been delivered and walks have been put in place
• Other activities are listed in 4.9

To support the park-based service the following work has been delivered:

• The park based Community Health Champions Service established, 33 Community Health Champions have been recruited to date who have committed 4 hours per week, for a minimum of 12 months
• Mandatory training delivered – 33 Community Health Trainers have completed Level 2 Understanding Health Improvement; 5 of these are from Barking Football Club
• 14 Children Centre staff have completed Level 2 Understanding Health Improvement
• 9 Community Health Champions have been trained as Walk Leaders (5 from Barking Football Club)
• 15 Community Health Champions have been trained in Motivational Interviewing
• 8 Community Health Champions have been trained in Cancer Awareness
• Application to become RSPH Accredited Centre submitted 11th November
• Leisure Staff – re-organisation in progress
• Stakeholder engagement – the establishment of the Healthy Lifestyle Operational Board
• Pilot of e-referral form for GP’s
• A school gate initiative is also being piloted across the 4 primary schools in the Mayesbrook ward to create smoke free zones around these schools.

4.2 The Healthy Lifestyle Event was held in Mayesbrook Park from 1pm – 5pm, on 28 October 2016. There were 19 community voluntary organisations in attendance and a total of 125 attendees throughout the afternoon.

The event showcased the new Community Health Champions and Barking Football Club as the first recipient of the Healthy Lifestyle Accreditation and was an opportunity to raise awareness of the Healthy Lifestyle Service to local residents.
Community Health Champions engaged with 32 new clients, of which 23 completed Healthy Lifestyle Assessments that included questions on Health Checks and Cancer Awareness.

Of these, 80% wanted more information on losing weight and healthy eating and stated they were interested in being approached with more information. 5 people who attended the event also signed up to become Community Health Champions.

Feedback from the event was positive and those who attended found it ‘very enjoyable and they learned a lot’; however, a number of improvements were noted, the most notable from visitors and stallholders alike was regarding the location of the event.

The event was placed directly behind the Jim Peters Stadium that meant it could not be seen by passers-by; the marquees were hidden from sight. People felt this meant we missed out on attracting people who may not have known the event was on.

However, feedback confirmed that the event was seen as a driver for change in the ward.

5. **Next steps**

5.1 Once the evaluation of the Mayesbrook pilot is complete and approved the model will be considered for roll out across other parks in the borough.

**Background Papers Used in the Preparation of the Report:**

None.

**List of appendices:**

None.
This page is intentionally left blank
Report of the Strategic Director, Service Development & Integration

Open Report

Report Author:
Andrew Hagger, Health & Social Care Integration Manager, London Borough of Barking & Dagenham

Contact Details:
Tel: 020 8227 5071
E-mail: andrew.hagger@lbbd.gov.uk

Accountable Director: Mark Tyson, Commissioning Director, Adult’s Care & Support

Accountable Strategic Director: Anne Bristow, Strategic Director, Service Development & Integration

Summary:
This report provides an update to the Select Committee on the development of the north-east London Sustainability and Transformation Plan (NEL STP) and work around health devolution.

The STP is being developed in response to NHS England planning guidance which requires health and care systems across the country to work together to develop sustainability and transformation plans (STPs). An STP is a new planning framework for NHS services which is intended to be a local blueprint for delivering the ambitions NHS bodies have for a transformed health service, including working with social care. A draft STP was submitted to NHS England on 21 October.

As part of the London Health and Care Collaboration Agreement, Barking & Dagenham, Havering and Redbridge agreed to run a pilot to develop an Accountable Care Organisation, where primary and secondary care are more closely integrated and patient pathways are redesigned with a focus on intervening early and managing the chronically ill. Throughout 2016 work has been ongoing to develop a Strategic Outline Case, which was finalised in the autumn. The report provides an update on this work.

For Barking & Dagenham, Havering and Redbridge, it remains the case that the detail of the local contribution to the Sustainability and Transformation Plan for north east London has been developed through the established programme to draft a business case for an Accountable Care Organisation.

Recommendation(s)
The Health and Adult Services Select Committee is recommended to note and discuss the information provided in the report.

Reason(s)
The NEL STP Board is developing a plan as stipulated by the NHS England guidance. The plan will reflect the work that has been initiated as part of the local devolution bid approved in December 2015, and which is being taken forward through the local
1. Introduction and Background

1.1 On 19 July 2016, the Committee received a report providing an update on the development of the north-east London Sustainability and Transformation Plan (known as the NEL STP) and the development of the business case for the Barking and Dagenham, Havering and Redbridge (BHR) Accountable Care Organisation (ACO) devolution pilot.

1.2 This report provides further information on the development of these plans.

2. Health Devolution

Background to the devolution pilot

2.1 On 15 December 2015, the London Health and Care Collaboration Agreement was published by the London Partners (London’s 32 Clinical Commissioning Groups, all 33 LA members of London Councils, the Greater London Authority, NHS England London Region and Public Health England London Region). It set out the overall commitment of the Partners to the transformation of health and social care through integration and devolution. Alongside it, five pilot projects were announced, one of which was for “Barking & Dagenham, Havering and Redbridge [to] run a pilot to develop an Accountable Care Organisation, where primary and secondary care are more closely integrated and patient pathways are redesigned with a focus on intervening early and managing the chronically ill.”

2.2 The announcement followed the submission of a bid to NHS England London Region for the support to develop a business case, focused on whether the model of an Accountable Care Organisation could deliver the next stage of integrated service delivery across the three boroughs, with the aim of delivering the improvements that are needed in the health of the population, the quality of care they receive, and the efficiency with which it is delivered.

Developing the Accountable Care Organisation business case

2.3 Over the past year, the eight organisations across Barking and Dagenham, Havering and Redbridge (BHR) have worked together to develop a strategic outline case for the development of an Accountable Care System (ACS). The programme was led by the BHR Democratic and Clinical Oversight Group comprising of leaders from across the system.

2.4 The output from this programme is the Barking and Dagenham, Havering and Redbridge Summary Outline Strategic Outline Case for an Accountable Care System. This document brings together the significant amount of work that has been carried out, highlighting the key findings and presenting options and recommendations. The Strategic Outline Case (SOC) is available here: http://moderngov.lbbd.gov.uk/documents/s104563/Appendix%20D%20-%20NEL%20STP%20BHR%20SOC%20Summary.pdf

2.5 The SOC identifies a vision for BHR, which is ‘To accelerate improved health and wellbeing outcomes for the people of Barking & Dagenham, Havering and Redbridge and deliver sustainable provision of high quality health and wellbeing services’. Beneath are a set of aims, including:
- Enabling and empowering people to live healthy lifestyles, with access to preventative care, the ability to live independently and manage their own health and wellbeing.
- Organising care around patient needs with a single point of access and provided locally where possible
- Integration between agencies to remove boundaries and work as seamlessly and collaboratively as possible.

2.6 An extensive review of the BHR population was carried out during the first half of 2016, led by the Director of Public Health for Redbridge, which outlined the context in which health and social care operates and has provided a robust understanding of our challenges to a level of detail not previously available. Each borough faces its own distinctive problems and there is considerable variation across the patch:

- Barking and Dagenham has a younger and ethnically diverse, mainly deprived population
- Havering has an older, largely white population
- Redbridge has an ethnically diverse, majority Asian, median income population

2.7 The variation between the three boroughs means that through working on a combined footprint, there is an opportunity to pool resources and redirect additional support to places where they are needed most. Demographic change is an important driver of demand for health and wellbeing services. BHR’s population has been increasing rapidly and is projected to rise for the next two decades. The current system will struggle to respond to the overall projected increase of 19 – 28% by 2031. BHR needs a new approach to preventing ill health and targeting people who are more likely to require health and social care in the future.

2.8 The Directors of Finance from BHRUT and NELFT, supported by PWC, led a review of the BHR financial position for the SOC which showed the health and care economy faces a considerable financial challenge over the five years from 2016/17 to 2020/21. There are many reasons for this, including:

- The existing challenge: At the end of 2015/16, the health and care organisations within Barking, Havering and Redbridge had a combined financial challenge of £44m.
- Demand for services is increasing: This is a result of a growing population, which is aging, meaning that health and care needs are becoming more complex.
- Costs of provision of health and care services are rising more rapidly than general inflation: Costs are growing more rapidly than allocations from government (which, in terms of the NHS, are linked to national inflation forecasts). These are driven by wages (i.e. the impact of the National Living Wage) as well as specific pressures on drug and litigation expenditure.
- Allocations for social care are forecast to reduce: While NHS allocations are expected to increase over the five year period, there are planned reductions in social care and public health allocations for the three local authorities.
2.9 An infographic available from the BHR Partnership website is a useful summary of our key system challenges, for the health and wellbeing of the population, the quality of local services, and the local financial position. It is available at http://www.bhrpartnership.org.uk/icc-news-items/our-challenge-in-pictures/19369.

2.10 There was also extensive engagement and consultation as part of the programme, including residents, staff and the third sector. Over 3000 residents were surveyed by phone by Ipsos MORI and 750 staff were surveyed. The findings from the surveys emphasised the current complexity of the system and the need for change.

2.11 Findings from the voluntary sector engagement included the importance of delivering holistic health and social care around key population groups such as those who are frail, complex cases, and a wider programme of prevention to support our population to live longer, healthier lives.

2.12 A further infographic is available to summarise the key points of the findings, at http://www.bhrpartnership.org.uk/downloads/UEC/BHR-UEC-codesign-and-research-infographic.pdf.

2.13 The SOC process drew on both national and international evidence to identify best practice, signalling priority service and pathway areas that need to change across BHR.

2.14 The SOC identified that the existing model of commissioning and providing prevention and care is struggling to meet the current levels of demand. With future pressure from rapid demographic changes including population growth, rising levels of long term conditions and variable levels of deprivation, the SOC recommended a new model of service delivery supported by more effective joint strategic commissioning arrangements. However, the SOC was clear that at this stage the BHR system does not support a direct move to an Accountable Care Organisation.

From ACO to ACP – Where we are and next steps

2.15 As can be seen from above, work on developing the ACO Business Case as part of the health devolution pilot has not progressed as anticipated and a new organisational form for delivering health and social care across the BHR area will not be forthcoming in the near future. There has been a shift in language from an Accountable Care Organisation to an Accountable Care Partnership (ACP) or System, reflecting the shift away from a new organisational form for health and social care delivery.

2.16 In part this has been due the changing policy landscape, with the arrival of the STP diverting attention and resource away from the ACO work and shifting the NHS focus from a BHR system to a much wider NEL footprint. The STP will be explained in more detail in the next section of the report. Whilst an Accountable Care Organisation could fit as a subset of the North East London STP work, in practice the work required, and the organisational disruption that would be involved, are not judged at this stage to be beneficial. It does remain, however, as a longer-term shared ambition.

2.17 In addition, detailed discussions about devolution and what it could mean in practice are also still ongoing across London. Any devolution asks will be framed as a London-wide approach which local areas can then draw upon, so no devolution is possible until a London-wide agreement has been reached. Work is still ongoing around finalising what these asks will be.
2.18 The ACO programme has recognised these developments and has also taken stock of the significant progress that has been made in developing the basis for further partnership working. It has also has identified immediate steps that can be taken in the coming months to progress the work around health devolution and further integration:

- To consolidate the strong partnership, including democratic and clinical leadership into a formalised commissioning and leadership group to drive forward change and delivery
- To further consider the emerging new models of care over the next few months with a view to considering the best model or models for BHR for the future
- To undertake further work to clarify the specific devolution asks that might be required to deliver the BHR plans in full (i.e. contracting, financial and workforce)

2.19 The Integrated Care Partnership Board has met for the first time (the development of the former Democratic & Clinical Oversight Group for the ACO programme). It is chaired by Cllr Maureen Worby and continues to have political, non-executive and senior clinical and executive participation from the BHR health and local government agencies.

2.20 An appropriate delivery structure is being developed, and there are ACP Executive and ACP Steering Groups being formed. The supporting Joint Commissioning Board is also being scoped, as are arrangements to govern provider collaboration which would also report to the ICP. The BHR Joint Commissioning Board will:

- Bring local authorities and CCGs together to strategically commission services
- Develop strategies that enable the shift in emphasis of commissioning towards services that prevent harmful behaviours or conditions
- Work with localities to develop the new service model
- Develop contracts that incentivise improvement in population outcomes
- Encourage links with the third sector who are already committed to developing innovative prevention activities

2.21 Locality working across the three boroughs forms the major body of work, and first discussions at the Integrated Care Partnership are being lined up for each borough to present their initial plans for locality pilots. Locality based delivery model is built around the key principle of organisations working together to manage common resources to improve the health and wellbeing of a geographically defined population. The proposed locality delivery model of care is designed to radically alter the way that residents access health and wellbeing services across BHR. Prevention will be the bedrock of the model, with a focus on early intervention and support at the point where it is the most beneficial to individual, family or community.

2.22 This dovetails with the Council’s transformation proposals to move from six clusters in adult services to three localities forming the main delivery mechanism for a wider range of services. It remains the case that a fourth locality will be brought on stream some time towards 2020 as population growth makes it viable.

2.23 While a new organisational form in the shape of an ACO will not happen soon, the work undertaken represents significant progress in terms of developing our
approaches for integration for BHR and understanding of the needs of our population, which takes the devolution and integration agenda beyond other much heralded approaches such as in Manchester.

3. **Sustainability and Transformation Plans**

**Background to the STP**

3.1 In December 2015 NHS England planning guidance required health and care systems across the country to work together to develop sustainability and transformation plans (STPs). An STP is a new planning framework for NHS services which is intended to be a local blueprint for delivering the ambitions NHS bodies have for a transformed health service, which is set out in a document called Five Year Forward View (5YFV). The STP will give access to transformational funding for the health system and is a key strategic lever for the NHS.

3.2 England has been divided into 44 areas (known as footprints); Barking and Dagenham is part of the north-east London footprint. The North-East London area encompasses the CCGs, local authorities, and provider organisations across Barking and Dagenham, City and Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest.

3.3 The STP aims to build upon existing local transformation programmes and supports their implementation. These are:

- Barking and Dagenham, Havering and Redbridge: devolution pilot
- City and Hackney: Hackney devolution in part
- Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme
- The improvement programmes of local hospitals, which aims to support Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust out of special measures

3.4 The STPs will become increasingly important in health service planning because they are the gateway to funding. In 2016/17 they are the basis for accessing a transformation fund of £2.1bn nationally. This will encompass the funding streams for all transformational programmes from April 2017 onwards, and will rise to £3.4bn by 2021. It is envisaged that this approach will have significant benefits over the earlier approach to transformation funding. Where there had previously been fragmented approaches there will now be a single unified approach across the STP footprint. The aim is that this will assist providers and commissioners to work in a more collaborative and coordinated way enabling transformation and efficiencies to be delivered.

**Developing the STP**

3.5 For Barking & Dagenham, the work to develop the detail underpinning the STP is being taken forward jointly with Havering and Redbridge through the work around devolution and wider BHR system-wide transformation approaches, with regular updates on the work provided to the Health and Wellbeing Board at their meetings on 26 July, 27 September, and 22 November.

3.6 A draft STP was submitted on 30 June as a ‘checkpoint’, which formed the basis of a local conversation with NHS England on 14 July. Formal feedback on the
submission was received at the end of August and asked for further information around the impact the STP proposals would have on the quality of care, clear and realistic actions, clear timelines and benefits. The feedback also asked that robust financial plans are included as well as plans for engagement with local communities, clinicians and staff.

3.7 The next iteration of the STP was submitted on 21 October 2016 and the NEL STP team are currently awaiting feedback and next steps from NHS England.

3.8 The document submitted on 21 October re-emphasised the agreed joint vision for the STP:

- Measurably improve health and wellbeing outcomes for the people of north east London and ensure sustainable health and social care services, built around the needs of local people
- Develop new ways of working to achieve better outcomes for all, focused on the prevention of ill health and out of hospital care
- Work in partnership to plan, commission (buy), contract and deliver services efficiently and safely.

3.9 Whilst each of the health and care economies within NEL has a different starting point, the STP has identified six key priorities which need to be addressed collectively across the NEL footprint. These are:

- The right services in the right place: Matching demand with appropriate capacity in NEL
- Encourage self-care, offer care close to home and make sure secondary care is high quality
- Secure the future of our health and social care providers. Many face challenging financial circumstances
- Improve specialised care by working together
- Create a system-wide decision making model that enables placed based care and clearly involves key partner agencies
- Using our infrastructure better

3.10 The STP submissions also highlights the financial challenges across the health system, with an anticipated total financial challenge of £578m in the ‘do nothing’ scenario. Even after all the existing approaches in place to drive savings out of the system (business as usual efficiencies of 2% p/a, transformation programmes in Hackney, WEL and BHR) there is still a gap of £92m for in 2021. By 2021 the Sustainability & Transformation Fund is expected to be £136m, which is equal to the amount assumed to be required to deliver the NHS Five Year Forward View investment priorities. All NEL local authorities and the Corporation of London have provided financial data for the STP modelling, though it is recognised that further detailed work is required to confirm assumptions and what effect local authority funding challenges and proposed services changes will have on health services and vice versa.

3.11 In addition, further work has been carried out on the governance arrangements for the delivery of the STP. The STP team have recognised that this will be an iterative process as ways of working evolve. There is an agreed route map for the development of new ways of working and decision making. A shadow governance arrangement, reflecting the current starting point, is being developed which will be reviewed and refined as further clarity about the new operating requirements and
landscape emerges. A series of governance principles underpins the proposed shadow arrangements and the development of further iterations of the governance structure:

- Participation
- Accountability
- Sovereignty
- Subsidiarity
- Professional leadership
- Accessibility
- Good governance
- Collaboration
- Engagement

3.12 Further details on the STP can be found in Appendix B, which is a narrative summary of the second draft STP submitted to NHS England on 21 October 2016. It should be noted that the full STP, which contains a considerable amount of additional technical detail, is still a draft working document and is subject to change.

**Key issues**

3.13 There is a considerable fit between the STP and the ambitions that have been agreed locally as part of the BHR level devolution work (for example closer integration, enhanced primary care provision, improved prevention). There is a degree of alignment, therefore, with the plans and approaches agreed across BHR and locally in Barking and Dagenham. The most significant exception concerns its push towards increased provider collaboration across NEL, in particular between Barts and BHRUT, which will see the management arrangements of those Trusts increasingly integrated.

3.14 There has been significant national concern about transparency and local political legitimacy of the Sustainability & Transformation Plan process. There have been ongoing concerns expressed by local authorities across NEL, and particularly by London Borough of Barking and Dagenham, London Borough of Havering and London Borough of Redbridge at the level of engagement of local authorities in the STP process. Although the basis of the BHR contribution to the STP is work that has been shaped through good engagement across BHR, the pace and complexity of reinterpreting this at NEL level has meant that local authorities have had limited engagement in the final product. NHS England does not require that local authorities ‘sign off’ the plan, which is a disappointing step in a plan which is intended to address whole system functioning, and is at odds with the devolution process that BHR had embarked on based on our inability to fix system problems by working alone. There has been an effort made by the NEL STP team to address concerns of local authorities, which has been recognised and appreciated by local authorities, but there are fundamental flaws in the process that remain a concern.

3.15 Other concerns are shared by some partners in the NEL system, which were discussed at the Health and Wellbeing Board meeting on 22 November. It was noted that, unlike some of the plans across the country there are no new big cuts or hospital closures contained in the NEL STP. The purpose of the plans are to impose financial control caps and unless activity in hospital is brought down there will be a financial gap. The Board made several points, including:
that there was a need for the local democratic voice to be heard within the larger regional and sub-regional area

pressure on budgets in other boroughs / areas does have a detrimental effect on the resources available for Barking and Dagenham residents

there was a need to share specialist care centres across the whole NEL STP area and for it not to centre it all in the teaching hospitals

local ‘exemplar’ services needed championing for specialist centre care status, such as the excellent Sickle Cell service at Queen’s Hospital

the proposed downgrade of the King George Hospital A&E Department needed to be considered alongside demographic changes

3.16 Early thinking about governance of the STP has been shared with councils, and in response the Leaders of Barking & Dagenham, Havering and Redbridge have written to their counterparts in the other NEL boroughs making a constructive suggestion of an alternative approach which gives greater prominence to the system-level governance arrangements (i.e. for BHR, WEL and City & Hackney) over a cumbersome all-NEL tier of governance. A key principle for Barking and Dagenham, and all BHR partners, is that decision making should lie at the local system and borough level as a starting point (with localities as a core delivery mechanism), with decisions and approaches taken at a NEL level where this is necessary. There is a concern that as the STP grows, more decisions will flow towards the NEL-level, and early sight of the governance options has reinforced this concern.

Next steps

3.17 The five STPs in London are working jointly to understand the implications of out of area flows on constituent STPs and ensure these implications are accounted for, and where necessary mitigated, in local plans. An approach is expected to be defined in December 2016. Further work is also underway within specialised commissioning.

3.18 CCG operating plans are currently in the process of being finalised and signed off by organisations and an STP wide approach to the 2017-19 contracting round has been agreed. This includes ensuring consistency wherever possible across the entire NEL STP area in relation to both contract form and substance.

3.19 From 21 October to January, local Healthwatch organisations will be working together to gather and understand the views of local people. The aim is to ensure engagement is relevant to local needs and that it builds on previous decisions made and the engagement and consultation work that has already take place across NEL on significant change programmes and developments. Healthwatch organisations will focus on gauging public views on a) promoting prevention and self-care b) improving primary care and c) reforming hospital services;

3.20 The latest draft submission of the STP has been circulated to health and social care partners, with feedback anticipated feedback from NHSE/I early in 2017 and will continue to evolve the STP following feedback from our local partners, local people and the national bodies.
4. **Mandatory Implications**

**Financial Implications**

4.1 The NEL STP will include activities to address current financial challenges across the health and social care economy. The ambition is to ensure that all NHS organisations are able to achieve financial balance by the end of the five year period of the plan.

4.2 As the STP does not yet include the local authority position there are no financial implications arising from the report.

**Legal Implications**

4.3 As set out in the NHS Shared Planning Guidance, all NHS organisations are required to contribute to the production of a Sustainability and Transformation Plan. Local authorities and other non-NHS partners are not required to produce an STP, but have been consulted in their development.

4.4 There is currently no proscribed role for Health and Wellbeing Boards to sign off on the final STP.

5. **Other Implications**

**Health**

**Joint Strategic Needs Assessment**

5.1 A [public health profile for north east London](#) (March 2016) is being used to help understand the health and wellbeing, care and quality and the financial challenges locally and identify priorities for inclusion in the NEL STP.

5.2 The public health profile for north east London identifies common themes that are also identified with the Barking and Dagenham JSNA, as outlined below:

- According to the updated Index of Multiple Deprivation (2010), Barking and Dagenham continues to be in the bottom 7% of most deprived boroughs. In a population weighted ranking the borough is 8th worst in England.
- In Barking and Dagenham there is predicted to be an increase in population from 203,060 to 223,185 between 2015 and 2020, an increase of 9.9%. The 2011 Census found that the population of children aged 0-4 years had grown by 49% in the previous ten years, the highest growth for this age group in England and Wales. In 2013 the numbers of children under 5 years made up 10% of the population and between the ages of 0-19 made up 32% of the population.
- By the end of March 2014, 10,797 people had been detected with diabetes in Barking and Dagenham, a 6.7% rise on the March 2013 figure (10,260) and a 28.6% rise on the March 2010 figure (8,349). The prevalence of diagnosed diabetes in the borough is 7.3%, higher than the England average of 6.2%. It is estimated that 16% of the total number of people predicted to have diabetes are currently undetected.
- Barking and Dagenham has a significantly higher prevalence of overweight and obese adults when compared with London and is similar to that of England. In 2013/14 Barking and Dagenham had the ninth highest proportion of overweight and obese children in Reception class (26.8%) and the third highest proportion in...
Year 6 (42.2%) in England. Provisional measurements for 2014/15 indicate that the prevalence of children in reception year that are obese or overweight increased by 1%, while the prevalence of overweight or obese children in year 6 fell by 1.9%.

- Cancer contributes significantly to the health inequalities gap. There are 352 cancer deaths per 100,000 people each year in LBBD, the second highest rate between all London CCGs after Tower Hamlet. This is over 21% higher than the England average of 290 death per 100,000 population. The one year survival rate for all cancers in 2012 was 64%, the lowest in London at 69.7% and 69.3% for England.

Health and Wellbeing Strategy

5.3 The NEL STP links well with the Barking and Dagenham Health and Wellbeing Strategy 2015-18 which identifies three important stages of life: starting well, living well and aging well. Many of the emerging themes of the STP are covered in the Barking and Dagenham HWB strategy including prevention; care and support; and improvement and integration.

Integration

5.4 The STP will act as an ‘umbrella’ plan for change: holding underneath it a number of different specific local plans to address certain challenges. It will build on existing local transformation programmes and support their implementation. These include the Barking and Dagenham, Havering and Redbridge: devolution pilot (accountable care organisation).

Public Background Papers Used in the Preparation of the Report

- NHS Five Year Forward View [https://www.england.nhs.uk/ourwork/futurenhs/](https://www.england.nhs.uk/ourwork/futurenhs/)


Further reading

North East London: Sustainability and Transformation Plan Summary Narrative (Draft Submission 21 October 2016)

<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Agenda items</th>
<th>Officer/ Presenter</th>
<th>Deadline for drafts for Chair’s pre-meeting</th>
<th>Chair’s pre-meeting date</th>
<th>Deadline for final versions</th>
<th>Relevant Cabinet Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weds 1 March</td>
<td><strong>Update on Eye Care recommendations</strong>&lt;br&gt;(The HASSC will receive an update report on the progress of the Eye Care Scrutiny Review recommendations).&lt;br&gt;Health and Local Government Ombudsman report on failures in discharge from hospital&lt;br&gt;(The HASSC will receive a report to consider the impacts of failure in discharge in relation to safeguarding concerns).&lt;br&gt;Provisional item - Cancer Scrutiny Review – draft report and recommendations&lt;br&gt;(The HASSC will receive the draft report arising from the Scrutiny Review on Cancer for review and comment. The Cabinet Member for Social Care and Health Integration will be invited to comment on the report).&lt;br&gt;Provisional item: Care Quality Commission’s re-inspection of BHRUT&lt;br&gt;(The HASSC will receive a report on the outcome of the CQC inspection of BHRUT in Sept 2016 and the Trust’s improvement plan, if the outcome of the inspection is that the Trust is to remain in special measures).</td>
<td>BDCCG Operational Director, Adults’ Care and Support Chair and Officers Matthew Hopkins, CE, BHRUT</td>
<td>Mon 30 Jan</td>
<td>Mon 6 Feb</td>
<td>Tue 14 Feb</td>
<td>Councillor Worby</td>
</tr>
<tr>
<td>Date</td>
<td>Topic</td>
<td>Chair/Officer</td>
<td>Meeting Date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>----------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weds 3 May</td>
<td>Cancer Scrutiny Review - final report</td>
<td>Chair</td>
<td>Mon 3 April</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(The HASSC will receive the final report arising from the Scrutiny Review on Cancer for agreement).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health checks – performance</td>
<td>Director of Public Health</td>
<td>Mon 10 April</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(The HASSC will receive a report providing data on the number of eligible people that have been offered and received NHS Health Checks).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Services</td>
<td>To be confirmed</td>
<td>Tue 18 April</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Healthwatch reports</td>
<td>Manisha Modhvadia, Healthwatch</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Healthwatch, the local consumer champion for health and social care services will present a report providing an overview of the visits it has undertaken and the projects it has worked on since its last report to the HASSC).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CQC inspections</td>
<td>Principal Commissioning Manager, Adults’ Care &amp; Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(The HASSC will receive a report providing an overview of CQC inspection reports of social care providers, covering the period since the last report to the HASSC).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Joint Health Overview &amp; Scrutiny Committee update</td>
<td>Democratic Services Officer/ Chair</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(The HASSC will receive an update on the matters discussed at the last JHOSC meeting)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>