

## Notice of Meeting

### HEALTH & WELLBEING BOARD

**Wednesday, 5 July 2017 - 6:00 pm**  
**Conference Room, Barking Learning Centre, 2 Town Square, Barking, IG11 7NB**

Date of publication: 27 June 2017

Chris Naylor  
Chief Executive

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#### Membership

CLlr Maureen Worby (Chair)	(LBBD) Cabinet Member for Social Care and Health Integration
Dr Waseem Mohi (Deputy Chair)	(Barking & Dagenham Clinical Commissioning Group)
CLlr Sade Bright	(LBBD) Cabinet Member for Equalities and Cohesion
CLlr Laila M. 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)
to be confirmed	(Metropolitan Police)
Ceri Jacob (Non-voting member)	(NHS England London Region)

# AGENDA

**1. Apologies for Absence**

**2. Declaration of Members' Interests**

In accordance with the Council's Constitution, Members of the Board are asked to declare any interest they may have in any matter which is to be considered at this meeting.

**3. Minutes - To confirm as correct the minutes of the meeting on 14 March 2017 (Pages 3 - 9)**

## **BUSINESS ITEMS**

**4. Liver Disease Prevention Strategy (Pages 11 - 38)**

**5. Care City Innovation Test Bed Update (Pages 39 - 41)**

**6. Stepping Up: The Future of Health and Wellbeing Board (Pages 43 - 49)**

**7. Integration and Better Care Fund Plan 2017/19 Update (Pages 51 - 99)**

**8. Annual Reports (Pages 101 - 126)**

**9. Joint Local Area SEND Inspection in Barking and Dagenham (Pages 127 - 143)**

**10. Future Integrated Arrangements for the Delivery of Mental Health Social Work in Barking & Dagenham (Pages 145 - 219)**

**11. Procurement of Integrated Adult and Young People Substance Misuse (Drug and Alcohol) Services (Pages 221 - 236)**

**12. Contract for the Provision of a Three-Borough Integrated Sexual Health Service (Pages 237 - 255)**

## **STANDING ITEMS**

**13. Integrated Care Partnership Board - Update (Pages 257 - 268)**

**14. Sub-Group Reports (Pages 269 - 278)**

**15. Chair's Report (Pages 279 - 283)**

**16. Forward Plan (Pages 285 - 295)**

- 17. Any other public items which the Chair decides are urgent**
- 18. 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 item below is in the private part of the agenda as it contains commercially confidential information which is exempt from publication under paragraph 3 of Part 1 of Schedule 12A of the Local Government Act 1972 (as amended) and the public interest in maintaining the exemption outweighs the public interest in disclosing the information.

- 19. Contract for the Provision of Mental Health Support Services for Mental Health Service Users (Pages 297 - 318)**
- 20. Any other confidential or exempt items which the Chair decides are urgent**

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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

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## MINUTES OF HEALTH AND WELLBEING BOARD

Tuesday, 14 March 2017  
(6:00 - 7:35 pm)

**Present:** Cllr Maureen Worby (Chair), Cllr Sade Bright, Anne Bristow, Cllr Laila M. Butt, Frances Carroll, Bob Champion, Matthew Cole and Cllr Bill Turner

**Also Present:** Sarah D'Souza, Max Chauhan and Cllr Eileen Keller

**Apologies:** Conor Burke, Cllr Evelyn Carpenter, Ceri Jacob, Dr Nadeem Moghal and Sean Wilson, Sarah Baker and Stephen Norman

### 72. Declaration of Members' Interests

There were no declarations of interest.

### 73. Minutes - 31 January 2017

The minutes of the meeting held on 31 January 2017 were confirmed as correct.

### 74. NELFT CQC Comprehensive Inspection - Quality Improvement Plan

Councillor M. Butt arrived during this item.

Bob Champion, Executive Director of Workforce and Organisational Development and Melody Williams, Integrated Care Director, NELFT jointly presented the report, which provided an overview of the Quality Improvement Plan that had been put into place following the CQC Comprehensive Inspection of NELFT during April 2016. That Inspection had resulted in an overall CQC rating of 'Requires Improvement'. The priority areas for action had centred on:

- The safe and effective assessment and management of clinical risk across all mental health services, especially in acute wards for adults of working age;
- Care plans that reflect patient needs and include patient contribution;
- The ward and environmental ligature reduction programme was expedited and risk assessments are known and understood by staff;
- Clean and safe clinical environment in the adolescent unit;
- Providing facilities and an environment to promote recovery, without any blanket restrictions;
- Safer staffing and improved governance in regards to reporting of clinical risk;
- Improved reporting of incidents in the adolescent unit;
- Improving the assessment of needs and planning of care in some services;

- Application of the 'fit and proper person' test.

NELFT drew attention to the significant improvement at Brookside, as detailed in the report, which had enabled it to be reopened in October 2016.

The Chair commended NELFT for its positive and rapid response when the Inspection report had been received, the work undertaken with partners to produce its quality improvement action plan and the effort and focus staff had given to resolve the issues.

Frances Carroll, Healthwatch, drew attention to paragraph 2.9 of the report and that CCG had not yet confirmed any further contract reductions for NELFT service within the CCG recent published service plans to achieve the savings required. Frances asked if it was known what cuts would be expected and when we would be advised. Sarah D' Souza, CCG, advised that a collaborative partnership board had been set up to look at moving away from the traditional 'salami slicing' of budgets and towards a more holistic and innovative approach to achieving £2.2m savings with NELFT. The potential savings would include a vigorous challenge by the clinicians to check the impact, feasibility and safety of each area of change. Parity of Esteem funding has been used to fund crisis pathways and work was also ongoing in regards to safer clinical wards.

The Chair advised that this collaborative board would report into the Integrated Partnership Board, which she also chairs. Once the draft business plan had been compiled, consultation would be undertaken. The Chair stressed that the anticipated £55m savings were not going to be easy to find and decisions would need to be made on where the effect of cuts could be mitigated and innovation used to provide safe and effective services.

Councillor Turner, LBBD Cabinet Member for Corporate Performance and Delivery, asked if there was any further information on what we must do, should do and would like to do for the NELFT services. The Chair suggested that additional information could be found through the electronic links detailed in the reports but should those links not provide the information required then contact should be made with the appropriate officer.

The Board:

- (i) Noted the rapid progress that had been made to improve from a CQC 'Requires Improvement' overall rating, which included the reopening of Brookside, and the ongoing work on the quality improvement action plan; and
- (ii) Noted that a further report would be presented from Barking, Havering and Redbridge (BHR) CCG, possibly to the next meeting, on the options to meet NELFT savings target.

## **75. Barking Riverside Healthy New Town**

Max Chauhan, representing BHRUT, arrived during this item.

Fiona Wright, Consultant in Public Health Medicine, LBBD, gave a presentation on the background to the Barking Riverside development and the importance of its



role in the regeneration of both the Borough and the east of London sub-regional area. The development would provide 10,800 primarily family home units of mixed tenure that will bring an expected 30,000 residents to Barking Riverside, a high proportion of which would be children and young adults. In addition, the aim was for the community assets at Riverside, including recreational, open space parkland and riverside mud-land areas, to be managed by the community in due course.

Fiona also explained the principles behind being a Healthy Town and the work that had been undertaken for Barking Riverside to become the only Healthy New Town site in London. The bid had resulted in funding of £150,000 this year and around £180,000 for the next two years and also support from NHS England and others to roll out the new Healthy Town project.

The presentation also covered the priorities and proposed activities, which were also set out in the report, around the principles of:

- Connected Community / No-one left behind
- Lifelong Health
- Sense of Place
- Healthy Mind and Body
- Future Health and Care.

Fiona also drew attention to the 10 Healthy Town Principles, which were already included in the Section 106 development strategy, and the need to use learning from Barking Riverside in other development in the Borough. This could be extended to each locality to ensure that the 10 Healthy New Towns principles are embedded within the growth areas.

In response to a question from Councillor Bright, LBBB Cabinet Member for Equalities and Cohesion, Fiona confirmed that community engagement was an integral part of the project and that a variety of engagement routes had been used in order to obtain the views and needs of all residents, including the hard to reach groups and the elderly.

In response to a question from Healthwatch, in regard to the growing health concerns from air pollution, Fiona advised that the number of car spaces would be limited and there would be walkways, cycleways and public transport to encourage active travel, which together with the work being undertaken on biodiversity and planting would reduce the air pollution. The Chair reminded the Board that the A13 tunnels would also help to reduce the pollution along the whole A13 corridor.

The CCG commended Fiona for her work, which had been instrumental in bring health and planning together. Sarah D' Souza, CCG, explained the way in which the CCG were planning to roll-out the health services as the project progressed and more people moved into the area. This would include utilising the under capacity at the three existing GP surgeries and the Health Centre by providing extended hours and more flexible use of the central space. Sarah explained that services would be monitored and further facilities would be engineered to open to provide the extra capacity as the tipping point on pressure was reached. Healthwatch asked what additional acute health provision would be provided as the numbers of people expanded, bearing in mind the pressures that were already being experienced in the local hospitals. Sarah advised that a new large centre

would be opened at Barking Reach, which would enable more services to be provided locally, however, the CCG were also aware of the planning required for acute needs. Cllr Turner was concerned about the impression that was being given to existing communities in the area, including Thames View, and the language being used especially phrases such as 'under capacity' when residents were waiting for days, or weeks, for appointments and treatment locally. Sarah responded that it was more about the density of use of the existing buildings and shared use, for example one reception for all GPs. Matthew Cole, Director of Public Health, reminded the Board that the intention of the PCT Lift Programme was to do exactly that, including higher use through initiatives such as three-shifts per day services, but it was only now that the Lift ideals were starting to come to fruition. It was suggested that discussion should be held with the Ward Councillors on how to impart information on the proposals and to engage with residents. Anne Bristow advised that the NHS was also looking at the various forms of local provision, such as walk-in, out-of-hours, health centres and poly-clinics, as this could be confusing for the public.

The Board noted the definition of affordable housing and that discussions were being held with developers to maximise the opportunities for local people through various types of tenure / ownership.

The Board:

- (i) Endorsed the vision of Barking Riverside Healthy New Town, as set out in the report;
- (ii) Recommended that each locality ensures that the 10 Healthy New Towns principles are embedded within the growth areas of their locality;
- (iii) Agreed that the learning from Barking Riverside Healthy New Town is considered on a regular basis to inform other developments within Barking and Dagenham; and
- (iv) Noted that a meeting would be arranged with the Ward Councillors in regard to the approach to explain capacity and other proposals to residents.

## **76. Health and Wellbeing Outcomes Framework Report - Quarter 3 2016/17**

Matthew Cole, Director of Public Health, presented the report which provided an overarching dashboard and drew attention to a number of specific indicators, including immunisations, teenage conception rates, smoking quitters, permanent admissions of over 65s to residential and care homes, health checks, diabetes, and cancer screening. and across the life course performance.

The issue of resident turn over and the effect that appeared to be having on children presenting for their immunisations was discussed and how the Children's Health Improvement Programme (CHIP) should enable children to be followed easier. It was noted that the CCG did not appear to have a target set and Matthew advised he would be discussing this with the CCG in due course. Councillor Turner stressed the risk this posed to children and asked if there was a need to look at institutionalised practice, especially to improve hard to reach groups. Councillor Turner asked if the practice level performance could be provided at the next meeting.

The Chair commented that she was concerned about the delay on achieving the target for health checks for Looked After Children, especially as we know where they are, GPs in the same borough policing their colleagues and a number of other issues. In view of this the Council had now formally requested a meeting with the CCG to discuss what proactive and other action they would undertake to deal with persistent year-on-year GP underperformance in achieving their targets.

The Board:

- (i) Noted that NHS England had devolved performance monitoring to a local level;
- (ii) Reviewed the overarching dashboard and noted the detail provided on specific indicators and raised its concern on the continued underperformance by some GP practices across a number of areas including, health checks, diabetes, smoking, vaccinations and cancer screening and also the delay on achieving the target for health checks for Looked After Children;
- (iii) Noted that the Council had formerly requested a meeting with the CCG on action that it would be taking to improve persistent year-on-year GP performance target under achievement; and
- (iv) Requested that GP practice level performance data is be provided at the next meeting.

## **77. Future Health and Wellbeing Board Dates 2017-18**

Anne Bristow pointed out that the dates of meetings were known in advance. Whilst substitution was not acceptable under the Constitution, regular attending support staff do occasional attend to represent Board Member's organisations. The Chair stressed that part of the trade-off in accepting the NEL STP was that there would still be a focus on health issues at the local level and the Board was a significant part of that. However, there appears to be a lack of consistent attendance from some Board Members and their organisations.

The Board received the report:

- (i) Confirmed the dates set out in the report and noted that four of the dates fall on a Tuesday and three on a Wednesday, which was to facilitate the attendance opportunities for Board Members who are unable to attend on some Tuesdays, due to other official engagements; and
- (ii) Concern was raised about the lack of consistent Board Member attendance. Democratic Service have been asked to provide details for circulation to Board Members.

## **78. Integrated Care Partnership Board Update**

Councillor Turner left during this item.

The Chair advised that further to Minute 67, January 2017, it was now anticipated

that that the decision on the North East London Sustainability and Transformation Plan (NEL STP) would be advised within the next week or so. What was clear was that the Government would be progressing forward with London health devolution, however, it was not clear how this would affect the two areas that are running pilot schemes, which could be slightly different to the anticipated STP and devolution programmes.

As discussed at earlier Board meetings services need to be delivered differently and the ICPB was the route for partners to come together locally and make the necessary decisions for the pooling of budgets and different ways of working to enable change to become a reality.

The Board:

- (i) Noted the update on the work of the Integrated Care Partnership Board (ICPB) and that the minutes of the ICPB would be reported to the Board on a regular basis; and
- (ii) Noted that the decision on the Sustainable Transformation Programme was now expected by the end of March 2017.

## **79. Sub-Group Reports**

The Board noted the reports of the:

- (i) Integrated Care Sub-Group
- (ii) Mental Health Sub-Group
- (iii) Children and Maternity Sub-Group and Children's Trust  
Following a review of the Children and Maternity Sub-Group and Children's Trust these had now both been disbanded.
- (iv) Children's Partnership Board (CPB)  
Noted that the Children's Partnership Board had now been set-up and would be a sub-group of the Health and Wellbeing Board.

The Children's Partnership Board would concentrate on a smaller number of agreed priority areas to ensure that the approach is solution focused and encourages working in partnership to unblock problems and issues.

## **80. Chair's Report**

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

- Healthy Workplace Charter  
The Chair encouraged Partners to consider the Charter in their organisations, if they had not already done so.
- Healthy Schools Survey  
This survey was being undertaken in secondary schools within the Borough. The children would be providing the details themselves through an online confidential survey. The results from the survey would provide real and more

accurate local data that will help prevention and planning work in the future.

- Mayesbrook Park Lifestyle Hub  
The Chair suggested that the hub could be promoted as an activity by partners to encourage healthy activity, especially for residents in the vicinity of the Park.
- January Integration Workshop
- News from NHS England

#### **81. Forward Plan**

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

#### **82. BHRUT Inspection**

The Chair advised that following the latest CQC Inspection, BHRUT Trust was now out of special measures and on behalf of the Board thanked the staff for their efforts to achieve 'Requires Improvement'.

The Board also noted that update reports from BHRUT should be presented at a future meeting on the progress on their action plan to achieve a 'Good' or better rating.

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## HEALTH AND WELLBEING BOARD

5 July 2017

<b>Title:</b>	<b>Liver Disease Prevention Strategy</b>
<b>Report of the Director of Public Health</b>	
<b>Open Report</b>	<b>For Decision</b>
<b>Wards Affected: All</b>	<b>Key Decision: No</b>
<b>Report Author:</b> Susan Lloyd, Public Health Consultant, LBBB Dr Paul Kooner, Liver Consultant, BHRUT Mary Kowner, Public Health Strategist	<b>Contact Details:</b> Tel: 020 8227 2998 E-mail: mary.kowner@lbbd.gov.uk
<b>Sponsor:</b> Matthew Cole, Director of Public Health	
<p><b>Summary:</b></p> <p>This paper is to inform the Board about the current situation with liver disease in Barking and Dagenham, particularly as many cases are preventable. The paper cites the sharply increasing prevalence of alcohol related issues, particularly liver disease in the borough. The paper highlights the associated demand on services and costs, both financial because of hospital admissions, but also the human costs, in terms of social disturbance, crime, and domestic violence.</p> <p>Liver disease is the 6<sup>th</sup> largest cause of death in Barking and Dagenham for men, and the numbers of women suffering from liver disease are increasing. Sufferers of liver disease often die at a very young age; average age of death is 59 years old.</p> <p>Liver disease is preventable in most cases, and effective prevention approaches are available for the three main causes; alcohol, obesity, and infection with viral hepatitis, particularly Hepatitis B and C. These decrease the risk of developing cirrhosis and liver cancer.</p> <p>In Barking and Dagenham there are many social costs of alcohol, including domestic violence and social disturbance. On-going effective interventions and support for residents reduces this burden.</p> <p>The Board are asked to support Barking and Dagenham partnership engagement in the development of a tri-borough strategy to address liver disease prevention.</p>	
<b>Recommendation(s)</b>	
<p>The Health and Wellbeing Board is recommended to support Barking and Dagenham partnership engagement in the development of a tri-borough liver disease prevention approach.</p>	

**Reason(s)**

This supports partnership working across Barking and Dagenham, Havering, and Redbridge; and is reflective of the Accountable Care Partnership approach to care delivery.

**1. Introduction and Background**

- 1.1 This paper is presented with Dr. Paul Kooner, Liver Consultant, Barking Havering Redbridge University Hospitals NHS Trust (BHRUT).
- 1.2 Areas of East London, including Barking and Dagenham are amongst those that have the highest prevalence for liver disease.
- 1.3 One in six early deaths from liver disease in Barking and Dagenham can be prevented, and the Five Year Forward View calls for a radical prevention approach. Alcohol is one focus of the North-East London STP prevention approach.
- 1.4 The most common causes of liver disease are:
  - alcohol abuse and dependency – the largest single cause locally
  - viral infection i.e. Hepatitis B & C
  - obesity, leading to a build-up of fat deposits around the liver

Advanced liver disease results in liver damage that presents as cirrhosis, the liver is not able to function properly and the person with liver disease becomes very unwell.

- 1.5 Liver disease is largely preventable and liver disease prevention is a public health issue, benefits to the borough's economy are also important for residents.
- 1.6 In this paper, we focus on the major cause of liver disease in the borough, alcohol abuse.

**2 Proposal and Issues**

- 2.1 In 2016 Barking and Dagenham approved a substance misuse strategy<sup>1</sup> which addresses education to prevent misuse, treatment and social responsibility linked to alcohol related disorder; the borough does not currently have an approach to prevent or detect liver disease at an early stage. This paper proposes an approach to address this.
- 2.2 The Barking and Dagenham community alcohol and substance misuse service is currently being re-commissioned and is the subject of a separate paper.
- 2.3 Demand for treatment services for those dependent upon alcohol is putting increased pressure on available borough wide services. Alcohol abuse also has far reaching effects on wider society, such as crime, community disturbance and domestic violence, as well as accounting for hospital admissions. It's impact on children and families can be particularly distressing.

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<sup>1</sup> Barking and Dagenham Substance Misuse Strategy (2016) available at [http://barking-dagenham.limehouse.co.uk/portal/substance\\_misuse\\_strategy\\_2016-2020?tab=files](http://barking-dagenham.limehouse.co.uk/portal/substance_misuse_strategy_2016-2020?tab=files)



## The cost of alcohol misuse

- 2.4 Alcohol abuse has a high cost. According to the Government's Alcohol Strategy of 2012, **alcohol related harm is estimated to cost UK society £21 billion annually**. The estimated cost of alcohol misuse to the NHS in 2011/12 was £3.5 billion.
- 2.5 Data on alcohol related crimes per 1,000 population, as produced by Local Alcohol Profiles England, was for the 2012/13 period. Barking and Dagenham had the 10th highest rate of alcohol related crime and violent crime in the country and the 9th highest in London per 1,000 population in 2012/13.
- 2.6 Alcohol-related disorder has been identified as a concern by residents of Barking and Dagenham through local and national surveys. Such disorder has the potential to generate violent crime, affecting residents' feelings of safety, and in addition has an adverse effect on the local environment through the careless disposal of cans and bottles.
- 2.7 Community safety services, social care and primary care are important as the providers where alcohol related issues are first highlighted, diagnosed and treated, and the alcohol liaison service is vital as the link between primary care, social care, and secondary care.
- 2.8 Progressive liver disease caused by alcohol abuse is a debilitating condition which, as it advances, often requires emergency admission to hospital in order that the symptoms, such as profuse bleeding can be brought under control. It is costly, both in financial terms and the distress that patients experience during these episodes.
- 2.9 Analysis of figures show that Barking and Dagenham is doing better than the national average for hospital admissions and mortality where alcohol was identified as the primary cause.
- 2.10 However, when alcohol is considered a contributory or related factor, Barking and Dagenham is much worse than the national average. One of the probable explanations for this are the Borough's overall poor health outcome rates which are compounded by a higher than average obesity prevalence.
- 2.11 In Barking and Dagenham for 2014/15 the rate of **alcohol specific** hospital admissions for females increased from the 2012/13 rate of 153.8 to 168 (per 100,000 residents), though the male rate of admission decreased from 473 to 463 (per 100,000 residents). Both remained below the London and England rates. In a similar pattern, latest release of figures for **alcohol related** admissions show the rate to have increased by 13% for females and by 5% for males.
- 2.12 A liver disease prevention approach will enable:
- 2.12.1 **Assessment of local need.**
- 2.12.2 **Effective interventions**, and evidence to be provided to commissioners, in a tri-borough strategy, if approval is given, will include an integrated care pathway, alcohol liaison, screening, and brief intervention.

- 2.12.3 **Integrated care pathway development:** it is essential that an integrated care pathway takes a whole system approach to liver disease prevention and is inclusive of community safety partnerships, drug and alcohol services, social care, primary health care and secondary health care.
- 2.12.4 **Benchmarking:** Alcohol liaison services standards are recommended through National Institute for Health and Clinical Excellence (NICE) guidelines. A current tri-borough service is in place, and is under review.
- 2.13 **Early detection:** Periodic opportunistic screening would highlight the issue and help detection of liver disease in the population. A pilot screening session was conducted in November 2016 at Dagenham library that offered residents a free liver scan to detect fibrosis. Thirty-seven people were scanned and of these sixteen were found to have abnormalities i.e. some degree of liver fibrosis and three were found to have liver cirrhosis (advanced fibrosis).
- 2.14 NICE guidelines (2010: 'Alcohol-use disorders: preventing the development of hazardous and harmful drinking') recommend brief advice as an effective initial intervention for those over 18 who show signs of excess alcohol consumption. The 'AUDIT' and 'AUDIT C' are the screening checks that have been in use for several years and have been incorporated into the NHS health check and other lifestyle assessments.
- 2.15 A tri-borough liver disease prevention strategy will assess need, review best evidence, and provide recommendations that are then available to commissioning partners and the Integrated Care Partnership.
- 2.16 The board are asked to support Barking and Dagenham partnership engagement in the development of a tri-borough liver disease prevention strategy.

### **3. Mandatory Implications**

#### **3.1 Joint Strategic Needs Assessment**

- 3.1.1 It is clear from the Joint Strategic Needs Assessment that healthy and safe communities and prevention of liver disease are important areas of focus for Barking and Dagenham.

#### **3.2 Health and Wellbeing Strategy**

- 3.2.1 The liver disease prevention strategy is one action that contributes to the agreed health and wellbeing strategy vision of improving the health and wellbeing of residents and reducing inequalities.

#### **3.3 Integration**

- 3.3.1 The proposed strategy clearly sets out to work to the Health and Wellbeing Board and to contribute to the work of the Accountable Care Partnership. There is a specific focus on a whole system approach to liver disease prevention.

### 3.4 **Financial Implications**

Implications completed by: Katherine Heffernan, Group Manager - Finance

- 3.4.1 There are currently no financial implications directly arising from this report. Should a prevention programme be recommended at a later date, funding for this may be available from the Public Health budget, which is funded through the Public Health Grant.

### 4.5 **Legal Implications**

Implications completed by: Dr. Paul Feild Senior Governance Lawyer

- 4.5.1 The Health and Social Care Act (2012) conferred the responsibility for health improvement to local authorities. The evidence is that Liver disease morbidity and mortality is preventable but it relies on early diagnosis and treatment. Furthermore, the evidence demonstrates that liver disease is a prevalent health issue for the borough. Effective prevention strategies or treatments are available for the three main causes of liver disease that is; alcohol, viral hepatitis and obesity. Intervention to reduce instances of liver disease is likely to decrease the risk of early mortality. A liver disease prevention approach as set out in this report is therefore a key component of the Councils legal responsibility to work to improve the health of its community.
- 4.5.2 The Health and Well-Being Board terms of reference establish its function to ensure that the provision of health and social care services work in their deliver in an integrated matter. These proposals are in keeping with this committee's function.

**Public Background Papers Used in the Preparation of the Report: None**

#### **List of Appendices:**

- Appendix A -** Presentation to Health and Wellbeing Board.  
Barking and Dagenham – liver disease prevention.

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# Liver disease in Barking and Dagenham

Dr Paul Kooner, Consultant Hepatologist, BHRUT/Barts Health  
Matthew Cole, Director of Public Health, LBBD  
Sue Lloyd, Consultant in Public Health, LBBD

Health and Wellbeing Board, 5 July 2017

# Why are residents livers' important?



Converts food into energy →



Fights infections

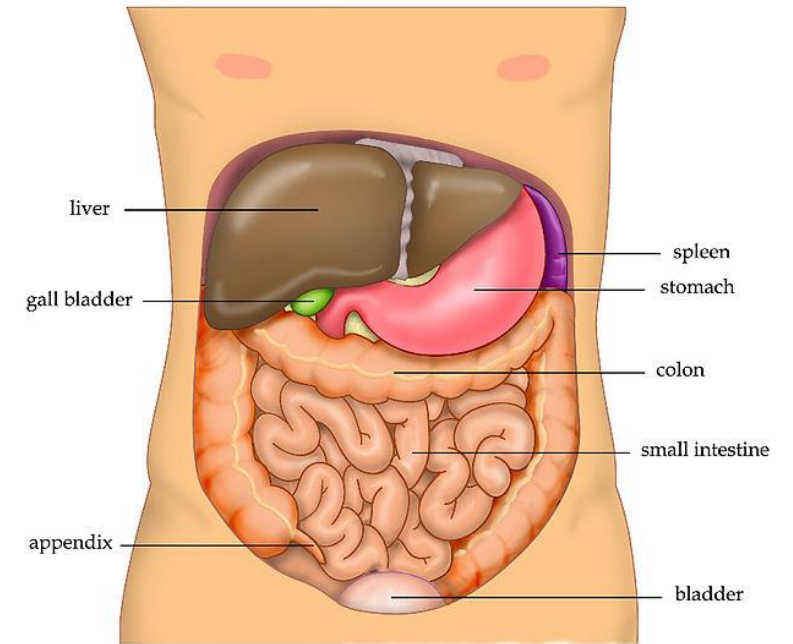


Breaks down toxins and drugs (including alcohol)



Makes, regulates and/or stores essential components:

- Stores iron and vitamins
- Produces and regulates hormones
- Makes enzymes and proteins that allow your body to repair itself
- Regulates fats/glucose in blood stream



Source: Ties van Brussel

# Most liver disease is preventable

## Three key modifiable risk factors:



### Alcohol misuse

- can cause inflammation (hepatitis) or scarring (cirrhosis)
- risk factor for liver cancer

### Overweight and obesity

- can cause non-alcoholic fatty liver disease (where fat builds up in the liver)



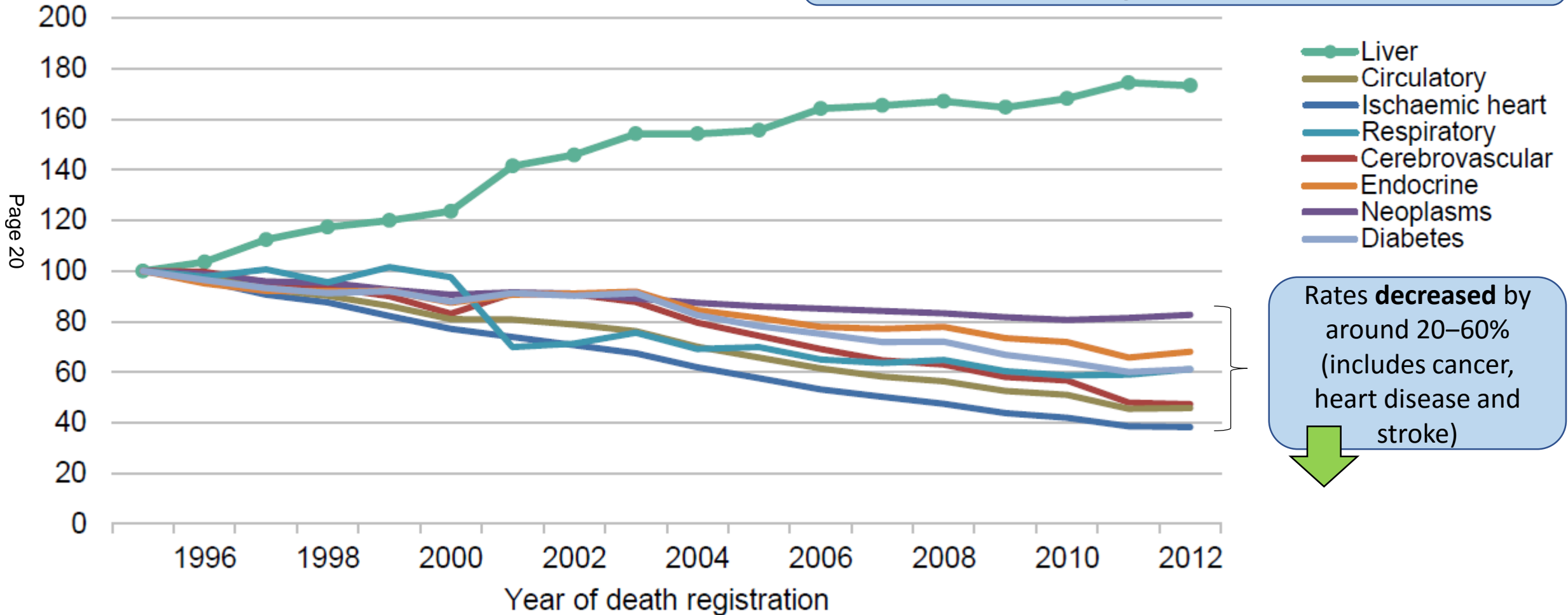
### Hepatitis B and C

- blood-borne viruses
- can cause liver inflammation/cirrhosis
- can increase risk of liver cancer

# Nationally, mortality from liver disease is increasing

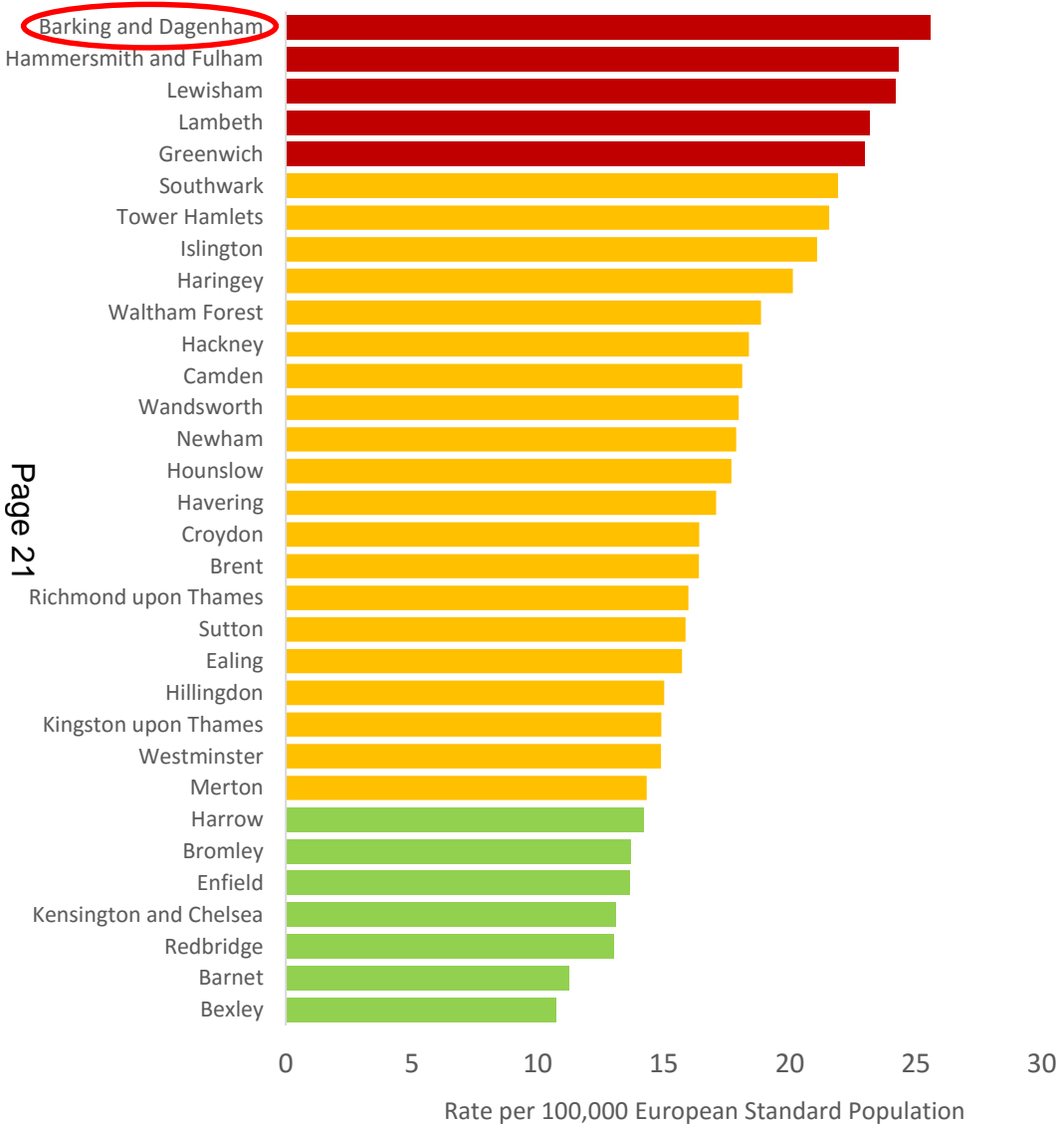
% change from 1995 age-standardised rates

Mortality rates for liver disease **increased by more than 70%** in England from 1995 to 2012





# Premature mortality (<75) from liver disease in B&D is high



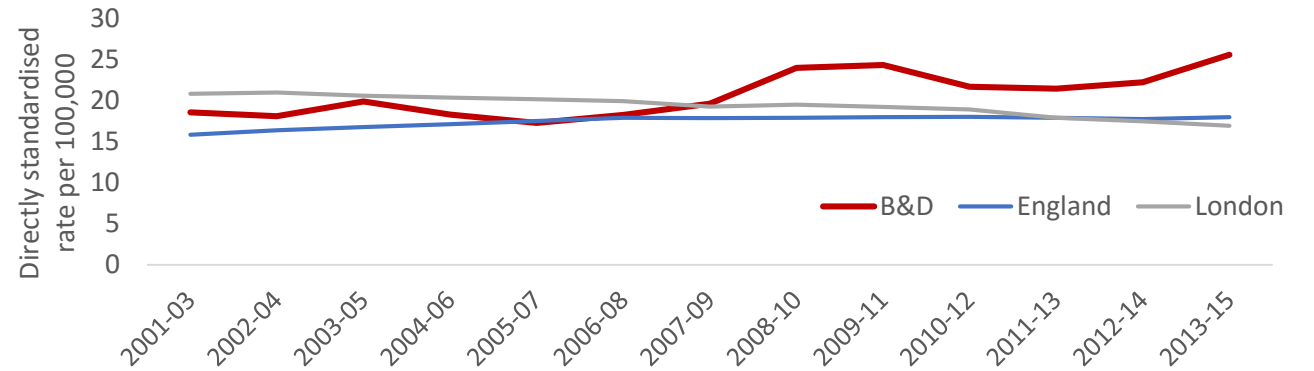
Page 21



Highest age-standardised rate in London



Upward trend



**89 deaths** (2013–15)  $\approx$  30 deaths/year in under 75s



Twice as many male deaths as female deaths



20 deaths/year



10 deaths/year

Men & women combined, directly standardised rate per 100,000. Red/yellow/green = worse/similar/better compared with England. Source: PHE, 2013-15

# 85% of these deaths were potentially preventable

Of the 89 deaths from liver disease in under 75s in 2013–15...



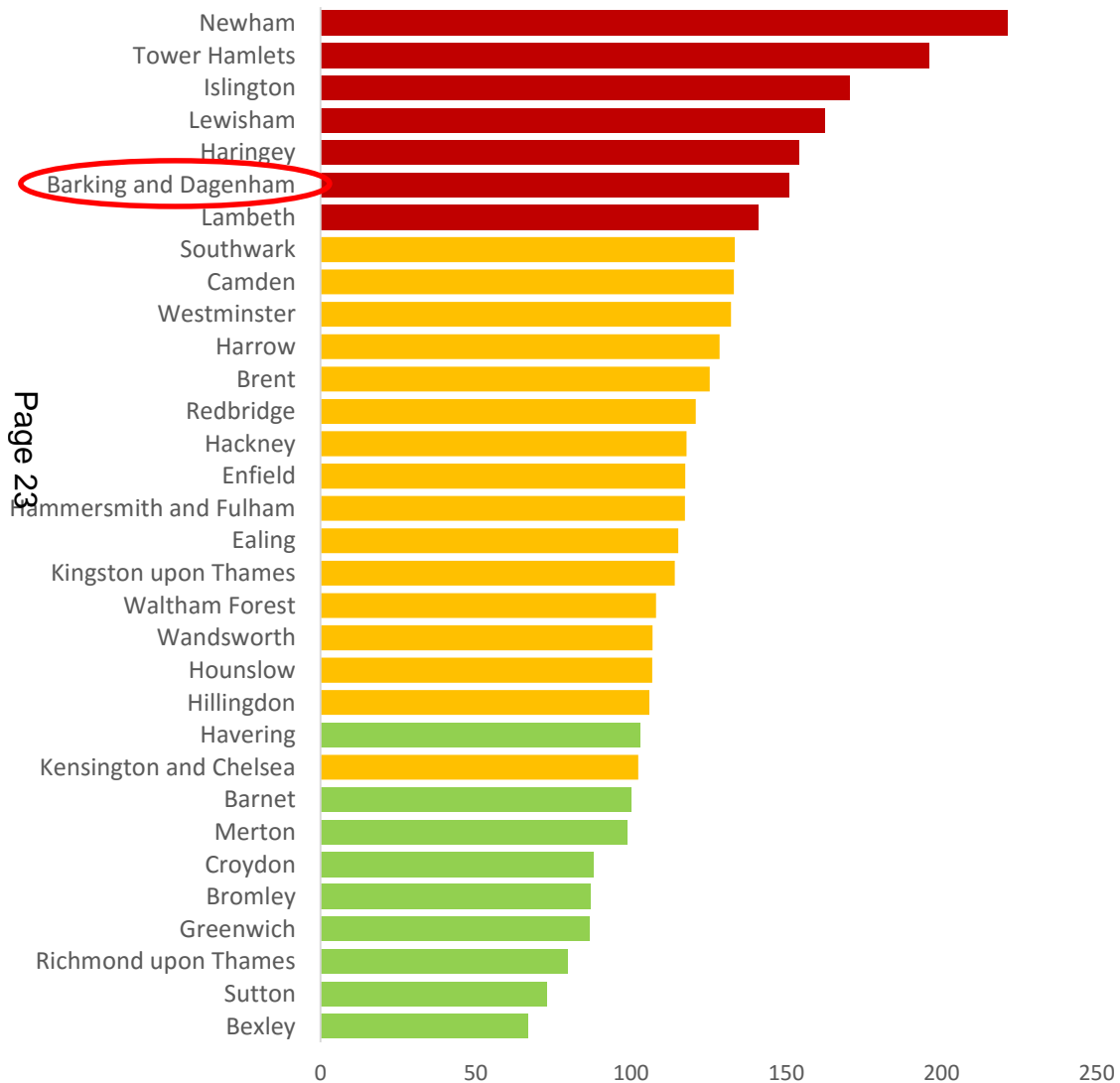
76 (85%) were classed as 'preventable'

i.e. around 25 of 30 deaths from liver disease in under 75s each year are considered preventable in B&D



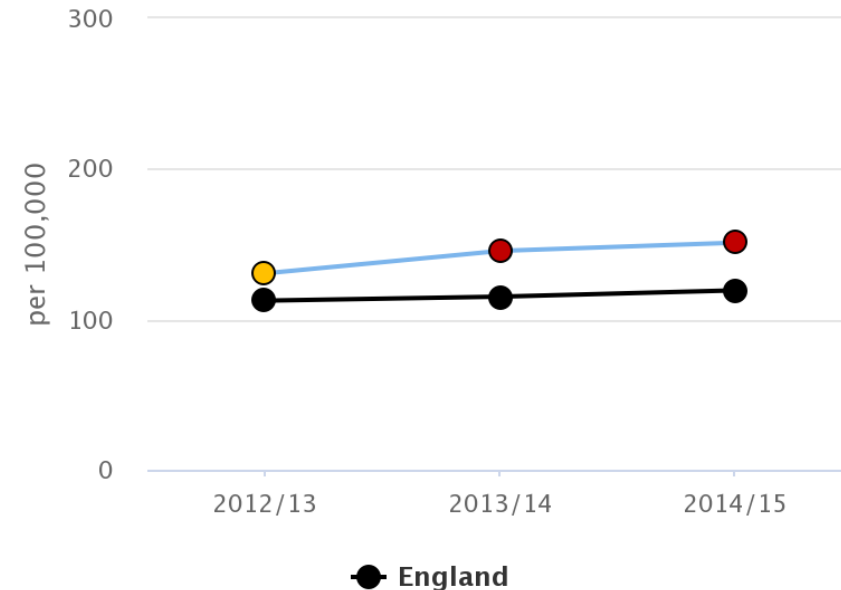
Barking and Dagenham has the highest rate of preventable deaths from liver disease in under 75s in London

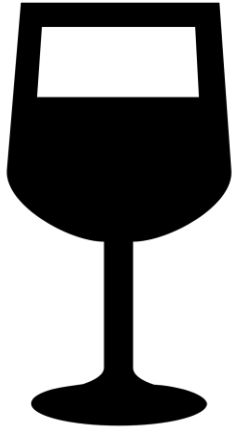
# B&D also has a higher rate of liver disease admissions than the English average



- There were **231 admissions** with a primary diagnosis of liver disease among B&D residents in 2014/15 (40% female, 60% male)
- This has increased over the past three financial years

Hospital admission rate due to liver disease (Persons) – Barking and Dagenham



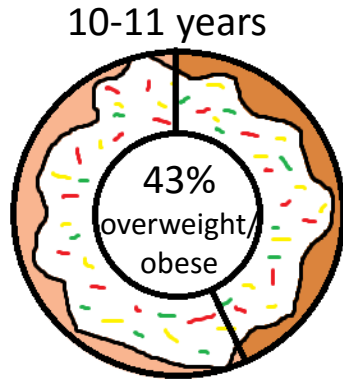


How does this relate to risk factors?



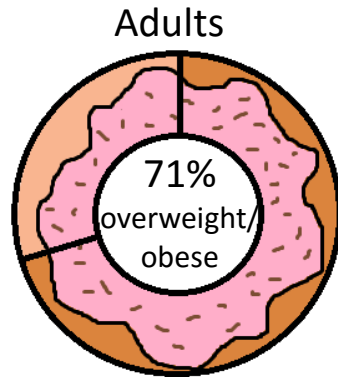
# Obesity-related liver disease

## High rates of overweight/obesity in B&D



Source: NCMP, 2015/16

Highest in London & England



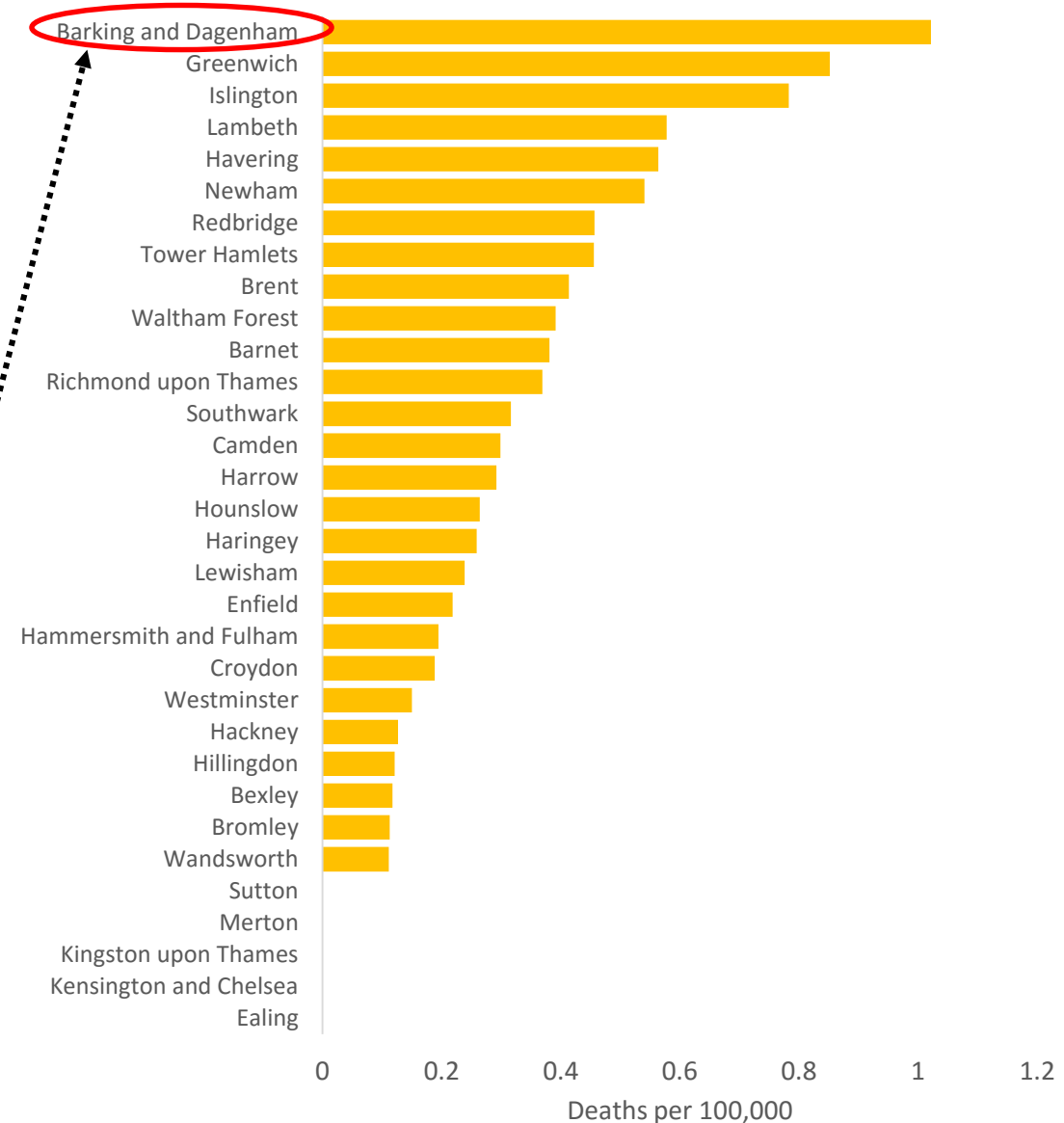
Source: Active People Survey, 2013-15

Highest in London

## Non-alcoholic fatty liver disease (NAFLD)

- Under 75 mortality – **6 deaths** in B&D over three years
- Hospital admissions – **21 admissions** (with primary diagnosis) in B&D over three years

## Under 75 mortality from non-alcoholic fatty liver disease



Men & women combined, crude rate per 100,000. Yellow = similar to England.

Source: PHE, 2013-15

<sup>1</sup> <http://www.nhs.uk/conditions/fatty-liver-disease/Pages/Introduction.aspx>

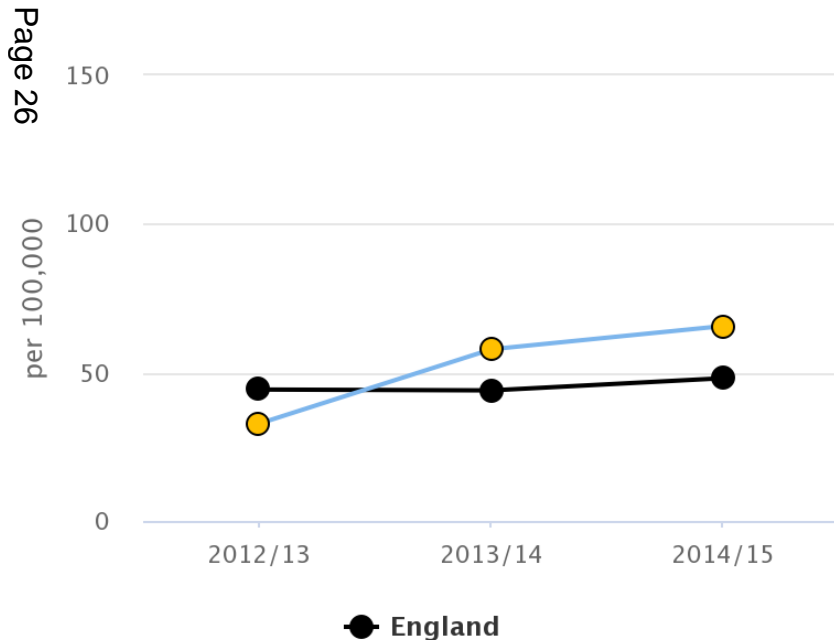
# Alcohol-related liver disease

## Alcoholic liver disease

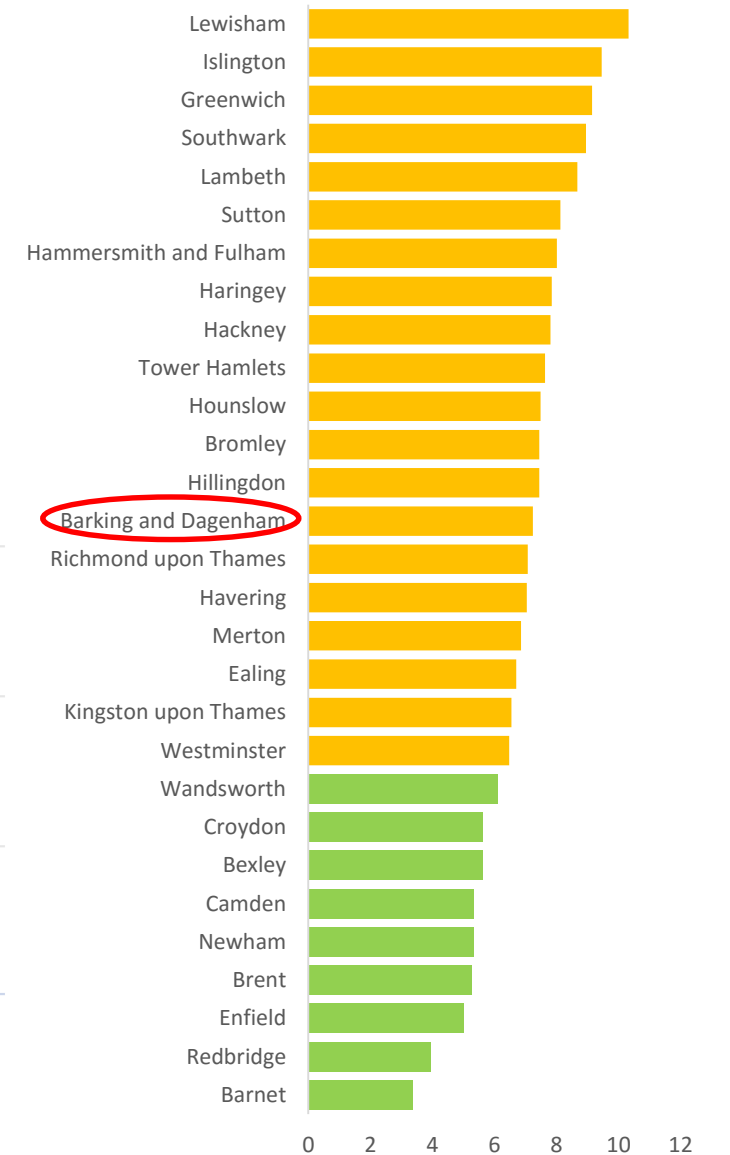
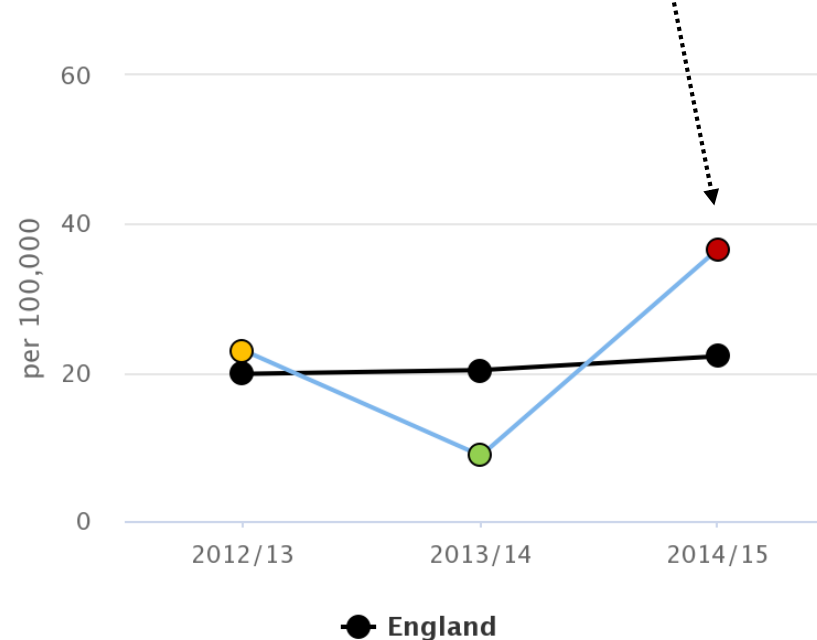
- Under 75 mortality – **30 deaths** over three years (77% male, 23% female)
- Hospital admissions – **84 admissions** (with primary diagnosis) over three years (58% male, 42% female – a higher rate than England in 2014/15)

## Under 75 mortality from alcoholic liver disease

Hospital admission rate for alcoholic liver disease (Male) – Barking and Dagenham



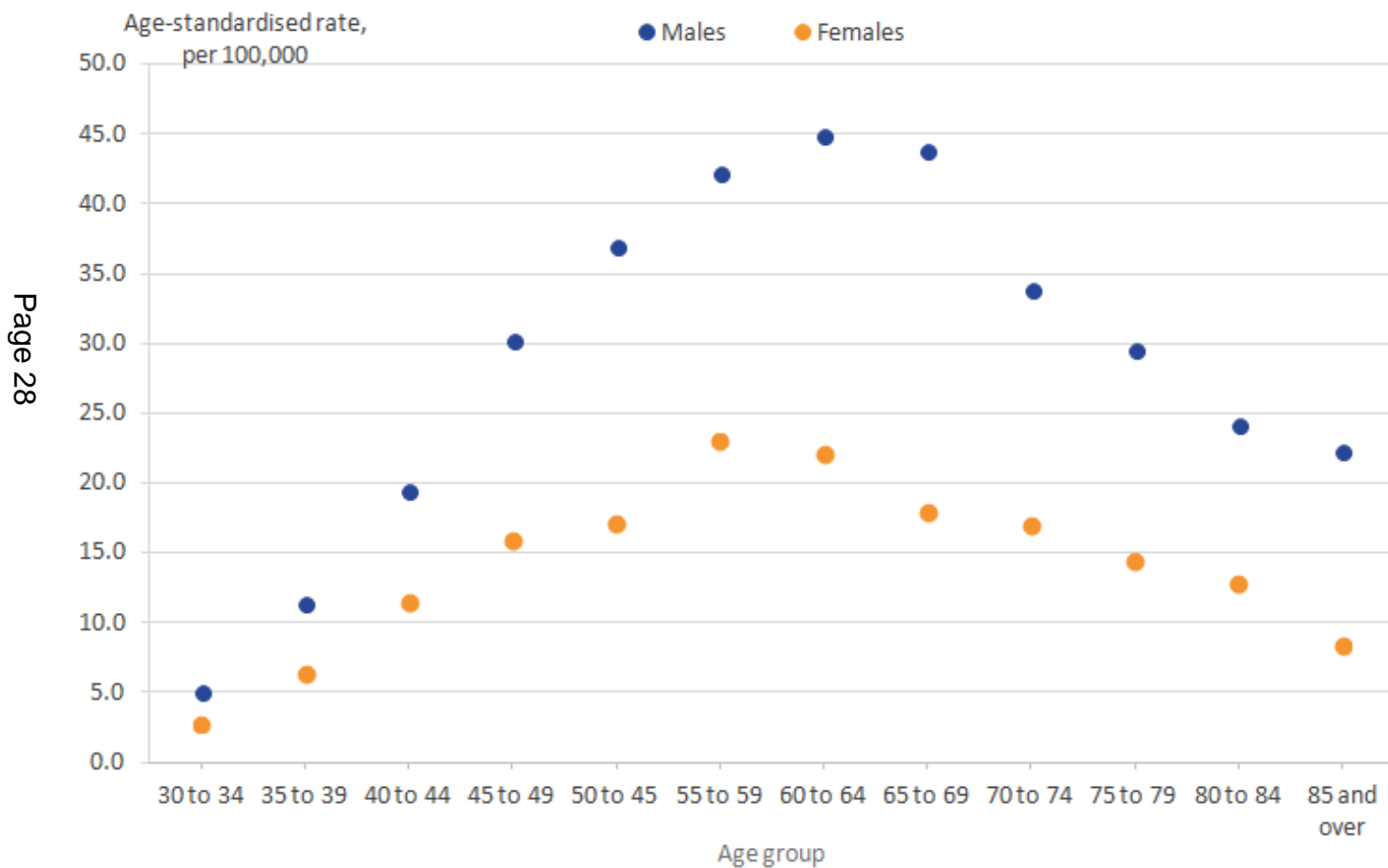
Hospital admission rate for alcoholic liver disease (Female) – Barking and Dagenham



# Other impacts of alcohol

# Alcohol-related deaths contribute to low life expectancy

Deaths from alcohol-related causes are highest in those in their late 50s/60s



UK, 2015

Source: ONS

Note: ONS uses different definition of 'alcohol-related' than PHE

Liver disease is among the top 5 causes of deaths for men and women aged 20–64

Age group	Male	Female
20–34	5th	5th
35–49	4th	2nd
49–64	3rd	5th

Cirrhosis and other diseases of liver  
England and Wales, 2015

Source: ONS





# Alcohol-related admissions in B&D



- Better/similar admission rates for alcohol-specific conditions, or alcohol-related admissions, using a narrow definition, than England
- Higher rate using the broad definition – this is likely to relate to CVD admissions and alcoholic liver disease admissions

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## Overall picture

Admission episodes for...	Male 	Female 	Persons
alcohol-specific conditions	Yellow	Green	Green
alcohol-related conditions (narrow)	Green	Green	Green
alcohol-related conditions (broad)	Red	Red	Red

## Conditions influenced by alcohol

Admission episodes for...	Male 	Female 	Persons
alcohol-related <b>unintentional injuries</b> *	Yellow	Yellow	Yellow
<b>mental and behavioural disorders</b> due to use of alcohol condition*	Yellow	Green	Green
<b>intentional self-poisoning</b> by and exposure to alcohol condition*	Grey	Grey	Green
alcohol-related <b>cardiovascular disease</b> conditions**	Red	Red	Red
<b>mental and behavioural disorders</b> due to use of alcohol condition**	Yellow	Green	Green
<b>alcoholic liver disease</b> **	Yellow	Red	Red
Incidence rate of alcohol-related <b>cancer</b>	Yellow	Yellow	Yellow

\*narrow definition; \*\*broad definition

Red/yellow/green = worse/similar/better compared with England

# Alcohol-related attendances/admissions - BHRUT

A&E attendances: primary alcohol problem		Inpatient admissions: a: alcohol-related primary diagnosis; b: alcohol-related primary or secondary diagnosis	
Queens	KGH	Queens	KGH
1,499	1,005	a) 496 b) 9,638	a) 153 b) 2,977
A&E data, 2015/16		<i>Inpatient coded data drug + alcohol related admissions, 12 months from Oct 2015</i>	

This equates to almost 7 attendances per day with a primary alcohol problem

This equates to 35 patients per day admitted to hospital with an alcohol-linked diagnosis across the trust

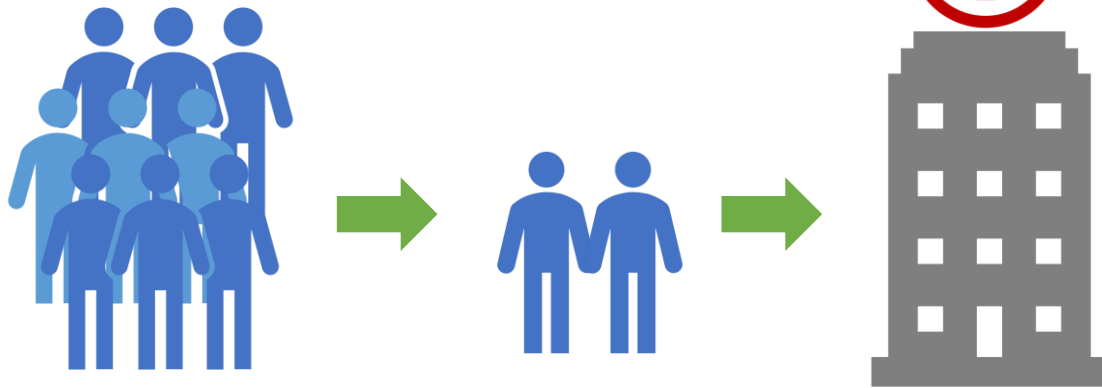
Re-attendances: 258 (10.3%)

- 10 patients attended > 10 times

# New models of care

## Community assessment

- High risk groups
- Screen for liver disease
- Refer to secondary care



## Pop up pilot – ‘Love your Liver’

- Dagenham library, Nov 2016
- Screened + Fibroscanned 37 people
  - 16 people (43%) had abnormal Fibroscans

## Alcohol liaison service

- NICE guidance
- CQC recommendation

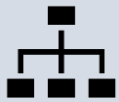


# Liver disease approach B&D

Deliver highest quality of care for all patients with liver disease in the region:



Aim to diagnose liver disease **early**



**Address issues** e.g. joined-up acute alcohol liaison model → **joint approach**

## Year 1

### **Regional strategy NE London**

Joined up approach between 3 boroughs

Robust links to STP prevention approach, alcohol

**BHR** Health system level

Clear pathways into secondary care e.g. Non- Alcoholic Fatty Liver Disease

BHRUT alcohol liaison service – robust + sustainable

Bring together into single network all disparate drug + alcohol services

## Years 2-3

### **Outreach**


Target difficult to reach groups

Screen for viral hepatitis and treat in community

Target alcohol + obesity for liver disease



# The Barking and Dagenham Prevention Approach




**Substance misuse strategy**

**Alcohol misuse**


- can cause inflammation (hepatitis) or scarring (cirrhosis)
- risk factor for liver cancer

**Overweight and obesity**

- can cause non-alcoholic fatty liver disease
- more fat builds up in the liver



**Healthy weight strategy**



**Health protection**

**Hepatitis B and C**

- blood-borne virus
- can cause liver inflammation/cirrhosis
- can increase risk of liver cancer



# The Barking and Dagenham Prevention Approach

**Substance misuse strategy**

**Alcohol misuse**

- can cause inflammation (hepatitis) or scarring (cirrhosis)
- risk factor for liver cancer

## Current Service

- Community De-Tox
- Structured Rehabilitation
- Hospital Liaison
- Borough awareness programmes
- Residential Rehabilitation
- Groups
- Outreach
- GP liaison
- Relapse prevention work

## Current projects

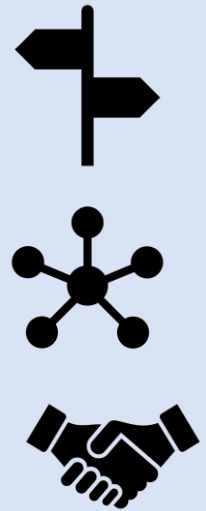
- Liver “pop-up” shops
- Probation Outreach
- Job Centre Outreach
- Street Drinking outreach



# The Future Community Alcohol Service

## Incorporated into the vision of a fully Integrated Drug and Alcohol Service in May 2018

- Trauma-informed service delivery
- Lessons learned from the Street Drinking Project
- Better community specific Outreach and satellite delivery
- Continuation of JCP and Probation Outreach
- Increased Mental Health Integration and Partnership working



# The Barking and Dagenham Prevention Approach



**Overweight and obesity**

- can cause non-alcoholic fatty liver disease
- ...are fat builds up in the liver)

**Healthy weight strategy**



NHS health checks – 40 – 74 years

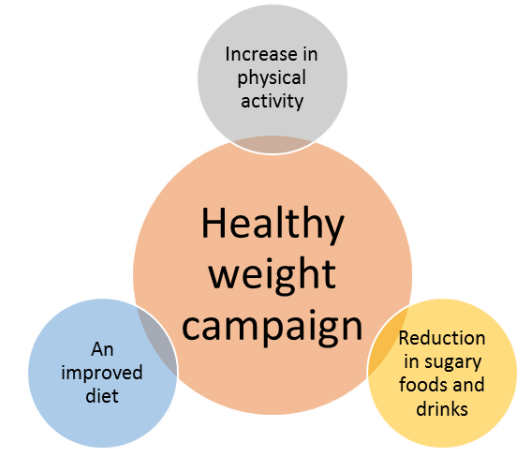
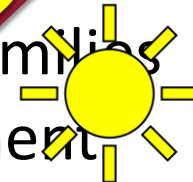
## Lifestyle services

- Exercise prescription
- Adult weight management
- Child weight management
- Active ageing

## Behaviour change approach

- Understanding our families
- Change the environment

**Summer fun**



## The Great Weight Debate

A London conversation on childhood obesity





# Liver disease in Barking and Dagenham

1. Do partners wish to support a tri-borough approach to liver disease prevention?
2. Do partners agree that prevention and early diagnosis are priorities, particularly for individuals with a higher than recommended alcohol intake?

# Liver disease in Barking and Dagenham

Dr Paul Kooner, Consultant Hepatologist, BHRUT/Barts Health  
Matthew Cole, Director of Public Health, LBBD  
Sue Lloyd, Consultant in Public Health, LBBD

Health and Wellbeing Board, 5 July 2017

## HEALTH AND WELLBEING BOARD

5 July 2017

<b>Title:</b>	<b>Care City Innovation Test Bed Update</b>		
<b>Report of the Deputy Chief Executive and Strategic Director for Service Development and Integration</b>			
<b>Open Report</b>		<b>For Information</b>	
<b>Wards Affected:</b> All		<b>Key Decision:</b> No	
<b>Report Author:</b> Rhys Clyne: National Management Trainee, LBBD		<b>Contact Details:</b> Tel: 020 8227 3033 E-mail: rhys.clyne@lbbd.gov.uk	
<b>Sponsor:</b> Anne Bristow, Deputy Chief Executive and Strategic Director for Service Development and Integration, LBBD			
<b>Summary</b>			
This report provides an introduction to a presentation from John Craig, CEO of Care City, on the work being undertaken by Care City within Barking and Dagenham.			
<b>Recommendation(s)</b>			
The Health and Wellbeing Board is recommended to:			
(i) Note the contents of this report, and of the presentation of the CEO of Care City;			
(ii) Note the work being undertaken by Care City in Barking and Dagenham, and keep abreast of the future progress of Care City; and			
(iii) Further discussions with Care City regarding its work and potential collaboration with the Board.			
<b>Reason(s)</b>			
The Board is responsible for encouraging integration and innovation in health and social care in Barking and Dagenham, and delivering improved health outcomes and reduced inequalities for its residents. Care City is undertaking relevant work to this remit, and so it is to the Board's advantage to be made aware and updated of its progress.			

**1. Introduction and Background**

- 1.1 With a growing population – expected to reach 275,000 by 2037 – and demand for health and social care services rising even faster, with continued poor health outcomes and inequalities experienced by the residents of Barking and Dagenham, and facing substantial pressures on budgets due to both this increase in demand as

well as the impact of the austerity of the past 7 years, health and care integration and innovation has never been so important.

- 1.2 Care City is an innovation centre for healthy ageing, based in Barking. It engages in research, innovation and education to enable local people to enjoy a better later life. It was founded by North East London NHS Foundation Trust (NELFT) and the Council in October 2013, and represents their joint endeavour to help the whole health and care system to enable healthy ageing. Care City is a team of ten people, with diverse backgrounds ranging from consulting, public policy, academia and design, to emergency medicine and pharmacy. They work closely with patients and citizens and with commissioners and providers of health and care services to support healthy ageing. It serves Barking & Dagenham, Havering, Redbridge and Waltham Forest, an area of around one million people. It attracts resources, ideas and talent in to the health and care economy, to help it to progress.
- 1.3 Two insights inspired the creation of Care City. First, while there is a lot of rhetoric about integrating health and care, under the pressure of austerity, this requires significant **innovation**. Second, while Care City's geography has relatively high unemployment, health and care providers face recruitment and retention challenges, and connecting these two issues represents an opportunity for **regeneration**. As a result, Care City seeks to enable healthy ageing through both innovation within public services and regeneration within the locality.
- 1.4 To make a reality of this approach to enabling healthy ageing, Care City organises its work around three activities; research, innovation and education. We aim to provide the research to develop new ideas, the innovation to put them into practice and the education to help them spread, unlocking new opportunities for care and for employment alike.
- 1.5 In October 2016 John Craig became CEO of Care City. He joined Care City after a year spent consulting to public service organisations, working on strategy and innovation. He has worked with FutureGov, the Cabinet Office's Policy Lab, Shelter and Stonewall. Previously Craig spent 5 years leading Innovation Unit, an independent non-profit which seeks to develop radically better, lower-cost public services.

## **2. Mandatory Implications**

### **Joint Strategic Needs Assessment**

- 2.1 The needs and inequalities identified by the 2016 Barking and Dagenham JSNA are among the targets of Care City's innovation, by keeping people healthy longer by improving healthy ageing.

### **Health and Wellbeing Strategy**

- 2.2 The Health and Wellbeing Strategy outlines priorities under the key themes of prevention, improvement and integration of services, care and support, protection and safeguarding. Care City's innovation aims to improve healthy ageing through preventative innovation, has significant interests in the improvement and integration of services, and forwards care and support.

## **Integration**

- 2.3 One of Care City's strategic priorities is to stimulate continuous improvement and innovation across the local health and social care system. The potential for integration within this context is substantial.

## **Patient/Service User Impact**

- 2.4 Innovation of the kind Care City pioneers has the potential for substantial improvements to impact of services available to users.

## **Financial Implications** (completed by: Katherine Heffernan, Group Manager, Service Finance)

- 2.5 There are no financial implications arising directly out of this report. Any future work commissioned from Care City will be funded from existing resources with the specific budget being identified at that point.

## **Legal Implications** (Implications completed by: Dr. Paul Feild, Senior Governance Lawyer)

- 2.6 There are no legal implications arising directly out of this report.

**Public Background Papers Used in the Preparation of the Report:** None

**List of appendices:** None

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## HEALTH AND WELLBEING BOARD

5 July 2017

<b>Title:</b>	<b>Stepping Up: The Future of the Health and Wellbeing Board</b>		
<b>Report of the Deputy Chief Executive and Strategic Director for Service Development and Integration</b>			
<b>Open Report</b>	<b>For Information</b>		
<b>Wards Affected:</b> None	<b>Key Decision:</b> No		
<b>Report Author:</b> Rhys Clyne: National Management Trainee	<b>Contact Details:</b> Tel: 020 8227 3033 E-mail: rhys.clyne@lbbd.gov.uk		
<b>Sponsor:</b> Anne Bristow, Deputy Chief Executive and Strategic Director for Service Development and Integration, LBBD			
<b>Summary</b>			
<p>In January 2017 members of the Board undertook a workshop on the future direction and vision of the Board, and how it can deliver better health and wellbeing outcomes for the residents of Barking and Dagenham.</p> <p>This report captures the outcomes of that workshop, and reflects on discussions held on the future practice, direction and vision of the Board. It outlines how the Board will seek in the future to prioritise its time and resources on the most substantive and important issues, how it will align and engage with wider Barking and Dagenham, Havering and Redbridge (BHR) integration work, and how it will seek further and more effective integration and collaboration.</p>			
<b>Recommendation(s)</b>			
The Health and Wellbeing Board is recommended to note and discuss the content of this report.			
<b>Reason(s)</b>			
In order for the Board to fulfil its responsibilities of encouraging health and social care integration, and delivering improved outcomes and reduced inequalities for the residents of Barking and Dagenham, it is vital that the focus, operation and direction of the Board be evaluated and improved as necessary.			

## 1. Introduction and Background

- 1.1 The remit of the Health and Wellbeing Board, established on 1 April 2013 under the provisions of the Health and Social Care Act 2012, is to strengthen working relationships between health and social care, and encourage the development of more integrated commissioning of services. Through its work the Board seeks to improve health and wellbeing outcomes, and reduce health inequalities, of local people.

- 1.2 With the population of Barking and Dagenham growing rapidly – expected to reach 275,000 by 2037 – and demand for health and social care services increasing even faster, with a wide range of health inequalities continuing to impact residents, and with budgets facing the pressures of this demand in conjunction with the last 7 years of austerity, the Board’s responsibility to encourage substantive integration and innovation has never been so important and urgent.
- 1.3 It is, therefore, essential to ensure that the Board is using its time and resources in the most efficient and effective way possible, targeting innovative and important proposals and challenges, in order to best serve the residents of Barking and Dagenham.

## **2. January 2017 workshop**

2.1 In January 2017 members of the Board took part in a workshop on the current state and future of the Health and Wellbeing Board, and how it can best serve its aims and purpose. This workshop generated a number of outcomes and perspectives:

- Momentum is key. It was agreed that the Board needs to maintain a strong pace behind the integration work being sought, in order to meet the urgent demand we face.
- It was agreed that the members of the Board need to ensure all resources and avenues for commissioning and integration are being utilised, and that the Board is placed at the centre of co-ordinating the impact of system-wide initiatives (for example the BHR programmes and the STP) on Barking & Dagenham. The Council’s role as the focal point for a community leadership for Barking & Dagenham needs to be expressed through the Board and through these discussions.
- The Board should devise and agree a narrative on the history of health and social care integration in Barking and Dagenham. This should prove the long-standing commitment to integration, the ‘ups and downs’ of what has been done before, what is currently being undertaken and the lessons learned so far. In addition, this narrative could be added to with a commonly agreed vision for the future of health and social care integration in the borough, outlining the principles of effective collaboration and integration we have learned over previous and current undertakings.
- We have a rich history of health and social care integration, and in many ways are currently pioneering the field. Yet the borough does not receive the praise, attention and engagement it deserves for this work, and partners remain overly modest with regard to integration achievements. This modesty holds back further progress, and the Board must foster a positive, optimistic attitude which both encourages future work, and informs others of our achievements.

## **3. Reframing the operation of the Board**

3.1 Since the workshop in January 2017, discussions have continued about how these findings can inform changes to the working of the Health and Wellbeing Board. In



summary, there is common agreement that the best way forward for the Board would be for its business to be conducted with:

- Fewer, more substantive items and less routine operational business;
- A stronger emphasis on ensuring a place for discussion about system interventions, principally the BHR Integrated Care Partnership and the East London Health & Care Partnership (the Sustainability & Transformation Plan);
- Consideration of the timing of meetings;
- A refreshed substructure for the Board

### **Proposals for the operation of the Board**

- 3.2 First and foremost is that, going forward, those **items brought to the Board are fewer but more substantive** in terms of impact. With shorter agendas, focusing on key issues or proposals, the Board will be freed to delve deeper into discussion and debate, developing a more focused and effective approach. This will mean that some items, such as some procurement contracts, are likely to be addressed through other Council member-level forums, principally Cabinet, with other regular items being circulated to members for informal consideration outside of the Board. Consequently, a review is being undertaken of the Board's forward plan for the next year.
- 3.3 It is important that the Board's **agenda is aligned with that of the wider BHR integration**. As joint commissioning and further integration are approached, the Board will dedicate more resource to investigating the relevant topics and developing shared stances. This will strengthen the Board's position within the region, and allow it to speak with a coherent, unified voice.
- 3.4 Members have also raised the issue of the **timing of its meetings**. Aware of the schedules of members, this is an issue which is being considered in the changing approach of the Board's operation.
- 3.5 The governance of **the Board and its sub-structure** is being further developed to improve its effectiveness and communication. This will reflect the new form and responsibilities of the Integrated Care Partnership, as well as reforming and strengthening of the Children's Partnership (formerly the Children and Maternity Group). It is vital that the Board is supported by an effective sub-structure with significant responsibility, so as to allow the Board itself to take a strategic overview and direct the health and social care sector in the borough. The current refreshed position is attached at Appendix A.

### **Development of a stronger narrative for integration in Barking & Dagenham**

- 3.6 As decided at the January 2017 workshop, a narrative is being developed, and will be presented to the September 2017 Board, on the history and theory of health and social care integration in Barking and Dagenham. As well as detailing previous and current undertakings, this report will outline the lessons learned from these projects, and how they inform our understanding of integration moving forward. This will act

as a guide to future collaboration, and a means of evidencing the achievements made thus far.

## **4. Conclusion**

- 4.1 It is important that members discuss these ideas, and share any other thoughts on how the Board can take the most effective approach possible to achieve its aims and deliver for residents.
- 4.2 A report will be brought to the September 2017 Board, further outlining the changing direction of the Board, presenting the integration narrative described above, and reflecting any additional proposals or challenges identified.

## **5. Mandatory Implications**

### **Joint Strategic Needs Assessment**

- 5.1 The remit of the Board is to encourage integration of health and social care and deliver improved health outcomes and reduced inequalities for the residents of Barking and Dagenham, including those identified in the 2016 JSNA. Therefore, working to maximise the efficiency, effectiveness and direction of the Board – as this report does – aims to improve the Board’s ability to react to the findings of the JSNA.

### **Health and Wellbeing Strategy**

- 5.2 The Health and Wellbeing Strategy includes in its key themes prevention, improvement and integration of services, care and support, protection and safeguarding. A more effective Health and Wellbeing Board would be able to forward each of these priorities, and in particular prevention, and improvement and integration of services, as more resource and time may be focused on these key issues.

### **Integration**

- 5.3 The proposed new direction of the Board will allow it to dedicate greater resources and time to substantive topics of health and social care integration; a central purpose of the Board.

### **Financial Implications** (completed by: Katherine Heffernan, Group Manager – Services Finance)

- 5.4 There are no financial implications directly arising out of this report.

### **Legal Implications** (completed by Dr. Paul Field, Senior Corporate Governance Lawyer)

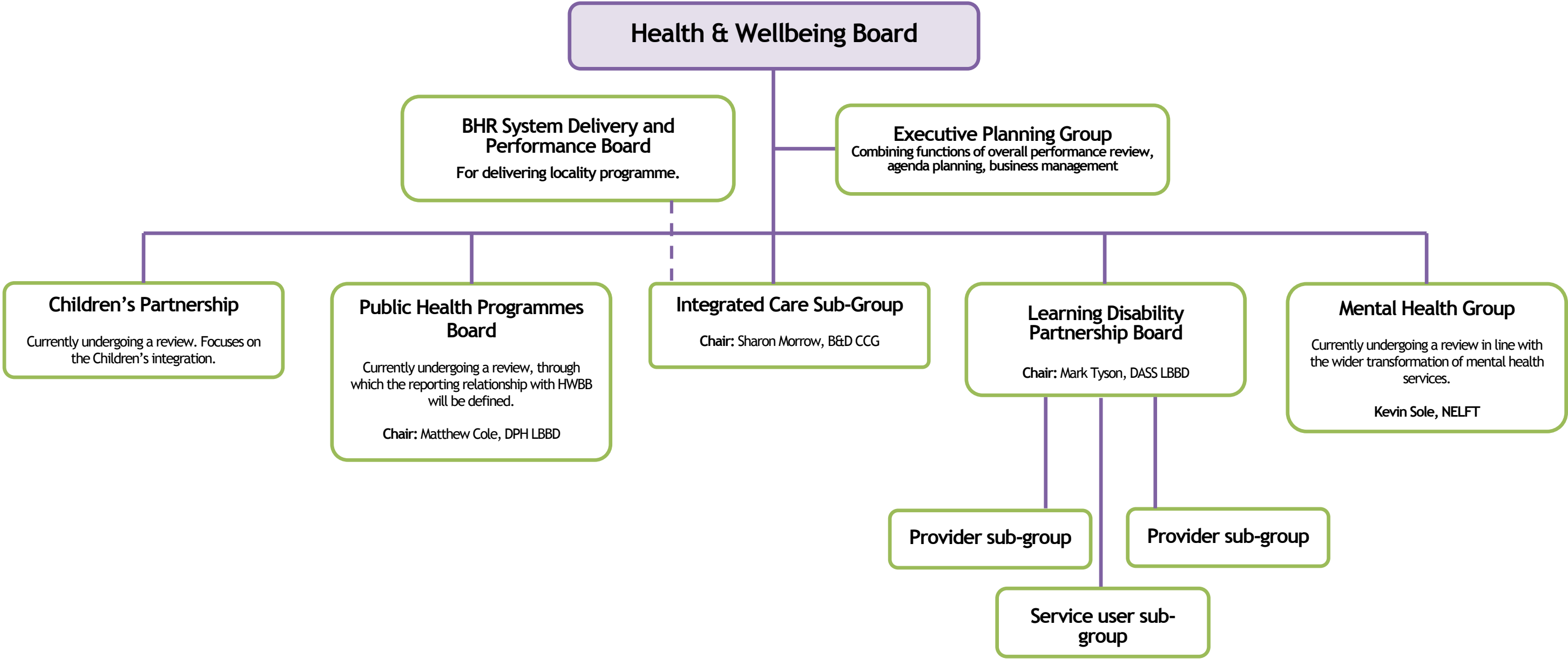
- 5.5 The Health and Social Care Act (2012) conferred the responsibility for health improvement to local authorities. In addition as a best value authority under the Local Government Act 1999 there is a duty on the Council to secure continuous improvement. The Health and Well-Being Board terms of reference establish its function to ensure that the providers of health and social care services work in their delivery in an integrated manner.

- 5.6 As the report explains the key trust of the Boards statutory responsibility is to secure continuous improvement this is overall a strategic role and the implication is that the boards business should be primarily focused to leadership by setting direction and promoting change. It therefore follows that with finite resources the time of the Board to consider items is inevitably precious and those matters which can be delegated to officers should be actively considered such as for example procurement. The Board can still monitor the work through periodic reporting by the appropriate directors.

**Public Background Papers Used in the Preparation of the Report: None**

**List of Appendices:**

**Appendix A: Health and Wellbeing Board governance sub-structure**



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## HEALTH AND WELLBEING BOARD

5 July 2017

<b>Title:</b>	<b>Integration and Better Care Fund Plan 2017/19 Update</b>		
<b>Report of the Strategic Director for Service Development and Integration</b>			
<b>Open Report</b>	<b>For Decision</b>		
<b>Wards Affected:</b> None	<b>Key Decision:</b> Yes		
<b>Report Author:</b> Rhys Clyne: National Management Trainee, LBBD	<b>Contact Details:</b> Tel: 020 8227 3033 E-mail: <a href="mailto:rhys.clyne@lbbd.gov.uk">rhys.clyne@lbbd.gov.uk</a>		
<b>Sponsor:</b> Anne Bristow, Strategic Director for Service Development and Integration, LBBD			
<b>Summary</b>			
<p>This report outlines the development of the 2017-19 Integration and Better Care Fund (BCF) Plan in Barking and Dagenham, Havering and Redbridge (BHR), and seeks delegated authority to approve the completed plan.</p> <p>The Integration and Better Care Fund is a joint Department of Health (DoH), Department for Communities and Local Government (DCLG), NHS England and Local Government Association (LGA) programme spanning local government and the NHS, which seeks to address mounting budgetary and demand pressures through health and social care integration, ultimately aiming to allow people to manage their own health and wellbeing, and live independently in their own communities for as long as possible.</p> <p>While final policy guidance is yet to be released, and is subject to continued delay, a preferred approach has been identified by the local authorities, utilising tools provided by the Local Government association, and discussions are ongoing with the relevant Clinical Commissioning Groups (CCGs) and other partners, in order to finalise the 2017-19 Plan for this region. The Plan will seek to build on the work of the 2015-17 Plan, and increase the resource and scope available for true integration, transformation and innovation across our local health and social care economy.</p> <p>The Government have also clarified that monies awarded to local government through the social care grant, whilst subject to specific conditions, will need to be managed through the BCF pool.</p>			
<b>Recommendation(s)</b>			
The Health and Wellbeing Board is recommended to:			
<ul style="list-style-type: none"> <li>(i) Note and discuss the content of this report, and in particular, the approach to the development of the 2017-19 BHR Integration and Better Care Fund Plan;</li> <li>(ii) Delegate authority to approve the final 2017-19 Integration and Better Care Fund Plan to the Strategic Director for Service Development and Integration, in</li> </ul>			

consultation with the Cabinet Member for Social Care and Health Integration, the Accountable Officer for the BHR Clinical Commissioning Groups and the Director of Law and Governance;

- (iii) Note that further steps in the development of the Plan beyond Year 1 will receive the full consideration of the Board and key stakeholders; and
- (iv) Agree that developments are reported back to the Board and that further approval be sought prior to Year 2 of the 2017-19 Plan.

**Reason(s)**

It is a requirement that the Plan be approved by each Health and Wellbeing Board, or the authority delegated and utilised as such, prior to its submission to NHS England.

## **1. Introduction and Background**

- 1.1 The population of Barking and Dagenham, and the wider BHR region, is growing rapidly. Between 2001 and 2011 LBBD's population rose from 164,000 to 186,000, and is projected to reach 275,000 by 2037. As well as growth, our population is becoming more complex and our health and wellbeing needs are intensifying and diversifying. For example, recent research by the University of Liverpool and University College London suggests a likely 25 per cent increase in the number of people requiring care in the UK between 2015 and 2025, a pattern we can expect to see mirrored in Barking and Dagenham.
- 1.2 This is placing increasing strain on already pressured budgets across health and social care services. Despite NHS budgets having been protected during the programme of public sector austerity followed by the past three national Governments, funding for the NHS is failing to keep up with both demand and economic growth. Between 2015/16 and 2020/21 funding increases will average 0.7 per cent a year in real terms, compared to the long-term average of approximately 4.0 per cent a year since the NHS was established. Despite the extra £2bn for adult social care announced in the 2017 Budget, to be incorporated into this BCF Plan, funding of the social care sector is facing similarly severe pressure. This pressure is manifesting with an increasing difficulty to provide safe, secure and high-quality services. For example, 75 care home businesses across the UK were declared insolvent in 2016.
- 1.3 The residents of Barking and Dagenham already live with a range of poor health and wellbeing outcomes and inequalities. The healthy life expectancy in Barking and Dagenham is 60 for men and 59 for women, compared to the London averages of 64. Obesity – especially among children – smoking, alcohol and drug abuse, a lack of healthy food options and regular activity are particular problems for Barking and Dagenham, and contribute to our already-high health and social care needs.
- 1.4 The severity of this crisis make efforts to design innovative and sustainable services which transform and integrate the health and care sectors more important than ever. Organisations across the country are approaching service integration and transformation in a variety of ways, at different levels, and with differing outcomes.



## **2. The Better Care Fund (BCF)**

- 2.1 One such attempt to progress towards health and social care integration has been the BCF, a joint DoH, DCLG, LGA and NHS England programme spanning local government and the NHS in the various regions of the country. The BCF, announced by the Government in the 2013 spending round, seeks to encourage integration by requiring CCGs and local authorities to enter into pooled budgetary arrangements and agree an integrated spending plan, in line with the vision of the NHS Five Year Forward View. The Better Care Fund has for 2017-19 been renamed the Integration and Better Care Fund to more fully reflect this emphasis.
- 2.2 It is intended that integrated and closer working relationships between the health and care sectors, supported by the integration and BCF, will allow health and wellbeing outcomes to be the focus of services, rather than bureaucratic process, for the benefit of the people, communities and health and care systems.

## **3. Governance**

- 3.1 The intricacies of the governance through which the BCF will be implemented will be confirmed during year 1 of the 2017-19 Plan, and detailed in the update brought to the Board prior to year 2. However it is proposed that the BCF Plan be developed and implemented by the recently established Joint Commissioning Board, which in turn is accountable to the Integrated Care Partnership Board and the Health and Wellbeing Board. This would ensure that the Plan is responsive to local need, and remains accountable to each Health and Wellbeing Board across the BHR region.
- 3.2 The current governance arrangements including the Joint Commissioning Board, Integrated Care Partnership and Health and Wellbeing Board is outlined in Appendix C.

## **4. The 2015-17 Plan**

- 4.1 While it is recognised that the 2015-17 BCF Plan was successfully implemented, and some valuable integration work has been undertaken, along with performance improvement in key metrics, analysis of the first BCF Plan has made apparent a number of issues of consideration when designing the 2017-19 Plan:
  - The range and depth of innovation made possible by BCF has been restricted by the extent to which pooled resources have been locked into pre-existing services and schemes. With tight budget constraints innovation has mostly arisen through utilisation of areas of underspend and 'carry forward'; relatively small areas of BCF spend, leading to less substantial integration and modest innovation.
  - The first Plan and policy guidance brought a focus on metrics which are monitored with little or no consequence, due to the removal of risk share.
  - Local areas are inevitably limited in the level of traction they are able to achieve on overarching services across BHR.

- There has been undue scrutiny on activity falling within the Protection of Social Care (PoSC) funds within joint management discussions, despite no policy requirement to breakdown PoSC in this fashion.
- Despite being conceptually permissible within our Section 75 Agreements, there has been an inability to re-target contractually significant commitments to fully match BCF needs.
- The national conditions of the BCF are not always clearly being met by activity described in the current plan.
- Prevention is not as prominent within the current plan as it should, most importantly in helping to reduce and prevent demand for social care and health services. For example, the importance of the role of public health and of local authorities in prevention should be increased.

## **5. The 2017-19 Plan**

- 5.1 Policy guidance for the 2017-19 BCF Plans is yet to be released, however the DoH and DCLG have published a policy framework and some supporting information, outlining some of the changes that will be made in the Fund's application and implementation.
- 5.2 The main change to the framework for the forthcoming Plan will be the inclusion of significant amounts of local authority social care grant funding, announced at the 2015 spending review and the 2017 Budget. However, these new funds will include conditions to ensure it has the expected impact on the frontline of social care.
- 5.3 To streamline the planning and performance process, the number of national conditions attached to BCF have been reduced from 8 to 4, and the requirements regarding the social care national condition are to be detailed more clearly.
- 5.4 The 4 remaining conditions are:
- Plans must be jointly agreed
  - The NHS contribution to adult social care must be maintained in line with inflation
  - There must be an agreement to invest in NHS-commissioned out-of-hospital services
  - There must be plans to manage transfers of care
- 5.5 There are further conditions from NHS England on the CCG elements of funding:
- A requirement that the BCF is transferred into one or more pooled funds established under Section 75 of the NHS Act 2006
  - A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authorities and CCGs

### **The Improved Better Care Fund (iBCF)**

- 5.6 The Government's Spending Review in 2015 announced new funds for the BCF to the value of £105m for 2017-18, £825m for 2018-19, and £1.5bn for 2019-20. The 2017 Spring Budget subsequently increased this to £1.15bn for 2017-18, £1.499bn

for 2018-19, and £1.837bn for 2019-20. The Government will require that this additional iBCF funding for adult social care be pooled into the BCF in each region. This funding does not replace, and must not be offset against the NHS minimum contribution to adult social care.

5.7 The new iBCF grant will be paid directly to local authorities via a Section 31 grant with a set of conditions, summarised as:

- It may be used only for the purpose of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.
- The recipient authority must pool the grant funding into the local BCF – unless with written ministerial exemption – and it must work with the relevant CCGs and providers to meet the national condition regarding managing transfers of care.
- It is to be used to quickly provide stability and extra capacity in local care systems. Whilst we recognise that the grant is non-recurring which may militate against establishing on-going commitments, such as those of fee increases, without planning to meet the on-going financial costs. It is also the case that the social care grant allocation merely goes part way to replace the loss of funding local authorities have seen in the last few years.

5.8 The national funding for the 2017-19 Plan can be summarised as such:

<b>BCF funding contribution (£bn)</b>	<b>2017-18</b>	<b>2018-19</b>
Minimum NHS (CCGs) contribution	£3.582bn	£3.65bn
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.431bn	£0.468bn
New grant allocation for adult social care (iBCF)	£1.115bn	£1.499bn
<b>Total</b>	<b>£5.128bn</b>	<b>£5.617bn</b>

## **6. Proposed Approach for the 2017-19 BHR BCF Plan**

6.1 The BHR BCF Plan is currently under development. However, due to the deadlines for the submission of local Plans to NHS England, the Board is asked to note, discuss and approve the approach being taken to the development of the shared BHR Plan, and delegate authority for final approval to the Deputy Chief Executive & Strategic Director for Service Development and Integration. However, developments will be brought to the Board, and further approval will be sought from the Board, prior to year 2 of the Plan.

6.2 In particular, a series of principles and proposals have guided the drafting of this agreement.

6.3 Protection of Social Care to be applied into the Councils' base budget, to better protect against services being stopped or reduced with severe consequences for the local health system.

- 6.4 The creation of an Intermediate Care Tier, funded by both the CCGs and the local authorities. It is proposed that the CCGs fund the majority if not the whole of the Community Health budget into the BCF, in order to meet the requirement for community spend. The local authorities to fund the Reablement, plus any other relevant spend, such as Help not Hospitals. Though all such decisions will be subject to the necessary governance of each partner organisation. Intermediate Care proposals are due for consideration by the Joint Commissioning Board on the 30<sup>th</sup> June but intermediate care would become an overarching BHR wide scheme within the BCF.
- 6.5 In light of the vision of the BHR Integrated Care Partnership, as well as the likely 'graduation' principles attached to the 2017-19 Plan, there is merit in reviewing the depth to which the BCF Plan might be joined across BHR's Health and Wellbeing Boards. Due to the delay in the publication of the policy guidance, and the likely speed with which the Plans will be required to be submitted, it is unlikely that there is sufficient time available to fully unite the 3 plans in 2017-18. However, a staged approach would allow the detail of a joint Plan to be formed during 2017-18, and implemented in 2018-19. This staged approach would also allow plans to be structured to ensure that the 'protection of social care' element of funding is still funded directly, and the remaining pool is used to support a more integrated Plan.
- 6.6 Under this staged approach, revised governance arrangements would be devised and implemented during 2017-18 across the BHR system, leading to an overarching pool of funding for substantive integration initiatives during 2018-19. This will be achieved by, in 2017-18, agreeing common commissioning and provision interests between the Boroughs, lead commissioning opportunities for these mutual interests with consequent delegations, and a single or separate Section 75 agreement(s).

## 7. Financial Breakdown

- 7.1 The allocations which have been made available for the Integration and BCF Pool in the next two years comprise of the following funding streams:

<b>Integration &amp; BCF funding streams</b>	<b>2017-18</b>	<b>2018-19</b>
<b>Local Authority funding</b>	<b>£000</b>	<b>£000</b>
LA Minimum contribution:		
Disabled Facilities grant (DFG):	1,391	1,391
Improved BCF allocation (iBCF):	1,044	4,910
Additional funding for ASC	4,385	2,616
LA Other contributions:		
Base Budgets:	1,523	1,523
<b>Total LA funding</b>	<b>8,343</b>	<b>10,440</b>
<b>CCG funding</b>		
CCG Minimum contribution:	13,415	13,670
<b>Total BCF pool</b>	<b>21,758</b>	<b>24,110</b>

- 7.2 The Local Authority would receive the minimum contributions, i.e. the DFG, iBCF and the additional funding for social care, directly from the DCLG. Currently the Council is the host of these funds, therefore the rest of the funds, excluding the LBBB base funds, would be drawn down via the CCG.

## **8. Conclusion**

- 8.1 The Integration and Better Care Fund – if devised and implemented effectively – is capable of enabling substantial and transformative integration in the health and social care sectors, much needed if services are to continue to meet the needs of a growing and increasingly in-need population.
- 8.2 To ensure that the 2017-19 Plan is implemented to its fullest potential a staged approach will be followed, in which year 1 will be spent revising governance arrangements and agreeing areas of mutual commissioning interest and consequent commissioning leads. Year 2 will use an overarching, freed and flexible pooled budget to follow these joint commissioning plans, in order to integrate sustainable health and social care services in Barking and Dagenham, Havering and Redbridge. This iterative approach will enable full engagement with stakeholders and learning from steps achieved through year 1.
- 8.3 Our approach to the delivery of a shared plan across BHR both recognises the benefits and opportunities this will bring and that with this ambition, comes a level of challenge, not least, the encompassing of BHR wide delivery with the retention of local priorities and flavours that each area brings.

## **9. Mandatory Implications**

### **Joint Strategic Needs Assessment (JSNA)**

- 9.1 The JSNA analyses the health and wellbeing needs of the residents of Barking and Dagenham. It highlights the critical importance of safe, high-quality and sustainable health and care services, in order to keep people healthy, happy and independent for as long as possible. Therefore, the JSNA outlines the urgent need for the successful implementation of the BCF, and with it the delivery of the necessary service integration.

### **Health and Wellbeing Strategy**

- 9.2 A priority area of the Health and Wellbeing Strategy is the 'improvement and integration of services'. In particular, the Strategy describes the Better Care Fund as 'an opportunity for much improved integration of services to ensure smooth and effective linkage of health and social care solutions'.

### **Integration**

- 9.3 The purpose of the BCF is to encourage the integration of health and social care services through the requirement that local authorities and CCGs pool budgets and mutually agree plans for integrated services and initiatives.

**Financial Implications** (completed by: Katherine Heffernan, Group Finance Manager)

- 9.4 The new Integration BCF which brings together health and social care funding and requires the Local Authority and the CCG to agree a two-year plan from 2017 -19 to align with the NHS's planning timetables thereby developing more co-ordinated and sustainable services which should result in efficient use of resources.
- 9.5 The total pooled fund for the two financial years are £21.758m in 2017-18 and £24.110m in 2018-19 respectively. At this stage details of spend against the plan in the two financial years are yet to be finalised.
- 9.6 The Local Authority's minimum contribution which includes the iBCF and the additional ASC grant, has specific grant conditions attached and quarterly reports on spend progress are to be submitted. The Disabled Facilities grant also has conditions attached and requires a signed declaration from the Chief Executive or the Chief Internal Auditor. All documents would be submitted to the Department for Communities & Local Government (DCLG).
- 9.7 The Council is currently the host for this funding, therefore monthly financial updates on spend against the agreed plan will continue to be submitted to the Joint Executive Management Committee and quarterly returns on performance to NHS England.
- 9.8 The Local Authority would need to ensure that the grant funds are spent in line with the specific conditions to ensure that the funding is not clawed back and future years funding reduced or suspended.

**Legal Implications** (completed by Dr. Paul Field, Senior Corporate Lawyer, LBBB)

- 9.9 Due to the urgency to meet the deadlines for the submission of local Plans to NHS England and to ensure the best outcome this Reports proposed approach for the 2017-19 BHR BCF Plan is to seek the Boards approval to delegate authority to approve the final 2017-19 integration and BCF Plan to the Deputy Chief Executive & Strategic Director for Service Development and Integration, LBBB, in consultation with the Director of Law and Governance, and the Cabinet Member for Social Care and Health Integration and Chair of this Board.
- 9.10 This delegation is qualified in the report by the recognition that further steps in the development of the Plan beyond year 1 will receive the full consideration of the Board and key stakeholders will continue to play their full part.

**Risk Management**

- 9.11 Risks have been managed by requiring the Plan to be brought back to the Board prior to Year 2 of the 2017-19 Plan.

**Public Background Papers Used in the Preparation of the Report: None**

**List of Appendices:**

<b>Appendix A</b>	Policy Framework
<b>Appendix B</b>	LGA BCF Frequently Asked Questions
<b>Appendix C</b>	Current Governance Arrangements



Department  
of Health



Department for  
Communities and  
Local Government

APPENDIX A

# 2017-19 Integration and Better Care Fund

Policy Framework

March 2017

<b>Title: Integration and Better Care Fund Policy Framework 2017-19</b>
<b>Author: Social Care, Ageing and Disability / Integration, Local Devolution and Policy Improvement / 11120</b>
<b>Document Purpose: Policy</b>
<b>Publication date:</b> 03/17
<b>Target audience:</b> This document is intended for use by those responsible for delivering the Better Care Fund at a local level (such as clinical commissioning groups, local authorities and health and wellbeing boards) and NHS England.
<b>Contact details:</b> Integration, Local Devolution and Policy Improvement Unit Richmond House Whitehall London SW1A 2NS  <a href="mailto:Bettercarefund@dh.gsi.gov.uk">Bettercarefund@dh.gsi.gov.uk</a>

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# 2017-19 Integration and Better Care Fund

## Policy Framework

**Prepared by the Department of Health and the Department for Communities and Local  
Government**

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# Executive Summary

## Why Integrate?

People need health, social care, housing and other public services to work seamlessly together to deliver better quality care. More joined up services help improve the health and care of local populations and may make more efficient use of available resources.

## How is Integration being done?

There is no single way to integrate health and care. Some areas are looking to scale-up existing initiatives such as the New Care Models programme and the Integration Pioneers. Others are using local devolution or Sustainability and Transformation Plans as the impetus for their integration efforts.

## One part of the solution – the Better Care Fund

The Better Care Fund is the only mandatory policy to facilitate integration. It brings together health and social care funding, with a major injection of social care money announced at Spring Budget 2017. This policy framework for the Fund covers two financial years to align with NHS planning timetables and to give areas the opportunity to plan more strategically. Details of the financial breakdown are below:

Better Care Fund funding contribution (£bn)	2017-18	2018-19
Minimum NHS (clinical commissioning groups) contribution	£3.582	£3.65
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.431	£0.468
New grant allocation for adult social care (Improved Better Care Fund)*	£1.115	£1.499
<b>Total</b>	<b>£5.128 billion</b>	<b>£5.617 billion</b>

\*Combined amounts announced at Spending Review 2015 and Spring Budget 2017

Many areas choose to pool more than is required. For 2017-19, there are four national conditions, rather than the previous eight:

- 1. Plans to be jointly agreed**
- 2. NHS contribution to adult social care is maintained in line with inflation**
- 3. Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care**

### 4. **Managing Transfers of Care** (a new condition to ensure people's care transfers smoothly between services and settings).

Beyond this, areas have flexibility in how the Fund is spent over health, care and housing schemes or services, but need to agree how this spending will improve performance in the following four metrics: **Delayed transfers of care; Non-elective admissions (General and Acute); Admissions to residential and care homes; and Effectiveness of reablement.**

### Going beyond the Better Care Fund through Graduation

The Better Care Fund is intended to encourage further integration and 90% of areas say it has already had a positive impact on integration locally. For the most integrated areas, there will be benefits in graduating from the Fund to reduce the reporting and oversight to which they are subjected. We are planning to test the graduation process with a small number of advanced areas (6 to 10) in a 'first wave', in order to develop our criteria for graduation for all areas. We are therefore inviting 'Expressions of Interest' from areas that think they are exemplars of integration, by 28th April 2017.

### Agreeing a local vision of integration

As part of Better Care Fund planning, we are asking areas to set out how they are going to achieve further integration by 2020. We would encourage areas to align their approach to health and care integration with Sustainability and Transformation Plan geographies, where appropriate. This may be an exact match (e.g. Greater Manchester) or it may be smaller units within Sustainability and Transformation Plans. The focus may also be on commissioning integration (e.g. North East Lincolnshire) or through Accountable Care Systems or Organisations that bring together provision (e.g. Northumberland). What matters is that there is locally agreed clarity on the approach and the geographical footprint which will be the focus for integration.

### Measuring progress on integration

To help areas understand whether they are meeting our integration ambition, we are seeking to rapidly develop integration metrics for assessing progress, particularly at the interface where health and social care interact. These will combine outcome metrics, user experience and process measures. Following the development of the metrics and an assessment of local areas, we will ask the Care Quality Commission to carry out targeted reviews in a small number of areas, starting as soon as is practical from May 2017. These reviews will be focused on the interface of health and social care.

### Need more detail?

Further information on everything here can be found in the full Integration and Better Care Fund Policy Framework 2017-19.

# Introduction

This document sets out the story of integration of health, social care and other public services. It provides an overview of related policy initiatives and legislation. It includes the policy framework for the implementation of the statutory Better Care Fund (BCF) in 2017-19, which was first announced in the Government's Spending Review of 2013 and established in the Care Act 2014. And it sets out our proposals for going beyond the BCF towards further integration by 2020. Whilst there will now be no separate process for integration plans, we will provide a set of resources, integration models and indicators for integration to help local areas towards our shared goal of person-centred, coordinated care.

This Policy Framework has been developed by the Department of Health (DH), Department for Communities and Local Government (DCLG), Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), and NHS England.

## The case for integrated health and care services

Today, people are living much longer, often with highly complex needs and multiple conditions. These needs require ongoing management from both health and care services, which combine both the medical and social models of care. As our population ages and the financial pressures on the health and care system increase, we need to be better at providing proactive, preventative care in community settings, so that people can be supported to live at home for longer and avoid the need for commissioned health and care services.

More joined up and sustainable services help improve the health and care of local populations and may make more efficient use of available resources (i.e. by reducing avoidable hospital admissions, facilitating timely discharge, and improving people's experiences of care). Integration needs to reflect the different strengths that the NHS and social care bring to an integrated response, including the role of social services of promoting and supporting independence, inclusion and rights as far as possible, invigorating wider community services and supporting informal carers.

People want services to work together to provide them with person-centred coordinated care. National Voices set out a narrative for person-centred care, which sums up what we are working to achieve: "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."<sup>1</sup> This translates into positive interactions with health and care services, and better experiences for individuals as illustrated by Figure 1.

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<sup>1</sup> <http://www.nationalvoices.org.uk/publications/our-publications/narrative-person-centred-coordinated-care>

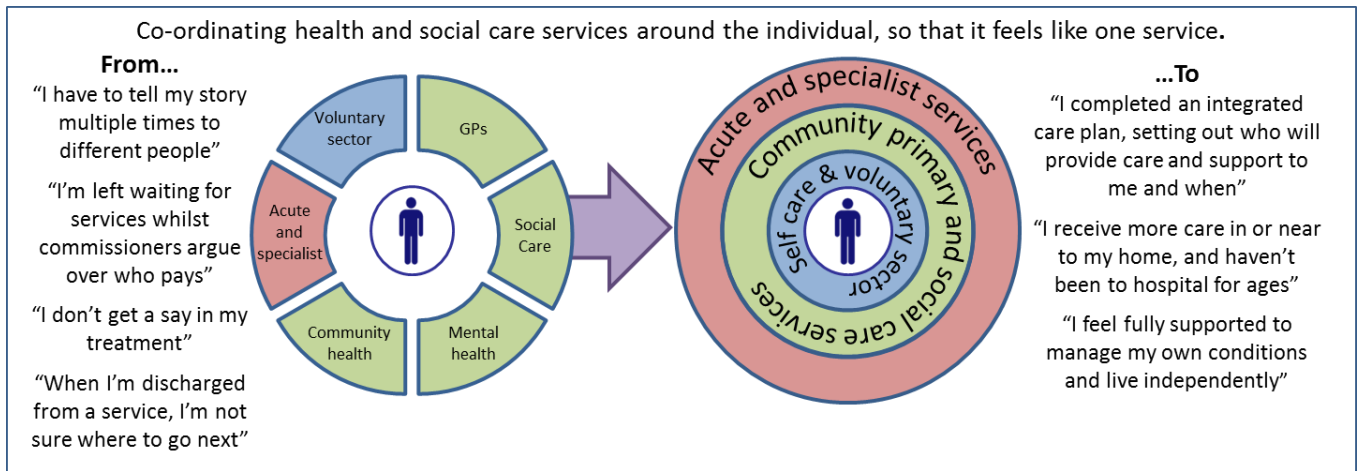


Figure 1: Co-ordinating health and care services around the individual

# 1. Integration to date

Integration is not a new goal and there have been initiatives over a number of years (see Figure 2).

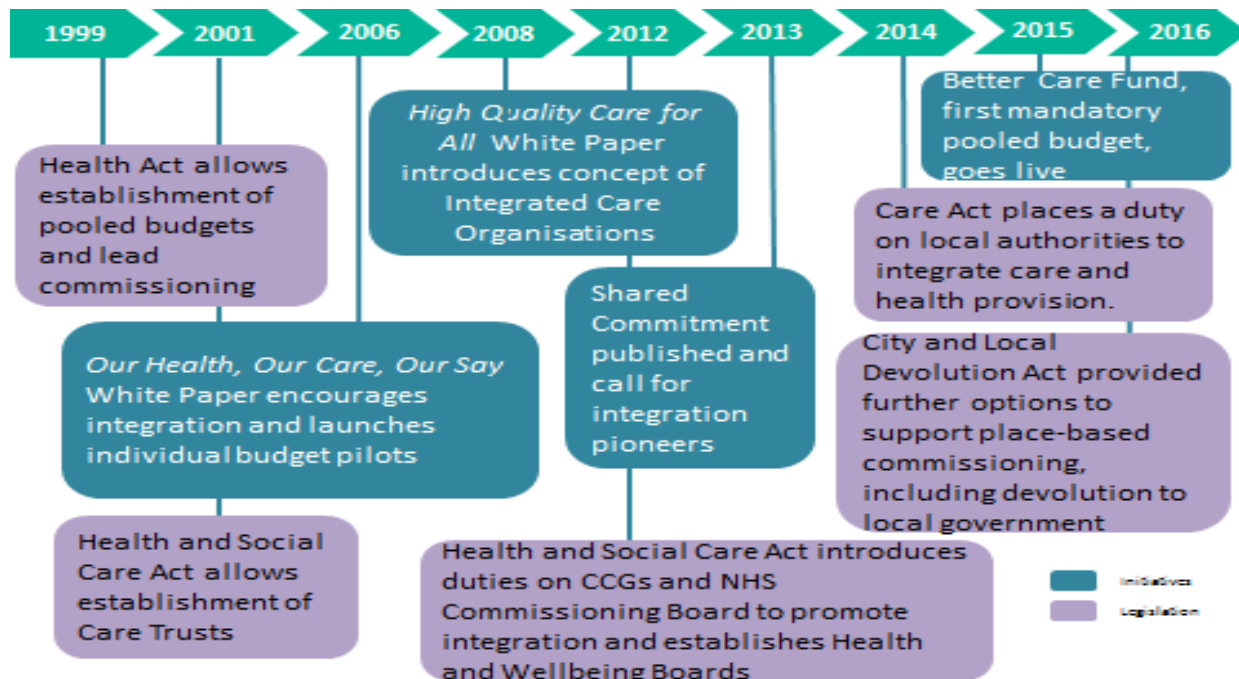


Figure 2: Key integration initiatives and enabling legislation

The Coalition Government and partners set out collective intentions on integration in [Integrated Care and Support: Our Shared Commitment](#) in 2013.<sup>2</sup> This showed how local areas can use existing structures such as **Health and Wellbeing Boards** to bring together local authorities, the NHS, care and support providers, education, housing services, public health and others to make further steps towards integration.

This collaboration with 12 national partners was backed by a call for areas wanting to lead the way to apply to become an ‘Integrated Care Pioneer’. We identified excellent examples of joined-up care happening in different ways up and down the country and the **Integrated Care Pioneers Programme** was launched to learn from the most innovative areas and to encourage change from the bottom up. The second annual report<sup>3</sup> of the Pioneers summarises some of the recent learning and experiences, and the Pioneers’ resource centre<sup>4</sup> contains a collection of tools, information and useful links.

<sup>2</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/198748/DEFINITIVE\\_FINAL\\_VERSION\\_Integrated\\_Care\\_and\\_Support\\_-\\_Our\\_Shared\\_Commitment\\_2013-05-13.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf)

<sup>3</sup> <https://www.england.nhs.uk/pioneers/wp-content/uploads/sites/30/2016/01/pioneer-programme-year2-report.pdf>

<sup>4</sup> <https://www.england.nhs.uk/pioneers/resource-centre/>

More recently, the LGA, ADASS, NHS Confederation and NHS Clinical Commissioners have developed a shared vision document, [Stepping up to the place](#)<sup>5</sup> for a fully integrated system based on existing evidence. This framework describes the essential characteristics of an integrated system to improve the health and wellbeing of local populations, and paves the way for integration to happen faster and to go further, so that integrated, preventative, person-centred care becomes the norm.

There is also a growing recognition of the important contribution of housing to integration. A national [Memorandum of Understanding to Support Joint Action on Improving Health through the Home](#)<sup>6</sup> has been signed by a spectrum of organisations including: DH, DCLG, NHS England, ADASS and the LGA, along with members of the wider housing sector. The proposals set out in the Housing White Paper – Fixing our Broken Housing Market<sup>7</sup> – also underline the Government’s commitment to do more to provide the homes we need for all in our society, including older people and those with care and support needs.

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<sup>5</sup> [http://www.nhsconfed.org/~//media/Confederation/Files/Publications/Documents/Stepping%20up%20to%20the%20place\\_Br1413\\_WEB.pdf](http://www.nhsconfed.org/~//media/Confederation/Files/Publications/Documents/Stepping%20up%20to%20the%20place_Br1413_WEB.pdf)

<sup>6</sup> <https://www.adass.org.uk/media/3957/health-and-housing-mou-final-dec-14.pdf>

<sup>7</sup> <https://www.gov.uk/government/collections/housing-white-paper>



## 2. Integration now and the wider policy context

Just as progress has already been made on integration, there are a number of current initiatives across the health and care system that contribute towards this goal.

Announced in June 2013, the **Better Care Fund (BCF)** brings together health and social care budgets to support more person-centred, coordinated care. In the first two years of the BCF, the total amount pooled has been £5.3bn in 2015-16 and £5.8bn in 2016-17.

The BCF offers a good opportunity to have shared conversations, and to consider issues from different perspectives, particularly how BCF plans can support the delivery of wider objectives and strategies around health and social care. In particular, every health and care system in England has produced a **Sustainability and Transformation Plan (STP)**, providing the system-level framework within which organisations in local health and care economies can plan effectively and deliver a sustainable, transformed and integrated health and care service. Local areas should ensure the financial planning and overall direction of travel within BCF plans and the local STP(s) are fully aligned.

The **vanguards**, which are part of NHS England's new care models programme<sup>8</sup>, have clear plans for managing demand more effectively across the local health and care system and reducing costs, at the same time as improving outcomes for patients and users. The vanguards programme has published two frameworks that cover population-based integrated models – the **Multi-speciality Community Providers (MCPs) and the Primary and Acute Care Systems (PACs)**.<sup>9</sup> Many of these two types of vanguards include social care as well as pursuing integration within health services. All areas are encouraged to take action against the core elements described in the models where these support local objectives around the integration of health and care services. Scaling up of PACS and MCPs in a small number of STP areas will create Accountable Care Organisations, with further details in the Next Steps on the NHS Five Year Forward View.

Local devolution deals can add impetus to all of these initiatives, offering local areas the opportunity to go beyond the integration of health and social care and drawing in other local government services such as housing, planning, skills, justice, and transport. This provides opportunities for local areas to further tailor public services around individual needs and also to tackle the wider determinants of health. Figure 3 shows how multiple integration initiatives interact, for example, within Greater Manchester.

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<sup>8</sup> [https://www.england.nhs.uk/wp-content/uploads/2015/11/new\\_care\\_models.pdf](https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf)

<sup>9</sup> <https://www.england.nhs.uk/wp-content/uploads/2016/09/pacs-framework.pdf> and <https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf>



Figure 3 – Integration initiatives in Greater Manchester

There is a growing evidence base on the contribution that **housing** can make to good health and wellbeing. At a system level, poor housing costs the NHS at least £1.4bn per annum. And there are also costs to local government and social care. On an individual level, suitable housing can help people remain healthier, happier and independent for longer, and support them to perform the activities of daily living that are important to them – washing and dressing, preparing meals, staying in contact with friends and family.

The increase in funding for the **Disabled Facilities Grant (DFG)** – and the decision to move it into the BCF in 2015-16 – is recognised as an important step in the right direction. Further action to support people into more suitable accommodation, and to adapt existing stock, is also to be welcomed.

The Department of Health is also currently working with NHS England, Local Government and others to improve the support available to informal **carers**. Supporting informal carers also supports those they care for: improving outcomes for both parties, enabling people to live independently in the community for longer and reducing impact on commissioned services. All areas are therefore encouraged to consider how BCF plans can improve the support for carers. In doing so, they may wish to make use of *'An Integrated Approach to Identifying and Assessing Carer Health & Wellbeing'*<sup>10</sup>, an NHS England resource that promotes and supports joint working between adult social care services, NHS commissioners and providers, and voluntary organisations.

Within an area, a number of initiatives can also contribute towards overall system integration. These are not sufficient to full integration of health and social care, but can offer important contributions to key cohorts of patients and service users. For example:

<sup>10</sup> <https://www.england.nhs.uk/wp-content/uploads/2016/05/identifying-assessing-carer-hlth-wellbeing.pdf>

- Some local areas are also taking action on '**Integrated Personal Commissioning**' (IPC), whereby individuals experience holistic, personalised care and support planning, and an option for them to commission their own care using a personal budget or direct payment arrangements that combine funding from health, social care and education. IPC is being progressed by nine demonstrator areas (covering 20 CCGs and 12 local authorities) that are leading the way in developing a practical operating framework to enable wider replication, with a further 10 early adopters set to join the programme by March 2017.<sup>11</sup>

NHS England expects that IPC will become a mainstream model of care for around 5 per cent of the population, enabling the expansion of personal health budgets and integrated personal budgets at scale. IPC is expected to be operational in 50% of STP footprints by 2019. Some Demonstrator sites (i.e. Luton and Stockton on Tees) are incorporating their work on IPC into BCF plans, using personal health budgets and integrated personal budgets to create more stable, coordinated care at home and in the community for high risk groups. Others parts of the country are also encouraged to consider this approach.

- Learning from the six **Enhanced Health in Care Homes** (EHCH) vanguard sites suggests that action to provide joined up primary, community and secondary health and social care to residents of care and nursing homes, as well as those living in the wider community, can have significant benefits. These include transforming the quality of care, reducing costs and activity levels, and supporting relationship-building at local level. Some parts of the country (i.e. East and North Hertfordshire and others) are already building in work around EHCH into their BCF plans and other parts of the country are encouraged to do the same. For more details, please see the 'Enhanced Health in Care Homes Framework'.<sup>12</sup>

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<sup>11</sup> <https://www.england.nhs.uk/commissioning/ipc/sites>

<sup>12</sup> <https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf>

## 3. Integration now and the Better Care Fund 2017-19

This Policy Framework for the Better Care Fund (BCF) covers two financial years (2017-19) to align with NHS planning timetables and to give areas the opportunity to plan more strategically. In 2017-18, the BCF will be increased to a mandated minimum of £5.128 billion and £5.617 billion in 2018-19.<sup>13</sup> The local flexibility to pool more than the mandatory amount will remain. Further details of the financial breakdown are set out in Table 1 below.

The main change to the Framework from last year is inclusion of significant amounts of local authority social care grant funding. Some of this was announced at the 2015 Spending Review, with an additional £2 billion over three years announced at Spring Budget 2017. There will be grant conditions on this new money to ensure it has the expected impact at the care front line.

In developing this framework, we have listened to feedback from local areas about the need to further streamline the processes around planning, assurance and performance reporting. There is also a halving of the number of national conditions that areas are required to meet through their BCF plans - reduced from eight to four. We have also set out more clearly, the requirements around the social care national condition.

The national conditions that areas will need to meet in their plans for 2017-18 and 2018-19 are: **plans to be jointly agreed; NHS contribution to adult social care is maintained in line with inflation; agreement to invest in NHS commissioned out of hospital services; and managing transfers of care.** The detailed requirements for each condition are set out in **Annex A.**

The removal of some national conditions from 2016-17 does not reflect a downgrading of the importance of these policies and we expect them to underpin local BCF plans. For example, all areas should be working to embed 7-day services across the health and care system. Shared information, interoperable IT and joint care assessments are critical enablers to deliver integrated services - therefore, we expect every area to continue taking action to build on the progress made in the last two years. In **Annex B** we have set out what you can do to keep up the momentum.

### Statutory and Financial Basis of the Better Care Fund

The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the BCF. It allows for the Mandate to NHS England to include specific requirements to instruct NHS England over the BCF, and NHS England to direct Clinical Commissioning Groups to pool the necessary funding.

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<sup>13</sup> These are indicative figures only.

## Better Care Fund in 2017-18

The Mandate to NHS England for 2017-18 requires NHS England to ring-fence £3.582 billion within its overall allocation to Clinical Commissioning Groups to establish the BCF in 2017-18. The Mandate was published on 20th March 2017.<sup>14</sup>

The remainder of the £5.128bn BCF in 2017-18 will be made up of the £431m Disabled Facilities Grant (DFG) and £1.115bn new grant allocation to local authorities to fund adult social care, as announced in the 2015 Spending Review and Spring Budget 2017. Both grants are paid directly from the Government to local authorities.

As in the previous two years, the NHS contribution to the BCF includes funding to support the implementation of the Care Act 2014. Funding previously earmarked for reablement (£300m) and for the provision of carers' breaks (£130m) also remains in the NHS allocation.

## Better Care Fund in 2018-19

The Mandate to NHS England for 2017-18 also denotes an indicative ring-fence of £3.65bn from allocations to Clinical Commissioning Groups for the establishment of the BCF in 2018-19. The actual amount will be confirmed via the Mandate for 2018-19, which will be published in winter 2017-18.

The remainder of the £5.617bn BCF in 2018-19 will be made up of the £468m DFG and an indicative amount of £1.499bn new grant allocation to local authorities to fund adult social care, both of which will be paid directly from the Government to local authorities.

As in 2017-18, funding previously earmarked for reablement (£300m) and for the provision of carers' breaks (£130m) remains in the NHS contribution.

*Table 1: BCF funding contributions in 2017-19*

Better Care Fund funding contribution (£bn)	2017-18	2018-19
Minimum NHS (clinical commissioning groups) contribution	£3.582	£3.65
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.431	£0.468
New grant allocation for adult social care (Improved Better Care Fund)	£1.115	£1.499
Total	£5.128 billion	£5.617 billion

<sup>14</sup> <https://www.gov.uk/government/publications/nhs-mandate-2017-to-2018>

## Conditions of access to the Better Care Fund

The amended NHS Act 2006 gives NHS England the powers to attach conditions to the amount that is part of Clinical Commissioning Group allocations (as discussed earlier, these are £3.582bn in 17-18, and an indicative amount of £3.65bn in 18-19). These powers do not apply to the amounts paid directly from Government to local authorities.

For the DFG, the conditions of usage are set out in a Grant Determination Letter, due to be issued by DCLG in April. This references the statutory duty on local housing authorities to provide adaptations to those disabled people who qualify, and sets out other relevant conditions.

For the new grant allocation to local authorities to fund adult social care, the conditions of usage will also be set out in a Grant Determination Letter. This will also be issued by DCLG in April, though a draft version of the conditions has been shared in March, for information.

## National Conditions for 2017-19

In 2017-19, NHS England will require that BCF plans demonstrate how the area will meet the following national conditions:

- **Plans to be jointly agreed;**
- **NHS contribution to adult social care is maintained in line with inflation;**
- **Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care; and**
- **Managing Transfers of Care**

The refreshed definitions of these national conditions are set out at **Annex A**.

NHS England will also set the following requirements, which local areas will need to meet to access the CCG elements of the funding:

- A requirement that the BCF is transferred into one or more pooled funds established under section 75 of the NHS Act 2006; and
- A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s).

Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of CCG funding where conditions attached to the BCF are not met, except, as mentioned above, for those amounts paid directly to local government. The Act makes provision

at section 223GA(7) for the mandate to NHS England to include a requirement that NHS England consult Ministers before exercising these powers. The 2017-18 Mandate to NHS England confirms that NHS England will be required to consult the Department of Health and the Department for Communities and Local Government before using these powers.

## Disabled Facilities Grant

In two-tier areas decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government should be passed down by the county to the districts (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations and in line with these plans; as set out in the DFG Grant Determination Letter due to be issued by DCLG in April 2017.

## New grant for adult social care (announced in the 2015 Spending Review and Spring Budget 2017 as 'Improved Better Care Fund' (iBCF) funding)

The Government's Spending Review in 2015 announced new money for the BCF of £105m for 2017-18, £825m for 2018-19 and £1.5bn for 2019-20. The Spring Budget 2017 subsequently increased this to £1.115bn for 2017-18, £1.499bn for 2018-19 and £1.837bn for 2019-20. The Government will require that this additional Improved Better Care Fund (iBCF) funding for adult social care in 2017-19 will be pooled into the local BCF. This funding does not replace, and must not be offset against the NHS minimum contribution to adult social care.

The new iBCF grant will be paid directly to local authorities via a Section 31 grant from the Department for Communities and Local Government. The Government will attach a set of conditions to the Section 31 grant, to ensure it is included in the BCF at local level and will be spent on adult social care. The final conditions will be issued in April. However, a draft has been shared with areas in March. The draft conditions of use of the Grant can be summarised as:

1. Grant paid to a local authority under this determination may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.
2. A recipient local authority must:
  - a) pool the grant funding into the local BCF, unless an area has written Ministerial exemption;
  - b) work with the relevant Clinical Commissioning Group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and

- c) provide quarterly reports as required by the Secretary of State.
3. The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans have been locally agreed.

In terms of the wider context, the funding is also intended to support councils to continue to focus on core services, including to help cover the costs of the National Living Wage, which is expected to benefit up to 900,000 care workers. This includes maintaining adult social care services, which could not otherwise be maintained, as well as investing in new services, such as those which support best practice in managing transfers of care.

Local authorities will be required to confirm that spending of the BCF money provided at Spending Review 2015 and Spring Budget 2017 will be additional to prior plans for social care spending, via a Section 151 Officer letter.

## The assurance and approval of local Better Care Fund plans

As in 2016-17, plans will be developed locally in each Health and Wellbeing Board area by the relevant local authority and Clinical Commissioning Group(s). Plans will be assured and moderated regionally in line with the operational planning assurance process set out in the Integration and Better Care Fund Planning Requirements, published by NHS England and the Local Government Association.

Recommendations for approval of overall BCF plans will be made following moderation of regional assurance outcomes by NHS England and local government. Plans will be approved and permission to spend the CCG minimum contribution to the BCF will be given once NHS England and the Integration Partnership Board have agreed that the conditions attached to that funding have been met.

Local authorities are legally obliged to comply with grant conditions. The NHS Act 2006 (as amended by the Care Act 2014) allows NHS England to direct the use of the CCG elements of the fund where an area fails to meet one (or more) of the BCF conditions. This includes the requirement to develop an approved plan. If a local plan cannot be agreed or other National Conditions are not met, any proposal to direct use of the CCG elements of the Fund will be discussed with the Integration Partnership Board.



## National performance metrics

As in 2015-16 and 2016-17, local areas are asked to agree and report metrics in the following four areas:

- Delayed transfers of care;
- Non-elective admissions (General and Acute);
- Admissions to residential and care homes; and
- Effectiveness of reablement

The detailed definitions of these metrics will be set out in the Integration and Better Care Fund Planning Requirements.

We are no longer requiring the national collection of a locally proposed metric.

## Better Care Fund support offer in 2017-19

In implementing the BCF from 2017-18 to 2018-19, the joint Better Care Support team hosted by NHS England will continue to:

- Provide support to local areas to ensure effective implementation of agreed plans;
- Build an intelligence base to understand the real impact of the BCF on delivering integration;
- Support local systems to enable the successful delivery of integrated care in 2017-19 by capturing and sharing learning, building and facilitating networks to identify solutions;
- Promote and communicate the benefits of health and social care integration;
- Monitor the ongoing delivery of the BCF – including quarterly reporting on national metrics and spending; and
- Support areas that are proposing to graduate or have graduated from the BCF.

## 4. Integration now - Graduating from the Better Care Fund

### Overview

The Government's Spending Review 2015 set out that "areas will be able to graduate from the existing Better Care Fund (BCF) programme management once they can demonstrate that they have moved beyond its requirements, meeting the government's key criteria for devolution."

It is the Government's ambition that all areas will be able to work towards graduation from the BCF to be more fully integrated by 2020, with areas approved in waves as they demonstrate maturity and progress towards greater integration. The best areas are showing that greater levels of integration bring positive benefits in terms of improving people's health, wellbeing and experience of care, particularly in wrapping services around people's needs and shifting the focus to keeping people well and happy at home, with reduced demand for hospital and other health and care services.

These areas can apply for 'earned autonomy' from the BCF programme management. Graduation will mean that we will have a different relationship with these local areas; with reduced planning and reporting requirements and greater local freedoms to develop agreements appropriate to a more mature system of health and social care integration. This will include a bespoke support offer for areas that graduate, in addition to them no longer being required to submit BCF plans and quarterly reports.

We are planning to test the graduation process with a small number of areas (6 to 10) in the first instance. We are inviting areas that believe they can demonstrate that they meet the criteria for graduation now to put themselves forward prior to the deadline for submission of first plans, with a view to graduating from the BCF in this first wave.

Subsequent waves of areas will have the opportunity to graduate over the course of this spending review period. Departments, the LGA and NHS England will work with graduated areas to role-model how integration can support better outcomes for populations across health, social care and housing.

### A "first wave" of Better Care Fund graduation

We have no set targets for the numbers of areas that graduate from the existing BCF programme management in each year. In the first round, we are planning to test graduation with a small number of areas (between 6 and 10), and will use this learning to refine the criteria and process going forward.

Graduation proposals should be made, at minimum, across an entire Health and Wellbeing Board geography, but could be aligned to Sustainability and Transformation Plan (STP)

footprints or devolution deal sites, as long as all relevant Health and Wellbeing Boards included in the proposal are supportive.

The eligibility criteria are set out below. Areas interested in participating in the first wave of graduates should benchmark themselves against these criteria and discuss their interest with their Better Care Manager.

The process of graduation will utilise sector-led improvement principles, supporting areas through peer review and development. This will culminate in a “graduation panel”, which will provide face-to-face support and challenge to local areas to agree the conditions for graduation.

### Eligibility criteria for Better Care Fund graduation

To keep the application process simple, all partners in an area wishing to apply for graduation will need to complete an Expression of Interest and demonstrate that they:

**a) Have in place a sufficiently mature system of health and social care with evidence of:**

- Strong shared local political, professional, commissioner and community leadership;
- An agreed system-wide strategy for improving health and wellbeing through health and social care integration to 2020. The government supports a range of models of health and social care integration, as set out in Chapter 5. You should reference your choice of model in your integration strategy or action plans and their links to wider health and local government strategies; and
- A robust approach to managing risk, including adequate financial risk management arrangements proportionate to the level of risk in the system, for example, if any CCG is subject to financial directions, a clear appraisal of any additional risk and approach to managing it.

**b) Can demonstrate the application is approved by all signatories required by BCF planning**

**c) Provide evidence of improvement and/or approach to improving performance on BCF national performance metrics and how graduation will enable the area to accelerate improvement on these metrics. This should include current performance data and stretch targets.**

**d) Set out plans to pool an agreed amount greater than the minimum levels of the BCF or align the commissioning of an equivalent or greater scope of services. Set out plans to maintain joint investment in integrated services, including:**

- Maintaining the NHS contribution to social care and NHS commissioned services in line with inflation;
- Maintaining additional contributions from CCGs and local authorities to the pooled fund, in addition to the ‘improved Better Care Fund’ grant funding to local government; and

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- Continuing to meet grant conditions attached to the newly allocated funding within the Improved Better Care Fund.
- e) **Are committed to a ‘sector-led improvement’ approach in which they are willing to act as peer leaders, working with national partners to support other areas looking to graduate.**

## Selection criteria

As the first wave is testing the process, we will use the Expressions of Interest and other available information, including the following additional criteria, to select a small pool of 6-10 applicants, as follows:

- a) The applicants commit and have the capacity to participate in the selection process which is set out below, participate in the pilot evaluation and share learning with peers and with national organisations supporting integration work.
- b) The applicants have discussed their proposal with their local Better Care Manager.
- c) The pilot cohort covers a range of different care model types as set out in Chapter 5.
- d) The pilot cohort covers a spread of geographical locations and local authority type.

The selection process will include graduation workshops to help local leaders identify the steps necessary to graduate from the BCF and progress integration, in line with the 2015 Spending Review commitments. The workshops are based on the existing LGA sector-led improvement model, and will involve a half-day session for senior local health and local government leaders; these workshops will run in May and June, in order to complete the pilot in the agreed timeframe. The process will culminate in graduation panels (in early-to-mid July) with representatives from Department of Health, Department for Communities and Local Government, NHS England, Local Government Association, and Association of Directors of Adult Social Services, and will agree with local leaders, clear, measurable and transparent objectives and milestones for integration locally to 2020. We also intend to develop a dedicated package of support, building on the learning and experience of sites which have graduated from the pilot.

We are seeking areas which have made the most progress in moving beyond the requirements of the BCF. We recognise that the restricted number of pilot areas is likely to mean some areas are unsuccessful. We do understand that this will be disappointing for those areas not selected, but subsequent graduation waves will not be restricted in numbers in the same way. In addition those areas which are not selected for the pilot can continue to prepare for subsequent waves.

## Expression of Interest process and timelines

- Applicants should submit to [England.bettercaresupport@nhs.net](mailto:England.bettercaresupport@nhs.net) an Expression of Interest, which demonstrates how local organisations meet the eligibility criteria a) to e) above by 5pm on 28th April 2017; this should include an indication of the discussion with their local Better Care Manager, which should take place before 19th April 2017.
- All applications will be assessed by the selection panel, with results communicated by 10th May 2017.
- Graduation workshops will run in May and June, with graduation panels taking place in early-to-mid July.

## Guidance on submitting an Expression of Interest

The form should specifically address the eligibility criteria outlined in a) to e) above. Any submitted documents, including any covering letters, must not be longer than 6 pages, and have no embedded or attached appendices. Any attached or embedded documents will not be considered by the selection panel.

The Expressions of Interest will be assessed by a panel of representatives from the Department of Health, Department for Communities and Local Government, NHS England, Local Government Association, and Association of Directors of Adult Social Services. Its decision will be based on the evidence provided against eligibility criteria a) to e), with adjustments made to ensure a fair selection of pilots across geography, care model and local authority type in order to maximise the potential for learning from the pilots.

## The support offer

We will put in place an ongoing support offer for areas, before, during and after the process of graduation. This will include:

- **Before** – Seminars, workshops or individual support for areas preparing for graduation (second and subsequent waves), including peer support from areas that have graduated;
- **During** - Advice and support for areas shortlisted for graduation to develop the core essential characteristics for integration including those required as evidence for graduation;
- **After** - Support for a peer network of graduated areas to share experience and evidence of what is working;

Once an area has been selected for graduation, we will aim to support them to achieve and/or maintain their integration vision. Areas that have 'graduated' from the BCF will continue to be subject to the normal local authority and CCG reporting requirements on finance and performance. We will develop with the first wave the format and process for providing a self-certifying annual report. In the unforeseen circumstances of serious financial or performance

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issues or a breakdown in local partnership's ability to realise their integration plan, it may be necessary to reinstate some or all of the BCF programme management. This would be considered a last resort to support local leaders. Local areas would be given adequate advance notice, before any assurance or reporting requirements are reinstated.

BCF graduates will be at the forefront of demonstrating how integration of health and care is becoming a reality by 2020 and we expect that early graduates will work with national partners to share learning with others and provide leadership in delivering fuller integration by 2020.

## 5. Integration future - Integration to 2020

### Overview

At the Spending Review 2015, the Government announced its ambition to integrate health and social care by 2020 so that it feels like one service. As noted by the Nuffield Trust there “is no one model of integrated care that is suited to all contexts, settings and circumstances”.<sup>15</sup>

The ways local areas integrate will be different, and some parts of the country are already demonstrating different approaches, which reflect models the government supports. For example:

- **Greater Manchester** – a devolution area pooling health and social care budgets within 10 HWB localities. Where there are clear benefits, services will be commissioned across the footprint through the joint commissioning board (comprising the CCGs, local authorities and NHS England). Each locality has its own individual plan for integrating services which feeds into the overarching health and social care strategy.
- **North East Lincolnshire** – a lead commissioner model, in which the CCG exercises the Adult Social Care functions on behalf of the local authority;
- **Northumberland** – a single Accountable Care Organisation (ACO), taking on responsibility for general practice, primary care, hospital and community services, adult social care and mental health services.<sup>16</sup>

	Joint commissioning	Lead commissioning	Accountable Care Organisation (ACO) <sup>17</sup>
Characteristics	<p>Some or all CCG/LA commissioning decisions made jointly.</p> <p>Budgets (and other resources) pooled or aligned in line with extent of joint commissioning.</p>	<p>One body exercises some or all functions of both the CCG and the LA, with the relevant resources delegated accordingly.</p>	<p>CCG and LA pay a set figure (possibly determined by capitation) to an Accountable Care Organisation to deliver an agreed set of outcomes for all health and care activity for the whole population, using a multi-year contract.</p> <p>The ACO decides what services to purchase to deliver those outcomes. MCPs and PACs are types of ACOs.</p>

<sup>15</sup> Nuffield Trust, An overview of integrated care in the NHS. What is integrated care? (London: Nuffield Trust, 2011), 20.

<sup>16</sup> Northumberland is a PACs vanguard site, but the ACO goes well beyond simply combining primary and secondary acute care.

<sup>17</sup> M McClellan et al., Implementing Accountable Care to achieve Better Health at a Lower Cost, WISH 2016 <http://www.wish-qatar.org/wish-2016/forum-reports>

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An integrated health and social care service should have full geographical coverage, with clear governance and accountability arrangements. As part of this, we would encourage areas to align their approach to health and care integration with STP geographies, where appropriate. This may be supplemented by initiatives for particular groups, such as Enhanced Health in Care Homes and Integrated Personal Commissioning.

The Government recognises the integration efforts that are already happening, including through the Better Care Fund (BCF), STPs and local devolution. There will be no separate process for integration plans. **Instead, we will simply require local areas to set out how they expect to progress to further integration by 2020 in their BCF 17-19 returns.**

## Next Steps

To help areas understand whether they are meeting our integration ambition, we will develop integration metrics for assessing progress, particularly at the interface where health and social care interact. This will combine outcome metrics, user experience and process measures. The metrics will build on work already carried out on behalf of Government (see Annex C) and the Integration Standard tested on the Government's behalf by the Social Care Institute for Excellence (SCIE) found at Annex D. SCIE found that the standard identified helpful integration activities such as risk stratification and multi-disciplinary community teams, but was process-focussed and did not tell the whole integration story. We therefore want to bring elements of the standard into the wider integration scorecard. SCIE's full report is available here:

[www.scie.org.uk/integrated-health-social-care/integration-2020/research](http://www.scie.org.uk/integrated-health-social-care/integration-2020/research)

Further work involving SCIE and key stakeholders will develop these integration metrics. If you have any thoughts on what to include in these, please email: [Bettercarefund@dh.gsi.gov.uk](mailto:Bettercarefund@dh.gsi.gov.uk)

Following the development of the metrics we will ask the Care Quality Commission (CQC) to carry out targeted reviews in a small number of areas, starting as soon as is practical from May 2017. These reviews will be focused on the interface of health and social care and will not cover wider council social care commissioning. This should lead to a tailored response to ensure those areas facing the greatest challenges can improve rapidly.

Other actions will include:

### a) Consideration of Section 75 arrangements

The Department of Health, working with NHS England, is now considering what further changes could be made to secondary legislation to support more integrated, place-based approaches to health and social care, for example:

- The commissioning functions that can be included in scope
- The governance and partnership working arrangements that are permissible, for example Joint Committees



Before NHS England can make arrangements involving combined authorities and local authorities for example, regulations would need to be made prescribing those bodies for the purposes of such arrangements. The Department is also considering whether further amendments to the section 75 partnership regulations would support local areas to extend the benefits of partnership working as they take forward their integration vision.

### **b) Developing our evidence base on integration, through independent evaluation and sector-led engagement**

We will build on our evidence base on what good integration looks like through:

- **The final report of the system-level evaluation of the Better Care Fund will be ready in winter 2017-18.** An interim report is expected in spring 2017, including a typology analysis of integration activities, initial findings from the comparative evaluation, and a BCF policy background paper (a documentary analysis of official BCF literature).
- **Learning from LGA's sector-led support using the Integration 'self-assessment' tool<sup>18</sup>** developed by LGA, ADASS, NHS Confederation and NHS Clinical Commissioners. The peer-led tool assesses local leaders' readiness, capacity and capability to integrate. We will build on this to facilitate graduation panels.
- **NHS England and NHS Improvement evaluation of the New Care Models Programme.** There is a wide range of national, local and independent evaluation of the NCM. Evaluations are progressing at pace.
- **DH and CQC testing the feasibility of a national survey of people's experience of integrated care.** This will be piloted in 2017-18 with a view to national roll out in the future.

### **Resources:**

**The LGA has developed a library of resources**, signposting local areas to evidence, case studies, tools and resources which will support the development of integration ambitions locally.<sup>19</sup> The resource is organised around the essential integration characteristics, such as leadership, governance, prevention, housing and planning, co-production, care models and workforce. Organisations may also find the slides on Integration, produced by consulting firm Oliver Wyman, a useful resource.<sup>20</sup>

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<sup>18</sup> <http://www.local.gov.uk/documents/10180/7632544/1.10+Stepping+up+to+the+place+-+integration+self-assesment+tool+WEB.pdf/017681db-bec4-405d-b51d-4ff6f930227d>

<sup>19</sup> [http://www.local.gov.uk/integration-better-care-fund/-/journal\\_content/56/10180/8026967/ARTICLE](http://www.local.gov.uk/integration-better-care-fund/-/journal_content/56/10180/8026967/ARTICLE)

<sup>20</sup> <http://www.oliverwyman.com/our-expertise/insights/2016/nov/global-health-strategy-hub.html>

# Annex A: Further information on the national conditions for 2017-19

NATIONAL CONDITION	DEFINITION
<p><b>Condition 1:</b> <b>Plans to be jointly agreed</b></p>	<p>Local areas must ensure that their Better Care Fund (BCF) Plan covers the minimum of the pooled fund specified in the BCF allocations spreadsheet, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area.</p> <p>The plans should be signed off by the Health and Wellbeing Board itself, and by the constituent councils and Clinical Commissioning Groups.</p> <p>The Disabled Facilities Grant (DFG) will again be allocated through the BCF. As such, areas are required to involve local housing authority representatives in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing. In two-tier areas decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government should be passed down by the county to the districts (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations and in line with these plans. During these discussions, it will be important to continue to meet local needs for aids and adaptations, whilst also considering how adaptation delivery systems can help meet wider objectives around integration. For both single tier and two tier authorities, areas are required to set out in their plans how the DFG funding will be used over the two years.</p> <p>In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with groups likely to be affected by the use of the fund (including health and social care providers) in order to achieve the best outcomes for local people.</p>
<p><b>Condition 2:</b> <b>NHS contribution to adult social care is maintained in line with inflation</b></p>	<p>For 2017/18 and 2018/19, the minimum contribution to adult social care will be calculated using the assured figures from 2016/17 as a baseline. This will apply except where a Health and Wellbeing Board secures the agreement of the Integration Partnership Board to an alternative baseline.</p> <p>The NHS contribution to adult social care at a local level must be increased by 1.79% and 1.9% (in line with the increases applied to the money CCGs must pool) in 2017-18 and in 2018-19 respectively.</p> <p>Local areas can opt to frontload the 2018-19 uplift in 2017-18 and then carry over the same level of contribution in 2018-19 as in 2017-18.</p> <p>The funding must be used to contribute to the maintenance of adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition, the Department of Health wants to provide flexibility for local areas to determine how this investment in adult social care</p>

	<p>services is best used.</p> <p>The additional funding for adult social services paid directly to local authorities by the government in each year (please refer to page 17) does not replace, and cannot not be offset against, the NHS minimum contribution to adult social care.</p>
<p><b>Condition 3:</b></p> <p><b>Agreement to invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care</b></p>	<p>Local areas should agree how they will use their share of the £1.018 billion in 2017/18 and £1.037 billion in 2018/19 that had previously been used to create the payment for performance fund (in the 2015-16 BCF).</p> <p>This should be achieved by funding NHS commissioned out-of-hospital services, which may include 7-day services and adult social care, as part of their agreed BCF plan. This can also include NHS investment in the high impact change model for managing transfers of care (linked to compliance with national condition 4), although CCGs can commission these services from funding outside of this ringfence.</p> <p>Local areas can choose to put an appropriate proportion of their share of the £1.018bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including 7-day services and adult social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 2016-17).</p> <p>Further guidance to support local areas on deciding whether to hold back a proportion of funds as part of a risk share agreement will be provided in the Integration and Better Care Fund Planning Requirements.</p>
<p><b>Condition 4:</b></p> <p><b>Managing Transfers of Care</b></p>	<p>All areas should implement the High Impact Change Model for Managing Transfer of Care<sup>21</sup> to support system-wide improvements in transfers of care. Narrative plans should set out how local partners will work together to fund and implement this and the schemes and services commissioned will be assured through the planning template.</p> <p>Areas should agree a joint approach to funding, implementing and monitoring the impact of these changes, ensuring that all partners are involved, including relevant Accident and Emergency Delivery Boards.</p> <p>Quarterly reports will be provided, as required by the Department of Health and the Department for Communities and Local Government.</p>

<sup>21</sup> Including arrangements for a Trusted Assessor model, as per the following link:  
<http://www.local.gov.uk/documents/10180/7058797/Impact+change+model+managing+transfers+of+care/3213644f-f382-4143-94c7-2dc5cd6e3c1a>

## Annex B: Maintaining progress on the 2016-17 national conditions

We have made changes to the national conditions and reduced the number of conditions to reflect wider changes in the policy and delivery landscape.

For the policy areas that are no longer national conditions of the Better Care Fund (BCF) in 17-19 (see table below), we encourage areas to continue taking action through their BCF plans or other local agreements to ensure these policy priorities and critical enablers for integration continue to feature in local planning and delivery.

National condition	Update for 2017-19 Better Care Fund planning
1. Plans to be jointly agreed	This is a condition for 2017-19 (see Annex A)
2. NHS contribution to adult social care is maintained in line with inflation.	This is a condition for 2017-19 (see Annex A)
<p><b>Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admission to acute settings and to facilitate transfer to alternative care settings when clinically appropriate</b></p>	<p>Improving services through the implementation of the 7-day service clinical standards remains an important priority.<sup>22</sup> All areas should be working to make progress on implementing the 4 priority clinical standards, supported by NHS England and NHS Improvement, so that by April 2018, 50% of patients have access to these standards of care every day of the week with this rising to everyone by 2020. Sustainability and Transformation Plans are providing an opportunity for areas to come together to consider the delivery of 7-day services across geographical areas.</p> <p>Although not a requirement for accessing BCF funding in 2017-19, BCF areas should continue to make progress locally, building on the action taken in 2016-17, on implementing standard 9 of the 7-day hospital service clinical standards which concerns the transfer of patients to community, primary and social care. Standard 9 sets out that: 'Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken, 'Academy of Medical</p>

<sup>22</sup> <https://www.england.nhs.uk/ourwork/qual-clin-lead/seven-day-hospital-services/the-clinical-case/>

	<p>Royal Colleges (2012): Seven day consultant present care’.</p> <p>Without the timely transfer of patients across settings of care there can be detriment to both existing hospital patients and newly-arriving patients. All BCF areas should work together to avoid unnecessary delays in patient pathways, including taking the actions to reduce delayed transfers of care set out in the section on DTOC below.</p>
<p><b>Better data sharing between health and social care, based on the NHS number</b></p>	<p>Data sharing is no longer a condition of the BCF but it remains an important enabler to delivery of BCF or wider integration commitments.</p> <p>To enable effective information sharing for direct care, Parliament introduced the Safety and Quality Act in 2015 which now makes it a legal requirement to share information where it is likely to facilitate the provision of health or care services and is in the individuals’ best interests. The Safety and Quality Act also now makes it a legal requirement to use a consistent identifier (such as the NHS number) to support local information sharing. There are examples of where leadership commitment is enabling information sharing at a local level.</p> <p>In addition, through Local Digital Roadmaps, local areas are outlining ambitions for the use of information sharing and technology to support the delivery of care. There are existing examples across the country of where local areas are joining up local systems to give a single health and care record to support the delivery of direct care. These approaches will enable improved coordination of care and support information sharing across health and care settings.</p> <p>The National Data Guardian has also published a review of data security, consent and opt outs across health and care. The report proposed a set of ten data security standards for the health and care system and made a series of recommendations to support information sharing. This includes a commitment to refresh the current Information Governance Toolkit, so that it becomes a portal to support organisations across health and social care to demonstrate increasing resilience and compliance with the standards. Local areas should consider how best to implement these recommendations in conjunction with national policy and services such as CareCERT. The review builds on the previous two Caldicott reports to emphasise the</p>

	importance of building public trust in data security and information sharing, and encouraging public bodies to ensure they engage with citizens regarding how their information is shared.
<b>Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional</b>	This is no longer a condition of the BCF; however, BCF plans should have embedded within them, an integrated and proactive approach to planning and managing care with other health and care professionals.
<b>Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans</b>	This is no longer a condition of the BCF but areas should engage with groups likely to be affected by the use of the fund (including health and social care providers) in order to achieve the best outcomes for local people (as set out in condition 1 for 2017-19)
<b>3. Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care</b>	This is a condition for 2017-19 (see Annex A)
<b>Agreement on local action plans to reduce delayed transfers of care (DTOC)</b>	<p>There is an improved condition around Managing Transfers of Care (National Condition 4), which requires areas to implement the High Impact Change Model for Managing Transfers of Care.</p> <p>Areas should agree a joint approach to funding, implementing and monitoring the impact of these changes, including setting out the intended impact on reducing delayed transfers of care.</p> <p>This will also support the target of a reduction in total delayed transfers of care to 3.5% by September 2017 (recognising existing variation between areas), which is referenced in the Mandate to NHS England for 2017-18.</p>

## Annex C: Draft Interface Metrics

### Proposed scorecard for measuring effectiveness of social and healthcare interfaces

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#### A Main performance indicators

- A1** NEL admissions (65+) per 1,000 65+
- A2** NEL admissions (65+) with length of stay >30 days per 1,000 65+
- A3** Emergency readmission (65+) per 1,000 emergency admissions 65+
- A4** Institutionalisation bed days (65+) per 1,000 65+
- A5** DTOC – overall and due to social care placement or package per 1,000 65+

#### B Supporting overarching indicator

- B1** Index of 'User reported quality of life' and 'Proportion of people feeling supported to manage their LTC'

#### C Contextual indicator

- C1** Index of multiple deprivation (IMD)

#### Additional contextual indicators to collect in the future:

- Public health and social care spend per capita for 65+
- Proportion of 65+ with shared care records in place which are accessible by all care manage teams

# Annex D: Integration Standard

	Objective	Improvement to person's experience	System change needed to deliver this objective
1	Digital interoperability	"I have access to a Digital Integrated Care Record that moves with me throughout the health and care system. All professionals involved in my care have access to this record (with the appropriate safeguards in place to protect my personal data)"	<ul style="list-style-type: none"> <li>• Areas reach <b>digital maturity</b>, including universal use of the NHS number as the primary identifier and fully interoperable IT across providers and commissioners.</li> </ul>
2	Resource targeted at key cohorts to prevent crises and maintain wellbeing	<p>"If I am at risk of emergency hospital admission, I will receive the right care at the right time to help me to manage my condition and to keep me out of hospital."</p> <p>"If it would benefit me, I will be able to access a personal budget, giving me greater control over money spent on my care."</p>	<ul style="list-style-type: none"> <li>• Areas use health and social care data to <b>risk stratify</b> their populations, identifying those most at risk of unplanned admissions and allocating resources according to need.</li> <li>• Areas will allow greater access to <b>Integrated Personal Commissioning</b>, for identified groups who could benefit.</li> <li>• Areas use <b>capitated budgets</b> where appropriate</li> </ul>
3	Value for money	"I receive the best possible level of care from the NHS and my Local Authority."	<ul style="list-style-type: none"> <li>• Areas deliver against a <b>clear plan for making efficiencies</b> across health and care, through integration.</li> </ul>
4	Single assessment and care plans	"If I have complex health and care needs, the NHS and social care work together to assess my care needs and agree a single plan to cover all aspects of my care."	<ul style="list-style-type: none"> <li>• Areas use <b>multi-disciplinary integrated teams</b> and make use of professional networks to ensure high-quality joined-up care is delivered in the most appropriate place seven days a week.</li> </ul>
5	Integrated community care	"My GP and my social worker or carer work with me to decide what level of care I need, and work with all of the appropriate professionals to make sure I receive it."	
6	Timely and safe discharges	"If I go into hospital, health and social care professionals work together to make sure I'm not there for any longer than I need to be."	
7	Social care embedded in urgent and emergency care	"If I have to make use of any part of the urgent and emergency care system, there are both health and social care professionals on hand when I need them".	



## BCF and iBCF – Frequently Asked Questions

The LGA is committed to ensuring that our member councils are kept up to date with information and advice. We shared the current draft planning guidance and supporting documentation in April and ADASS also shared it with their members. Better care managers have copies also.

This document sets out answers to the most frequently asked questions we have received in relation to planning and delivering the Better Care Fund (BCF) for 2017-19 and is intended to support councils in local discussions and joint working with partners. The answers given represent the most accurate and up to date information we have at the time of writing [16 May 2017].

### Policy and planning guidance

*1. When will the BCF planning guidance be published?*

There is no agreed date for publication of the planning guidance for the BCF for 2017-19. The LGA continues to work with NHS England to agree the final guidance and get it published as soon as possible. We recognise how frustrating the delay is for councils and CCGs, and have shared the latest draft version of the document on 28 April to help local planners progress their plans. Please note this version is draft and may be subject to change in the final version – it represents current expectations.

*2. What is the status of the BCF Policy Framework without the planning guidance?*

The [Integration and BCF Policy Framework for 2017-19](#) was published by the government on 31 March. This provides the policy basis for the BCF and, combined with the NHS Mandate for 2017/18, provides the basis for planning and implementing the BCF nationally and locally. The planning guidance – formally called Planning Requirements – provides the detailed operational information to support the implementation of this policy framework, but does not supplant it. Until the planning guidance is published, the most detailed advice to local areas is contained in the policy framework.

### BCF assurance process

*3. What is happening to the assurance process?*

The BCF assurance process cannot be initiated until the planning guidance is published by NHS England. This is because NHS England uses the process to approve the CCG minimum contribution to the fund, and so the process will not begin until NHS England has signed off the guidance.

*4. What should local areas do in absence of published guidance?*

In the absence of published planning guidance, local leaders are encouraged to use the draft planning guidance and supporting documentation to support local discussions. The policy framework sets the objectives for the BCF, and the draft guidance gives an indication of current expectations for planning and assurance. Local areas are encouraged to work together to ensure vital services continue and local priorities are implemented, while being mindful that CCGs must seek approval from NHS England (through the assurance process) before they can spend the ring-fenced BCF funding.

The Better Care Adviser support programme, provided by the LGA on behalf of the Better Care Support Team, is available to support these local discussions, particularly where there are any

disagreements about the national conditions or programme requirements. The LGA will also continue to advocate at a national level for the removal of obstacles, so please make us aware of any issues.

5. *Does the delay in the assurance process affect local spending of the iBCF?*

No. Councils need only meet the improved BCF (iBCF) grant conditions, which are specified in the grant determination letter issued by the Department for Communities and Local Government (DCLG) on 24 April. The grant conditions are:

1. Grant paid to a local authority under this determination may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.
2. A recipient local authority must:
  - a. Pool the grant funding into the local Better Care Fund, unless the authority has written ministerial exemption
  - b. Work with the relevant clinical commissioning group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and
  - c. Provide quarterly reports as required by the Secretary of State
3. The government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans for spending the grant have been locally agreed with clinical commissioning groups involved in agreeing the Better Care Fund plan.

The last condition clearly sets out the government’s ambition to see the funding spent quickly. DCLG plans to use the BCF assurance process to check these conditions have been met, but this is not the same as being subject to the assurance process. DCLG could, for example, choose another approach, such as writing to councils directly asking for assurance.

6. *Does the BCF plan need to be approved by the local A+E delivery board?*

The BCF plan need only be agreed by the relevant health and wellbeing board, council and CCG(s), in line with the first national condition of the fund. The current draft of planning guidance encourages local planners to involve the local A+E Delivery Board in planning a whole-systems approach to implementing the [High Impact Change Model for Managing Transfers for Care](#).

**Spending the iBCF**

7. *What is the difference between the BCF and the iBCF?*

The BCF is the national programme, through which local areas agree how to spend a local pooled budget in accordance with the programme’s national requirements. The pooled budget is made up of CCG funding as well as local government grants, of which one is the iBCF. The iBCF was first announced in the 2015 Spending Review, and was increased in the 2017 Spring Budget.

	2017/18 £m	2018/19 £m	2019/20 £m

iBCF funding as per 2015 Spending Review	105	825	1,500
iBCF funding as per 2017 Spring Budget	1,010	674	337
Total iBCF funding	1,115	1,499	1,837

8. *What agreement is required locally to spend the iBCF?*

As outlined in the answer to question 5, the iBCF grant conditions state: “Local authorities are ... able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans for spending the grant have been locally agreed with clinical commissioning groups involved in agreeing the Better Care Fund plan.”

9. *What can councils spend the iBCF on and what is the current information on iBCF spend?*

According to the grant conditions, the funding grant can be spent on three purposes:

- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

There is no requirement to spend across all three purposes, or to spend a set proportion on each. The current feedback the LGA is receiving suggests many councils are using the funding to address short-term pressures and reduce planned service reductions. Some councils report it is impossible to fund long-term commitments, such as increasing payments to social care providers, because the funding is short term and reducing year on year.

10. *Can the iBCF be spent on stabilising the social care provider market?*

Yes, this is one of the purposes for the grant, and councils are free to decide this is the best use of some or all of the funding. Uplifting fees to providers is difficult, however, given the short-term nature of the funding. Some are looking to increase other support, such as through recruitment or training. Providers note challenges in planning year to year also.

11. *Are councils required to share funding with hospitals to ‘free up acute beds’ or to give CCGs their ‘proportion’?*

No, there is no requirement for councils to share the funding with hospitals or CCGs according to the grant conditions, although they may decide that is the most effective use of the funding. There is no requirement, however, to do so. The NHS ambition to see some of the funding spent “freeing up to 2,000 to 3,000 acute beds” is set out in the NHS document Next Steps for the Five Year Forward View. It is not included as a requirement in the BCF Policy Framework.

12. *Can the iBCF be spent on adult social care need?*

Yes, this is one of the purposes of the grant, and councils are free to decide this is the best use of some or all of the funding. The expenditure, however, must meet the test of additionality although this can include reducing planned service cuts or maintaining existing services, as well as on new provision.

*13. Can CCGs reduce their minimum contributions to the BCF to balance the additional iBCF funding?*

No, the iBCF is additional funding for social care. It does not replace, and must not be offset against the NHS minimum contribution to adult social care.

*14. Does the money need to be spent on implementing the High Impact Change Model?*

No. There is a grant condition that councils must work with their CCG(s) to implement the fourth national condition – to implement the High Impact Change Model for Managing Transfers of Care – but they are not required to spend the grant on this purpose. The national condition applies to both councils and CCGs, and both are expected to agree how the model's implementation will be funded. This will include other funding streams, some of which may be outside the BCF.

*15. Can CCGs refuse to agree the BCF plan until the iBCF spend is agreed locally?*

The grant conditions make clear the government's ambition to see the funding used quickly, ahead of the formal assurance process for the BCF plan. Any areas experiencing difficulties agreeing how the iBCF is to be used locally can ask for support through the Better Care Adviser support programme, delivered by the LGA.

*16. How is the additional iBCF funding announced in the Spring 2017 Budget allocated?*

The Government is distributing the funding in such a way so as to ensure all councils receive some of the additional funding. The distribution comprises:

- 10 per cent of each year's additional funding on the basis of the adult social care relative needs formula. This is a calculation based on a set of indicators that estimates the relative need of spending on adult social care services. The result is a percentage share of any given amount that goes to a specific local authority. All local authorities receive some funding through this method.
- 90 per cent using the method employed to calculate the allocations of the improved Better Care Fund (BCF) prior to the Budget. Not all councils receive funding through this method as it is used to equalise the variable benefit of the council tax social care precept.

For a fuller description of the distribution mechanism please read our [technical FAQ](#) on the additional funding for adult social care.

### **Agreeing and implementing a local BCF plan**

*17. Can councils and CCGs spend the BCF if the local plan has not been approved?*

CCGs need NHS England approval before they can spend the ring-fenced funding. For the local government grants, councils need only to demonstrate that they have complied with the conditions of the disabled facilities grant (DFG) and iBCF. There are no restrictions on CCGs or councils agreeing local priorities or working together to jointly commissioning local services using other funding sources. In terms of the BCF, CCGs and councils can minimise the financial risks by ensuring that there is clear agreement and that the spending plans are consistent with the Policy Framework and draft guidance. BCF plans will have to comply with the final planning guidance, once it is published. If plans are subsequently not approved in the assurance process, it may be necessary to make changes in year, but NHS England powers of direction in relation to the CCG spend can be used only in a proportionate fashion.

*18. How can I work out what the allocations in the BCF pooled budget?*

The different funding streams can be identified as follows:

- CCG minimum allocation: to calculate an approximation, apply an uplift for inflation of 1.79% for 2017/18 and 1.9% for 2018/19 to the local allocation for 2016/17; this is available at <https://www.england.nhs.uk/wp-content/uploads/2016/02/bcf-allocations-1617.xlsx>. This approximation would also apply to the NHS commissioned out-of-hospital ringfenced spend
- Social Care maintenance from CCG minimum: to calculate an approximation, apply an uplift for inflation of 1.79% to the local allocation for 2016/17 (and another 1.9% for 2018/19); this figure is found in the final planning template submitted to NHS England; the draft planning guidance provides a mechanism for areas to challenge the published figure if they think it is wrong
- Improved BCF grant: the allocations are available at <https://www.gov.uk/government/publications/the-allocations-of-the-additional-funding-for-adult-social-care>
- DFG: the allocations are specified in the grant determination letter, which was distributed by the Department for Communities and Local Government to local authorities on 20 April 2017

*19. Is there support available to help agree local priorities and plans?*

Yes, the Better Care Adviser support programme, delivered by the LGA, is designed to support areas to agree compliant plans, accelerate implementation of BCF or wider integration plans, or strengthen leadership. Further information is available here: <http://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/better-care-support-offer>

**Meeting the national conditions**

*20. What are the national conditions for 2017-19?*

The Integration and BCF Policy Framework sets out four national conditions:

1. Plans to be jointly agreed
2. NHS contribution to adult social care is maintained in line with inflation
3. Agreement to invest in NHS commissioned out of hospital services
4. Managing transfers of care

The policy framework also states: “The removal of some national conditions from 2016-17 does not reflect a downgrading of the importance of these policies and we expect them to underpin local BCF plans. For example, all areas should be working to embed 7-day services across the health and care system. Shared information, interoperable IT and joint care assessments are critical enablers to deliver integrated services – therefore, we expect every area to continue taking action to build on the progress made in the last two years.”

*21. Do local areas need to implement the High Impact Change Model?*

Yes, implementing this model is a new national condition (number 4 – Managing transfers of care), as set out in the Integration and BCF Policy Framework (see also question 15 above). The condition applies to CCGs and councils. The draft guidance currently sets the expectation that all areas should agree a joint approach to funding and implementing these changes, building on existing successful

local practice and tailored to local circumstance. Where all parties in an area have agreed to a variation on the model or not to implement one of the changes (for example if an existing, successful, approach would be duplicated by elements of the eight change model), their BCF plan should briefly explain the rationale for this and provide assurance that a comprehensive approach to managing transfers of care and meeting performance metrics in the BCF plan is in place.

*22. Do local areas need to implement a trusted assessor model?*

Yes, the High Impact Change Model includes trusted assessor approaches as a key change. There are many definitions of ‘trusted assessors’ and no one model will suit all. NHS England is developing, with input from the LGA and ADASS, a guidance note to help local areas. The draft guidance also lists other guides which provide advice and examples of good practice.

## **Graduation**

*23. Is the BCF graduation process going ahead?*

Yes, the process was launched in the Integration and Policy Framework. The Better Care Support Team recently announced an extension to the timeline in the policy framework, to take account of the general election. The new deadline for submitting an expression of interest is 19 May.

## **Reporting and metrics**

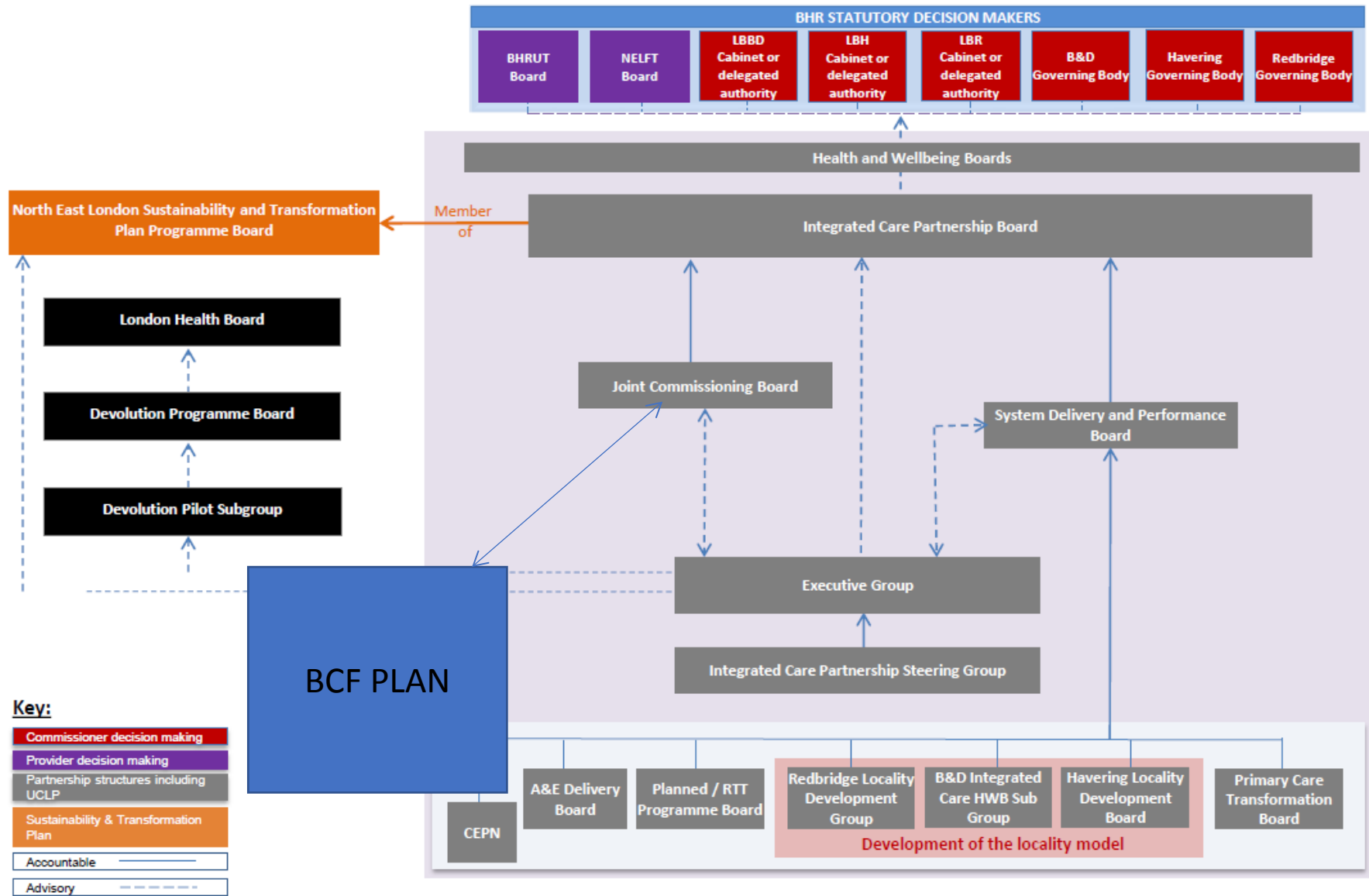
*24. What quarterly reporting will be required on iBCF?*

The LGA is in discussion with government about these requirements. We have consistently argued against any increase in the reporting burden. Our response to the Spring Budget announcement called for any measures to assess councils’ performance to be “proportionate and efficient and local government must be part of the design”.

*25. What is happening with the CQC reviews and national DTOC visits?*

The Department of Health will identify 20 areas for CQC to review, which will include at least three high-performing areas. The reviews are likely to start in July, and around 12 should be completed by December. CQC is committed to focusing on whole-system issues, not just social care. CQC is keen to engage LGA in devising the methodology for the reviews and in identifying people to work with them, to ensure the review teams include front line social care expertise. While the LGA does not support mandatory reviews, we are committing to influencing the CQC reviews, emphasising the benefits of a sector-led approach, and encouraging CQC to engage early and openly the areas selected. We also wish to highlight overlaps with similar work, including the NHS England national DTOC visits which are entering a second phase.

# APPENDIX C CURRENT GOVERNANCE ARRANGEMENTS



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## HEALTH AND WELLBEING BOARD

5 July 2017

<b>Title:</b>	<b>Annual Reports</b>	
<b>Report of the Deputy Chief Executive &amp; Strategic Director of Service Development and Integration</b>		
<b>Open Report</b>	<b>For Information</b>	
<b>Wards Affected:</b> None	<b>Key Decision:</b> No	
<b>Report Author:</b> Rhys Clyne: National Management Trainee, LBBB.	<b>Contact Details:</b> Tel: 020 8227 3033 E-mail: rhys.clyne@lbbd.gov.uk	
<b>Sponsor:</b> Anne Bristow, Deputy Chief Executive & Strategic Director for Service Development and Integration, LBBB		
<b>Summary</b>		
This paper introduces the following annual reports for information:		
<ul style="list-style-type: none"> <li>• Health and Wellbeing Outcomes Framework Performance Report Q4 and Outturn 2016/17</li> <li>• Healthwatch Annual Report 2016/17</li> </ul>		
<b>Recommendation(s)</b>		
The Board is recommended to note and discuss the annual reports at Appendix A and B.		
<b>Reason(s)</b>		
The Board is responsible for improving health outcomes for Barking and Dagenham residents, and reducing health inequalities, by strengthening working relationships between health and social care and encouraging the development of more integrated commissioning of services. It is, therefore, necessary for key stakeholders in the health and care sector to be held accountable by the Board. This accountability can be tracked through key performance indicators and annual reports, such as those included in this paper.		

## 1. Health and Wellbeing Outcomes Framework Performance Report Q4 and Outturn (2016/17)

- 1.1 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 4 (to end March 2017) on the latest data available.

## **2. Healthwatch Annual Report 2016/17**

- 2.1 This paper is a summary of the work undertaken by Healthwatch Barking and Dagenham in the operating year 2016-17. It outlines the work that has been undertaken by the Healthwatch team during the year and highlights their achievements and challenges. Above all it shows how we interact with the public, capture their opinions and reflect them back to commissioners of both health and social care services. This includes the extensive training programme delivered by Healthwatch Barking and Dagenham on behalf of Barking and Dagenham, Havering, Redbridge Community Education Provider Network.

## **3. Mandatory Implications**

### **Joint Strategic Needs Assessment**

- 3.1 The Health and Wellbeing Outcomes Framework Performance Report tracks progress across the remit of the Board, which agreed an outcomes framework of key priorities to improve public health in light of findings captured in the Joint Strategic Needs Assessment.
- 3.2 Healthwatch Barking and Dagenham is an independent consumer champion, which aims to give residents and communities a stronger voice to influence and challenge how health and social care services are provided. Its annual report surmises the work undertaken over the past year and how this work, in turn, seeks to build more robust services and improve outcomes for residents.

### **Health and Wellbeing Strategy**

- 3.3 These annual reports inform the Board of progress towards improving outcomes for residents and achieving the aims of the shared Health and Wellbeing Strategy. The priority themes which these reports are informed by include care and support, improvement and integration of services, protection and safeguarding, and prevention.

### **Integration**

- 3.4 There is a causal relationship between effective integration and improved outcomes, identified by improved performance across the key indicators detailed in the Framework Performance Report.

### **Financial Implications** (completed by Katherine Heffernan – Group Manager, Service Finance)

- 3.5 There are no financial implications arising directly out of these reports. Healthwatch is funded from within existing Council resources including use of the Community Voices and Local Reform grant.

### **Legal Implications** (completed by Dr. Paul Field - Senior Governance Lawyer)

- 3.6 The Health and Social Care Act (2012) conferred the responsibility for health improvement to local authorities. In addition as a best value authority under the Local Government Act 1999 there is a duty on the Council to secure continuous

improvement. The Health and Well-Being Board terms of reference establish its function to ensure that the providers of health and social care services work in their delivery in an integrated manner.

- 3.7 The function of this report is to set the scene for the combination of the attached longitudinal reports setting out the performance of services and outcomes to inform the Health and Well-Being Board in carrying out its role to ensure that providers of health and social care are working to their best effect, which it will do by giving its reflection on the reports and making recommendations for improvement where that can be identified.

**Public Background Papers Used in the Preparation of the Report: None**

**List of Appendices:**

- |                   |   |
|-------------------|---|
| <b>Appendix A</b> | Health and Wellbeing Outcomes Framework Performance Report Q4 and Outturn (2016/17) |
| <b>Appendix B</b> | Healthwatch Annual Report 2016/17   |

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APPENDIX A

Outcomes Framework Performance Report  
HEALTH AND WELLBEING BOARD

5 July 2017

<b>Title:</b>	<b>Health and Wellbeing Outcomes Framework Performance Report – Quarter 4 2016/17 (January to March 2017)</b>		
<b>Report of the Director of Public Health</b>			
<b>Open Report</b>		<b>For Decision:</b> No	
<b>Wards Affected:</b> ALL		<b>Key Decision:</b> No	
<b>Report Author:</b> Mark Tyrie, Senior Intelligence and Analysis Officer, Performance and Intelligence Unit, Care and Support, Service Development and Integration		<b>Contact Details:</b> mark.tyrie@lbbd.gov.uk 020 8227 3914	
<b>Sponsor:</b> Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham			
<b>Summary:</b>  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 4 (to end March 2017) on the latest data available.			
<b>Recommendation(s)</b> Members of the Board are recommended to: <ul style="list-style-type: none"> <li>• Review the overarching dashboard and raise any questions with lead officers, lead agencies or the chairs of subgroups as Board members see fit.</li> <li>• Note the detail provided on specific indicators, and to raise any questions on remedial actions or actions being taken to sustain good performance.</li> </ul>			
<b>Reason(s)</b>  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 and 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 key 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.
- 1.2 The Health and Wellbeing Board has a strategic responsibility and is accountable for improving outcomes for local people, as outlined in the Health and Wellbeing Strategy. This strategy documents the borough's top health and care priorities, and identifies respective targets and indicators, agreed across all members of the Board. This end-of-year report is, therefore, critical in evaluating our progress in achieving the outcomes identified by the Health and Wellbeing Strategy. This is especially relevant in light of recent discussion between the Chair of the Board and the Barking and Dagenham CCG regarding the performance of primary care in delivering public health commissioned outcomes.

## **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 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 Measles, Mumps and Rubella (MMR2) immunisation at 5 years old;
  - The number of children subject to Child Protection Plans.
- 3.2 Appendix ii contains further detail on these indicators for Board Members' reference.
- 3.3 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**

- 3.4 There remains a 'red' rating for the under-18 conception rate (per 1,000 population). Additional data is now available for 2015/16 Quarter 3 and can be seen in Appendix ii.
- 3.5 Care leavers 'not in education, employment or training' (NEET) has improved from 'amber' in 2016/17 Q3, to 'green' in 2016/17 Q4 and for the year overall.

#### **Adults**

- 3.6 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. However, Barking and Dagenham has successfully applied for an adjustment to the denominator used to calculate the Health Check eligible population, which will come into effect in 2017/18; this will lead to improved performance and could move the programme from a 'red' rating.
- 3.7 Appendix ii contains an updated account of actions being taken to address these performance issues.

#### **Older Adults**

- 3.8 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.
- 3.9 There remains positive performance in injuries due to falls for people aged 65 and over, which is a Better Care Fund measure, although data has not been updated since the last meeting.

### **Across the Life Course**

- 3.10 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.

## **4 Care Quality Commission (CQC) Inspections**

- 4.1 There were 19 CQC inspections to healthcare organisations in the borough in quarter 4. 12 inspections returned a rating of "Good", 5 received a rating of "Requires Improvement", and two received a rating of "Inadequate".
- 4.2 The two organisations who received a rating of "Inadequate" were Heathway Medical Centre, and Barking Enterprise Centre.
- 4.3 For further information, refer to Appendix iii, which details all the inspections carried out.

## **5 Mandatory implications**

### **Joint Strategic Needs Assessment**

- 5.1 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**

- 5.2 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**

- 5.3 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**

Implications completed by: Dr. Paul Feild Senior Governance Lawyer

- 5.4 The Health and Wellbeing Board is established under Section 194 of the Health and Social Care Act 2012. The primary duty of the Health and Wellbeing Board is to encourage those who arrange for the provision of health or social care services to work in an integrated manner. This is further extended to include encouraging integrated working with those who arrange for the provision of health-related services (defined as services that may have an effect on the health of individuals but are not health services or social care services).
- 5.5 This report highlights how the various bodies have met specific targets such as the performance indicators: whether they have or have not been met in relation to the indicators for London and England and how the authority is measuring up against the national average.

**Financial**

Implications completed by: Katherine Heffernan, Group Manager - Finance

- 5.6 There are no financial implications arising from this report.

**6 List of Appendices**

- Appendix i: Performance dashboard
- Appendix ii: Performance summary reports
- Appendix iii: CQC reports, 2016/17 Quarter 4

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## Key

## Appendix i: Indicators for HWBB - 2016/17 Q4

	Data unavailable due to reporting frequency or the performance indicator being new for the period
..	Data unavailable as not yet due to be released
	Data missing and requires updating
	Provisional figure
<b>DoT</b>	The direction of travel, which has been colour coded to show whether performance has improved or worsened
<b>NC</b>	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		
<b>1 - Children</b>																	
Percentage of Uptake of Measles, Mumps and Rubella (MMR2) Immunisation at 5 years old	82.7%	81.0%	81.2%	80.3%	78.6%	..	80.5%	82.5%	79.9%	..	..	↘	R	87.8%	79.1%	1	PHOF
Year end figures for 2015/16 have not yet been published by NHS Digital. 2016/17 Q4 data not yet available.																	
Prevalence of children in reception year that are obese or overweight	27.5%					25.4%					..	↘	R	22.1%	22.0%	2	PHOF
Prevalence of children in year 6 that are obese or overweight	40.6%					43.4%					..	↗	R	34.2%	38.1%	3	PHOF
Number of children and young people accessing Tier 3/4 CAMHS services	1,217	585	490	526	539	1,114	530	525	565	..	..	↗	NC			4	HWBB OF
Year end figure is the number of unique people accessing CAMHS over the course of the year. Q4 data will be available July 2017.																	
Annual health check Looked After Children	91.8%	82.0%	72.0%	73.8%	94.2%	94.2%	80.1%	76.2%	77.3%	91.5%	91.5%	↗	G	88.0%	90.0%	5	HWBB OF
The number of children subject to Child Protection Plans		320	323	292	253	253	265	271	266	294	294	↗	R			6	HWBB OF
<b>2 - Adolescence</b>																	
Under 18 conception rate	29.3	32.1	32.8	29.8	..	..	..	..	..	..	..	→	R	20.3	19.4	7	PHOF
Crude rate per 1,000 women aged 15-17 years.																	
Care leavers in education, employment or training (NEET)		52.0%	43.3%	45.2%	50.2%	48.4%	50.0%	50.8%	52.3%	55.1%	55.1%	↗	G	48.0%	53.0%	8	HWBB OF
<b>3 - Adults</b>																	
Number of four week smoking quitters	643	121	89	131	211	551	191	162	196	162*	..	↗	R			9	HWBB OF
*Please note that the most recent quarter is an incomplete figure and will be revised in the next HWBB report.																	
Cervical Screening - Coverage of women aged 25 - 64 years	70.1%					67.9%					..	↘	A	72.7%	66.7%	10	PHOF
Percentage of eligible women screened adequately within the previous 3.5 (25-49 year olds) or 5.5 (50-64 year olds) years on 31st March. 2016/17 data due to be published November 2017.																	
Percentage of eligible population that received a health check in last five years	16.3%	2.5%	2.9%	3.2%	3.1%	11.7%	2.7%	2.8%	2.7%	2.8%	11.0%	↘	R	9.0%	10.7%	11	PHOF
Please note that annual figures, and London and England figures, are a cumulative figure accounting for all four previous quarters. Please note base eligible population changed from 2014/15 and 2015/16.																	

## Key

## Appendix i: Indicators for HWBB - 2016/17 Q4

	Data unavailable due to reporting frequency or the performance indicator being new for the period
..	Data unavailable as not yet due to be released
	Data missing and requires updating
	Provisional figure
<b>DoT</b>	The direction of travel, which has been colour coded to show whether performance has improved or worsened
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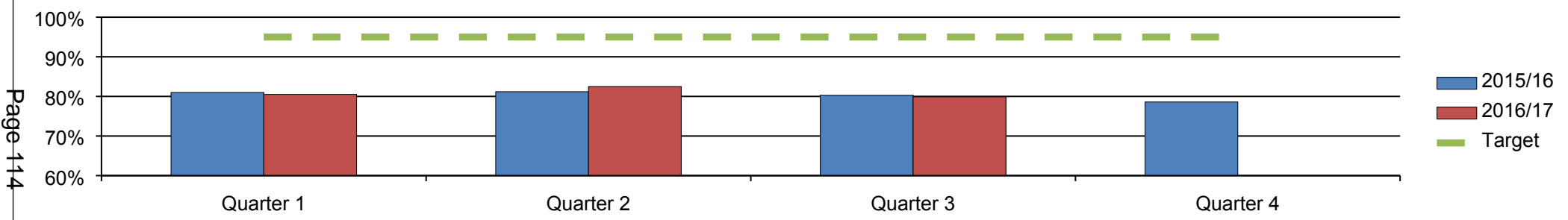
Title	2014/15	2015/16				2015/16	2016/17				2016/17	DoT	RAG Rating	BENCHMARKING		HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4				England Average	London Average		
<b>4 - Older Adults</b>																	
Breast Screening - Coverage of women aged 53-70 years	64.3%					66.5%					..	↗	A	75.5%	69.2%	12	HSCIC
Percentage of women whose last test was less than three years ago. 2016/17 data due to be released February 2018.																	
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	936.58	188.24	401.91	625.35	910	910	223.7	437.2	615.2	737.2	737.2	↘	G	628.2	516.5	13	BCF/ASCOF
Rates are cumulative throughout the year																	
The outcome of short term services: sequel to service	55.0%					77.5%	60.8%	59.8%	61.4%	61.3%	61.3%	↘	A	75.8%	71.4%	14	ASCOF
Injuries due to falls for people aged 65 and over	1656.0					..					..	↘	G	2125.0	2253.0	15	BCF/PHOF
Directly age-sex standardised rate per 100,000 population over 65 years.																	
<b>5 - Across the Lifecourse</b>																	
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%	69.0%	69.9%	↘	A	62.1%	67.4%	16	ASCOF
Delayed transfers of care from hospital	135.2	158.0	197.5	213.7	251.8	205.3	184.6	260.0	217.7	204.1	205.5	→	G	401.66	N/A	17	ASCOF
Emergency readmissions within 30 days of discharge from hospital		..	..	..	..	8.99%	..	..	..	..	..	↘	G			18	NHSOF
Taken from BHRUT board papers - standard 14.5%																	
A&E attendances < 4 hours from arrival to admission, transfer or discharge (type all)	85.3%	93.4%	92.3%	86.5%	79.8%	88.0%	81.7%	89.1%	87.1%	84.5%	85.6%	↘	A	95.0%		19	SRG
Please note this figure is for BHRUT																	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	1,015.8					..					..	↘	R	807.4	723.3	20	NHSOF
The number of leisure centre visits	1,282,430	384,043	373,784	334,615	363,103	1,455,545	383,895	371,040	340,086	371,722	1,466,746	↗	A			21	Leisure
The number of children and adults referred to healthy lifestyle programmes		692	753	512	735	2,692	677	620	516	605	2,418	↘	G			22	Leisure

## **Appendix ii - Performance Summary Reports**

Health and Wellbeing Board Performance Indicators  
 Indicator 1: Percentage uptake of MMR (measles, mumps and rubella) vaccination  
 (2 doses) at 5 years old

Meeting date: June 2017, Data: December 2016  
 Source: NHS England

<b>Definition</b>	Percentage of children given two doses of MMR vaccination by their fifth birthday.				<b>How this indicator works</b>	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.						
<b>What good looks like</b>	Quarterly achievement rates to be above the set target of 95% vaccination coverage.				<b>Why this indicator is important</b>	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.						
<b>History with this indicator</b>	2011/12: 82.8%, 2013/14: 82.3%, 2015/16: 82.4%		2012/13: 85.5%, 2014/15: 82.7%		<b>Any issues to consider</b>	Quarter 4 data 2016/17 is expected to be available on 23 June 2017.						
	<b>Apr</b>	<b>May</b>	<b>Jun</b>	<b>Jul</b>	<b>Aug</b>	<b>Sep</b>	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>	<b>Jan</b>	<b>Feb</b>	<b>Mar</b>
<b>2015/16</b>	81.0%			81.2%			80.3%			78.6%		
<b>2016/17</b>	80.5%			82.5%			79.9%					



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<b>Performance Overview</b>	<ul style="list-style-type: none"> <li>Poor performance is seen across the whole of London with this indicator.</li> <li>In LBBD 10 GP practices are above the 95% rate and 12 below 80%.</li> <li>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.</li> </ul>	<b>Further Performance comments</b>	<ul style="list-style-type: none"> <li>Ensure Barking and Dagenham GP Practices have access to IT support for generating immunisation reports.</li> <li>Work jointly with the CCG (commissioners) to target GP practices with poor performance to increase rates by:                             <ul style="list-style-type: none"> <li>Children who persistently miss immunisation appointments followed up to ensure they are up to date with immunisations.</li> <li>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.</li> <li>Encourage GP practices to remove ghost patients.</li> </ul> </li> </ul>
<b>RAG Rating</b>	Red		
<b>Benchmarking</b>	In Quarter 3 2016/17, Barking and Dagenham's MMR2 coverage at 5 years was 79.9%, marginally above London (79.1%) and below England (87.8%).		

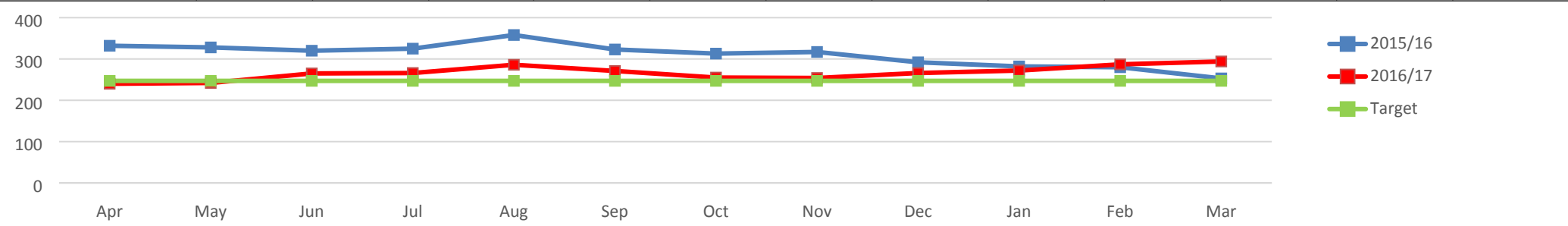
Indicator 6: The number of children subject to child protection plans

Source: Children's Services

<b>Definition</b>	This indicator measures the number of children on child protection plans monitored each month as part of Care and Support performance reporting.	<b>How this indicator works</b>	It is reported as a number and a rate per 10,000 children aged 0–17 in the borough. Children on child protection plans have been assessed as at risk of significant harm or abuse by a Child Protection Conference. A child protection plan is then put in place to ensure children are protected. This plan is monitored and reviewed regularly by social workers and multi-agency professionals.
<b>What good looks like</b>	For the number to remain in line with population change and to be stable throughout the year. LBB rate per 10,000 to be in line with benchmark data and in line with London rate.	<b>Why this indicator is important</b>	The data allows us to make performance comparisons with other areas and provides data on trends on the number and rate of our children's population at risk of harm and abuse. It is also an indicator of how well our safeguarding threshold is being applied and is a significant KPI for LSCB and is an Ofsted area of inspection.
<b>History with this indicator</b>	2012/13: 200 (36 per 10,000)    2013/14: 318 (56 per 10,000) 2014/15: 353 (60 per 10,000)    2015/16: 253 (43 per 10,000)		

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
<b>2015/16</b>	332	328	320	325	358	323	313	317	292	282	280	253
<b>2016/17</b>	240	242	265	266	286	271	255	254	266	272	287	294

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<b>Performance Overview</b>	<ul style="list-style-type: none"> <li>The number of children on child protection plans increased to 294 in March 2017 compared with 287 last month. Child protection numbers are higher when compared to our year-end 15/16 outturn of 253. The rate per 10,000 has subsequently increased to 48.7, higher than the London rate (38) and the national rate (43), and just below our statistical neighbours (49).</li> </ul>	<b>Further Performance comments</b>	<ul style="list-style-type: none"> <li>Child Protection numbers have fluctuated in 16/17 increasing in the first 5 months of the year followed by a decline up to November 2016 and are now rising again.</li> <li>The CPRS and Performance team are analysing the CP end of year data to ascertain factors causing the increase. One of the factors contributing to the rise is that a lower number of children are being de-planned in 16/17 compared to 15/16: 291 compared to 411 respectively. There has been a slight increase in the number of new plans – 332 in 16/17 compared to 310 in 15/16.</li> </ul>
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<b>Benchmarking</b>	National, London and SN rate per 10,000 is 43, 38 and 49 respectively (based on latest published data for 2015/16).
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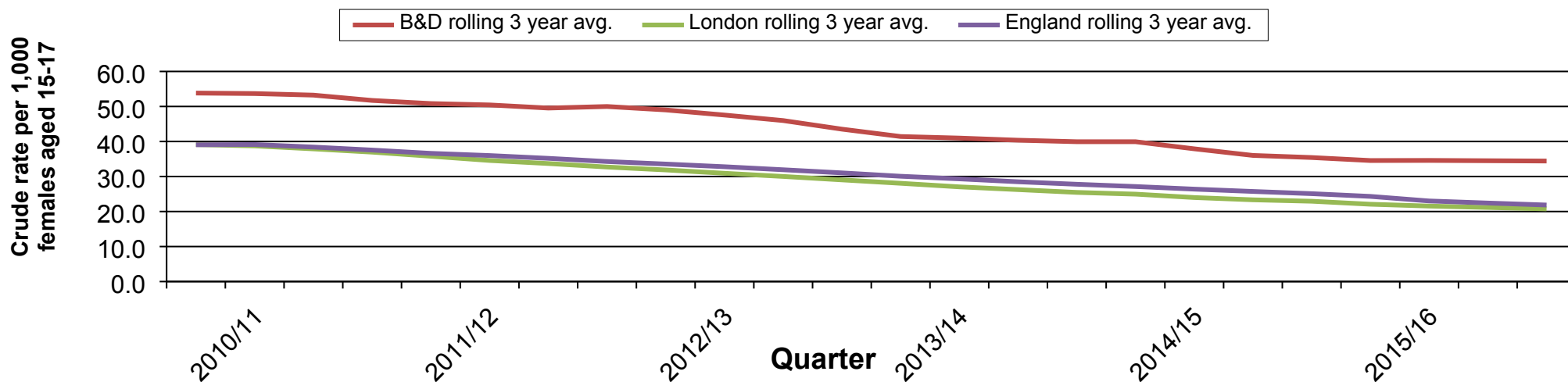
Health and Wellbeing Performance Indicators  
Indicator 7: Under 18 conception rate (per 1,000)

Meeting date: June 2017, Data: December 2015  
Source: ONS

<b>Definition</b>	Conceptions in women aged under 18 per 1,000 females aged 15-17.	<b>How this indicator works</b>	This indicator is reported annually by the Office for National Statistics and refers to pregnancy rate among women aged below 18.
<b>What good looks like</b>	For the number of under 18 conceptions to be as low as possible, with the gap to regional and national averages narrowing.	<b>Why this indicator is important</b>	Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children.
<b>History with this indicator</b>	2009: 54.7 per 1,000 women aged 15-17 years 2010: 54.9 per 1,000 women aged 15-17 years	<b>Any issues to consider</b>	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
<b>2014/15</b>	31.0	20.5	37.1	28.6
<b>2015/16</b>	32.1	32.8	29.8	

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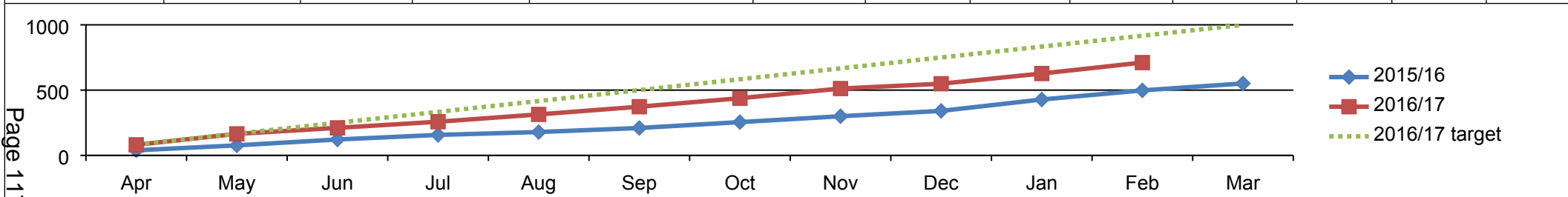


<b>Performance Overview</b>	The rate of under 18 conceptions is showing a generally decreasing trend over the last 4 years, with the quarterly-rolling annual average falling from 47.7 at the start of 2011/12 to 31.0 in 2015/16 Q3.	<b>Further Performance comments</b>	Barking and Dagenham remains above the national and London averages (20.3 and 19.4 per 1,000 respectively), who both saw a continued decline in their conception rate.
<b>RAG Rating</b>			
<b>Benchmarking</b>	Barking and Dagenham's rate is above the national and regional averages, with Barking & Dagenham currently having one of the highest rates nationally and regionally.		



<b>Definition</b>	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.	<b>How this indicator works</b>	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.
<b>What good looks like</b>	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.	<b>Why this indicator is important</b>	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.
<b>History with this indicator</b>	<b>2012/13:</b> 1,480 quitters <b>2013/14:</b> 1,174 quitters <b>2014/15:</b> 635 quitters <b>2015/16:</b> 551 quitters	<b>Any issues to consider</b>	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
<b>2015/16</b>	39	38	45	35	22	31	45	45	41	87	70	53
<b>2016/17</b>	81	64	46	47	56	59	65	74	37	78	84	



<b>Performance Overview</b>	<ul style="list-style-type: none"> <li>From April to February there were 691 quitters. This is 75.4% achievement against the year to date target.</li> <li>This compares favourably with 498 quitters for the same month in 2015/16 (193 more quitters this year)</li> </ul>	<b>Further Performance comments</b>	<ul style="list-style-type: none"> <li>Pharmacy continues to have the highest number of quits (280 quits), followed by Tier 3 (267) and then General Practice (144).</li> <li>There has been a small increase in GP performance, with February figures showing the second highest levels of GP quitters to date.</li> <li>Because of time lags, recent data in Quit Manager shows a greater increase in activity (figures have now surpassed 700)</li> <li>Tier 3 have continued to support GP practices and pharmacies. In consultation with Public Health, this support for practices is being addressed in three waves and prioritised according to practice prevalence and paucity of activity.</li> <li>In order to meet the end of year target we would require an additional 309 quitters by the end of the March data collation, with 209 quitters required for an amber RAG rating.</li> </ul>
<b>RAG Rating</b>			

<b>Benchmarking</b>	Between April and December 2016/17 there were 357 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 (240), Havering (2), Newham (74), Hackney (525), City of London (1,533), Waltham Forest (292) and Tower Hamlets (333).
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HWB Performance Indicators

Meeting date: June 2017, Data: March 2017

Indicator 11: Those aged 40-74 who receive an NHS Health Check

Source: Department of Health

<p><b>Definition</b></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><b>How this indicator works</b></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 5years. 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><b>What good looks like</b></p>	<ul style="list-style-type: none"> <li>Increased number of patients invited for a health check</li> <li>Measured Targets: 20% invited each year; 75% uptake each year, i.e. 15%.</li> </ul>						<p><b>Why this indicator is important</b></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><b>History with this indicator</b></p>	<p>2012/13*: 10.0%, 2013/14*: 11.4% received 2014/15*: 16.3%, 2015/16*: 11.7% received *Please note this is a fraction of the 5-year programme where there is an annual target uptake of 15%.</p>						<p><b>Any issues to consider</b></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><b>Apr</b></p>	<p><b>May</b></p>	<p><b>Jun</b></p>	<p><b>Jul</b></p>	<p><b>Aug</b></p>	<p><b>Sep</b></p>	<p><b>Oct</b></p>	<p><b>Nov</b></p>	<p><b>Dec</b></p>	<p><b>Jan</b></p>	<p><b>Feb</b></p>	<p><b>Mar</b></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>0.77%</p>	<p>0.84%</p>	<p>1.08%</p>	<p>0.87%</p>	<p>1.00%</p>	<p>0.95%</p>	<p>0.92%</p>	<p>1.01%</p>	<p>0.73%</p>	<p>0.78%</p>	<p>0.87%</p>	<p>1.18%</p>																																																				
<table border="1"> <caption>Monthly Performance Data (Estimated from Chart)</caption> <thead> <tr> <th>Month</th> <th>2015/16 (%)</th> <th>2016/17 (%)</th> <th>2016/17 Target (%)</th> </tr> </thead> <tbody> <tr><td>Apr</td><td>0.93</td><td>0.77</td><td>15.00</td></tr> <tr><td>May</td><td>0.73</td><td>0.84</td><td>15.00</td></tr> <tr><td>Jun</td><td>0.90</td><td>1.08</td><td>15.00</td></tr> <tr><td>Jul</td><td>0.97</td><td>0.87</td><td>15.00</td></tr> <tr><td>Aug</td><td>1.03</td><td>1.00</td><td>15.00</td></tr> <tr><td>Sep</td><td>0.89</td><td>0.95</td><td>15.00</td></tr> <tr><td>Oct</td><td>0.87</td><td>0.92</td><td>15.00</td></tr> <tr><td>Nov</td><td>1.07</td><td>1.01</td><td>15.00</td></tr> <tr><td>Dec</td><td>1.24</td><td>0.73</td><td>15.00</td></tr> <tr><td>Jan</td><td>1.10</td><td>0.78</td><td>15.00</td></tr> <tr><td>Feb</td><td>1.08</td><td>0.87</td><td>15.00</td></tr> <tr><td>Mar</td><td>1.02</td><td>1.18</td><td>15.00</td></tr> </tbody> </table>													Month	2015/16 (%)	2016/17 (%)	2016/17 Target (%)	Apr	0.93	0.77	15.00	May	0.73	0.84	15.00	Jun	0.90	1.08	15.00	Jul	0.97	0.87	15.00	Aug	1.03	1.00	15.00	Sep	0.89	0.95	15.00	Oct	0.87	0.92	15.00	Nov	1.07	1.01	15.00	Dec	1.24	0.73	15.00	Jan	1.10	0.78	15.00	Feb	1.08	0.87	15.00	Mar	1.02	1.18	15.00
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<p><b>Performance Overview</b></p>							<p><b>Further Performance comments</b></p>	<ul style="list-style-type: none"> <li>Public Health has successfully submitted revised denominator figures for use in 2017/18 to Public Health England. These changes will lead to improved performance figures and will likely improve the RAG rating from 'Red' should current delivery be maintained.</li> <li>For March Health Check performance is RAG rated amber, with the highest performance to date for 2016/17 (555 Health checks). However, the overall 2016/17-year performance remains RAG rated red.</li> <li>An additional 1,881 Health checks were required to achieve the annual target, with 1,730 health checks required for an amber RAG rating.</li> <li>19 practices have now achieved their 75% target for completed HCs (50% of practices).</li> </ul>																																																								
<p><b>RAG Rating</b></p>	<ul style="list-style-type: none"> <li>5,177 health checks have been delivered in 2016/17.</li> <li>9,339 people have been invited for a health check in the same period.</li> </ul>																																																															
<p><b>Benchmarking</b></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>																																																															

## Appendix iii - CQC Inspections - 2016/17 Q4

Name	Report publication date	Link to inspection report	Overall rating	Service types
Barking Medical Group Practice	04/01/2017	<a href="http://www.cqc.org.uk/location/1-546149998">http://www.cqc.org.uk/location/1-546149998</a>	Good	Doctors/GPs
Fortis House	14/01/2017	<a href="http://www.cqc.org.uk/location/1-2311633552">http://www.cqc.org.uk/location/1-2311633552</a>	Requires Improvement	Homecare agencies, Supported living
Dr Aarron Patel	17/01/2017	<a href="http://www.cqc.org.uk/location/1-516078976">http://www.cqc.org.uk/location/1-516078976</a>	Good	Doctors/GPs
Dr Beheshti	18/01/2017	<a href="http://www.cqc.org.uk/location/1-541901529">http://www.cqc.org.uk/location/1-541901529</a>	Good	Doctors/GPs
Barking Enterprise Centre	20/01/2017	<a href="http://www.cqc.org.uk/location/1-777256040">http://www.cqc.org.uk/location/1-777256040</a>	Inadequate	Homecare agencies
The White House Surgery	23/01/2017	<a href="http://www.cqc.org.uk/location/1-567937486">http://www.cqc.org.uk/location/1-567937486</a>	Good	Doctors/GPs
Siloamlodge - Dagenham	24/01/2017	<a href="http://www.cqc.org.uk/location/1-114596241">http://www.cqc.org.uk/location/1-114596241</a>	Good	Residential homes, Rehabilitation (illness/injury)
Darcy House	28/01/2017	<a href="http://www.cqc.org.uk/location/1-1698526332">http://www.cqc.org.uk/location/1-1698526332</a>	Requires Improvement	Supported housing
Hedgemans Medical Centre	07/02/2017	<a href="http://www.cqc.org.uk/location/1-544348179">http://www.cqc.org.uk/location/1-544348179</a>	Requires Improvement	Doctors/GPs
Homecare UK (Dagenham)	08/02/2017	<a href="http://www.cqc.org.uk/location/1-1123272658">http://www.cqc.org.uk/location/1-1123272658</a>	N/A	Homecare agencies
Heathway Medical Centre	10/02/2017	<a href="http://www.cqc.org.uk/location/1-2687718289">http://www.cqc.org.uk/location/1-2687718289</a>	Inadequate	Doctors/GPs
Dr Mohammed Ehsan	14/02/2017	<a href="http://www.cqc.org.uk/location/1-562316965">http://www.cqc.org.uk/location/1-562316965</a>	Good	Doctors/GPs
Laburnum Health Centre	15/02/2017	<a href="http://www.cqc.org.uk/location/1-559160107">http://www.cqc.org.uk/location/1-559160107</a>	Good	Doctors/GPs
Drs B B Quansah and A Adedeji Practice	28/02/2017	<a href="http://www.cqc.org.uk/location/1-584799345">http://www.cqc.org.uk/location/1-584799345</a>	Requires Improvement	Doctors/GPs
Disablement Association of Barking and Dagenham	09/03/2017	<a href="http://www.cqc.org.uk/location/1-124966110">http://www.cqc.org.uk/location/1-124966110</a>	Good	Homecare agencies
Child and Family Doctors Surgery	14/03/2017	<a href="http://www.cqc.org.uk/location/1-1242879913">http://www.cqc.org.uk/location/1-1242879913</a>	Good	Doctors/GPs
Dr Padma Prasad	14/03/2017	<a href="http://www.cqc.org.uk/location/1-499441696">http://www.cqc.org.uk/location/1-499441696</a>	Good	Doctors/GPs
Gables Surgery	23/03/2017	<a href="http://www.cqc.org.uk/location/1-542030223">http://www.cqc.org.uk/location/1-542030223</a>	Good	Doctors/GPs
Br3akfree Limited	29/03/2017	<a href="http://www.cqc.org.uk/location/1-2161237091">http://www.cqc.org.uk/location/1-2161237091</a>	Requires Improvement	Homecare agencies

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**HEALTH AND WELLBEING BOARD**

**5 July 2017**

<b>Title:</b>	<b>Healthwatch Review 2016-2017</b>
<b>Report of the Healthwatch Review 2016-2017</b>	
<b>Open Report</b>	<b>For Information</b>
<b>Wards Affected:</b> ALL	<b>Key Decision:</b> Yes / No
<b>Report Author:</b> Marie Kearns, Contract Manager Healthwatch Barking and Dagenham.	<b>Contact Details:</b> Tel: 020 8526 8200 E-mail: mkearns@harmonyhousedagenaham.org.uk
<b>Sponsor:</b> Frances Carroll: Chair of Healthwatch Barking and Dagenham	
<b>Summary:</b> This report is for members to review the work of Healthwatch Barking and Dagenham during 2016-2017.  This paper is a summary of the work undertaken by Healthwatch Barking and Dagenham in the operating year 2016-2017. It outlines the work that has been undertaken by the Healthwatch team during the year and highlights our achievements and challenges. Above all it shows how we interact with the public, capture their opinions and reflect them back to commissioners of both Health and Social Care services. This includes the extensive training programme delivered by Healthwatch Barking and Dagenham on behalf of Barking and Dagenham Havering Redbridge Community Education Provider Network.  This report is supplemented by a short film.	
<b>Recommendation(s)</b>  The Health and Wellbeing Board is recommended to:  (i) Consider the report, noting the impact that Healthwatch has had in the last year.	
<b>Reason(s)</b>  To bring to the attention of the Board trends in public opinion with regard to health and social care services in Barking and Dagenham. To advise the Board of the impact Healthwatch has had throughout the year.	

## **1. Introduction and Background**

- 1.1 Healthwatch is an independent consumer champion for both health and social care. It exists in two distinct forms—Healthwatch England, at the national level and local Healthwatch, at a local level. Healthwatch England is a committee of the Care Quality Commission.
- 1.2 The aim of our local Healthwatch in Barking and Dagenham is to give our citizens and communities a stronger voice to influence and challenge how health and social care services are provided in the borough.
- 1.3 All work undertaken by the Healthwatch team is driven by public opinion or where we have been asked specifically to look at a service.

## **2. Annual plan: enter and view visits, project work and training programme.**

- 2.1 During this year Healthwatch has completed 6 Enter and View visits. From our findings we made 16 recommendations in total: 5 have been accepted and we await the outcome of the others. We have looked at both health and social care services.
- 2.2 The aim of Healthwatch Barking and Dagenham is to highlight good practice as well as areas for development. Three of our enter and view reports: Heathlands, Fred Tibble Court, and Bennett's Castle Lane contained no recommendations for improvement and we were pleased to highlight the good work taking place in these settings.

## **3. Project work**

- 3.1 This year Healthwatch has completed 6 pieces of project work which included primary research. This is a smaller number than last year, and is as a result of the professional and public consultation work that we have undertaken in preparation for the coming of the Sustainable Transformation Plan and the anticipated closer working arrangements between health and social care in the BHRUT area. In addition we have delivered an extensive training programme in partnership with the Community Education Partnership Network (CEPN)
- 3.2 One of our projects looked at the amount of waste there is in the area of prescribed medication. The report highlights that nationally it is estimated that £300 million a year is wasted by patients who discard prescribed medication. This was echoed in our primary research where people told us that medicines were thrown in the bin, down the sink or flushed down the lavatory. Some people were collecting drugs on repeat prescriptions which were no longer required, but were kept at home in case they were needed in the future.
- 3.3 Individuals reported not taking their medication for a number of reasons including being nervous about the side effects, the medicine did not agree with them or they no longer felt ill. A large number of respondents would like to see some thought given to this situation with a view to finding a way of being able to safely recycle at least some of these expensive drugs.
- 3.4 People felt that more information about the safe disposal of medicines should be displayed in easily accessible formats in pharmacies and doctor's surgeries and more needed to be done in regards to medications that can no longer be used. We have made recommendations to the CCG and the LPC and are awaiting a response.

#### **4. The Patient and Service User Experience of using Health and Social Care Services in the Barking, Havering and Redbridge area.**

- 4.1 This year Healthwatch Barking and Dagenham delivered training on behalf of Barking Havering Redbridge Community Education Provider Network. The training was delivered across Barking and Dagenham, Havering and Redbridge. We worked in partnership with our neighbouring Healthwatch in Redbridge and Havering to deliver the 23 training sessions. The title of the workshops was “The Patient and service user experience of using health and social care services”.
- 4.2 The training was attended by practitioners, administrators and managers from 34 different areas of work. Delivering the training gave Healthwatch the perfect opportunity to show the course participants what their patients and service users experienced when they used their services.
- 4.3 The course was well received and enjoyed by participants. The use of role play scenarios and interactive sessions were effective in engaging participants and helped their learning. Many participants were surprised to find out about the number of services that are available in the BHRUT area: especially for patients needing urgent or emergency care. As a result they were prompted to find out more information and use it to signpost patients and service users more effectively.
- 4.4 Participants identified several ways in which they would now try to change their practice as a result of the workshops, but also identified what they thought might be challenges to change. The biggest difficulty was seen to be a lack of resources, however all agreed that having patience and a friendly manner was an inexpensive quick win.
- 4.5 All course participants had to commit to ways in which they would alter their practice as a result to the patient experience training.

#### **5. Signposting**

- 5.1 We have assisted and sign posted 686 individuals to a number of services. Below is a breakdown of the areas they made contact about.
- Hospital Services – 337 (49%)
  - GP – 239 (35%)
  - Social Care – 55 (8%)
  - Mental Health Services – 34 (5%)
  - Other Requests – 21 (3%)

#### **6. Consultation and Engagement**

##### **Residents**

- 6.1 Healthwatch Barking and Dagenham consults with local residents to better understand their experiences of using local health and social care services. These opinions are then used to inform our annual plan.
- 6.2 We have consulted and engaged with a number of residents through the various projects and enter and views. We have continued to take part in outreach events

across the borough, including the One Borough Day, World Mental Health Day and the Young people's listening event. All the events have contributed to obtaining the views of the public.

- 6.3 This year Healthwatch Barking and Dagenham have engaged with the public using a variety of means;
- Using Twitter we sent 748 tweets to our 940 followers
  - Through Streetlife (a local on-line social media platform) we were able to engage 4769 members of the public each time we posted information or asked for public opinion. We received replies from conversations that emerged from topics including, breast cancer screening, GP hub services and homelessness.

### **Associates and interested members**

- 6.4 As part of our hub and spoke model Healthwatch Barking and Dagenham have 25 Associate Member groups. These are groups and organisations who focus on a particular area of health or social care for example the Stroke Society. The majority of our Associates have large followings. The Associate groups are both a conduit for data gathering and information dissemination.
- 6.5 We also have 104 interested individuals from the public plus a further 103 people from provider and local service organisations to whom we send information and circulate our reports.

## **7. Networks and Partners**

- 7.1 This year we have worked with Havering and Redbridge on delivering a large training programme on behalf of CPEN.
- 7.2 Healthwatch Barking and Dagenham are regularly represented on;
- The Health and Wellbeing Board
  - The Learning Disability Partnership
  - The Mental Health Sub Group
  - The Safeguarding Adults Board
  - The Health and Adult Services Select Committee
  - The London Healthwatch Group and Healthwatch England
  - Sustainable Transformation Plan
  - North East London Healthwatch Meeting
  - Clinical Commissioning Group Governing Body

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



- 7.3 Healthwatch Barking and Dagenham contributed to the Barking Havering Redbridge University Trust's Annual Account and the Annual Report of the Safeguarding Adults Board. In addition, we have worked in partnership with the 8 local Healthwatch bodies from the Sustainability and Transformation Plan area; this has included regular meetings and research work.

## **8. Mandatory Implications**

### **Joint Strategic Needs Assessment**

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

### **Health and Wellbeing Strategy**

- 8.2 All the topics for the Healthwatch work plan fall within the four themes of the Health and Wellbeing Strategy; care and support, protection and safeguarding, prevention, Improvement and Integration of Services.

### **Integration**

- 8.3 Healthwatch were fully involved in all the discussions around the Accountable Care Organisation and contributed to the discussions reflecting the views of local residents and how their experiences could be enhanced by the closer integration of health and social care services.

### **Financial Implications**

- 8.4 Healthwatch Barking and Dagenham are commissioned by the Local Authority. Harmony House is funded until 31st July 2017 to deliver the Healthwatch programme.

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

### **Legal Implications**

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

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

### **Risk Management**

- 8.6 All those undertaking Enter and View visits who are authorised representatives have undertaken specific training and have a DSB clearance. Ongoing training on safeguarding awareness is available to all staff and volunteers.

### **Patient/Service User Impact**

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

**9. Non-mandatory Implications**

**Crime and Disorder**

9.1 None

**Safeguarding**

9.2 All staff and volunteers of the Healthwatch team are given awareness training on Safeguarding issues. A Healthwatch representative sits on the Safeguarding Adults Board. All staff and volunteers have updated DBS checks.

**Property/Assets**

9.3 Healthwatch Barking and Dagenham are currently located at Harmony House Dagenham and have no ongoing commitment to other property or assets.

**Customer Impact**

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

**Contractual Issues**

9.5 Healthwatch Barking and Dagenham is commissioned by the Local Authority and is funded until August 2017.

**Staffing issues**

9.6 At the time of writing this report Healthwatch Barking and Dagenham have a team of 2 full time equivalent members of staff and 8 volunteers.

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

The Joint Strategic Needs Assessment

## HEALTH AND WELLBEING BOARD

5 July 2017

<b>Title:</b>	<b>Joint Local Area Special Educational Needs and Disability (SEND) Inspection in Barking and Dagenham</b>		
<b>Report of the Strategic Director for Service Development and Integration</b>			
<b>Open Report</b>	<b>For Information</b>		
<b>Wards Affected:</b> None	<b>Key Decision:</b> No		
<b>Report Author:</b> Vikki Rix: Head of Performance and Intelligence, Children's Care and Support Commissioning	<b>Contact Details:</b> Tel: 020 8227 2564 E-mail: Vikki.Rix@lbbd.gov.uk		
<b>Sponsor:</b> Anne Bristow, Deputy Chief Executive and Strategic Director for Service Development and Integration, LBBB.			
<b>Summary</b>			
<p>In March 2017, Ofsted and the Care Quality Commission conducted a joint local area inspection of Barking and Dagenham to judge the effectiveness of the area in implementing the disability and special educational needs (SEND) reforms as set out in the Children and Families Act 2014. This report introduces and appends the inspection findings, published on 21st June 2017.</p>			
<b>Recommendation(s)</b>			
<p>The Health and Wellbeing Board is recommended to:</p> <ul style="list-style-type: none"> <li>(i) Note and discuss the findings of the SEND inspection, and, in response, the current development of a multi-agency Local Area SEND Action Plan; and</li> <li>(ii) Note that the multi-agency action plan is a consolidation of the work that has already begun to address the identified areas for improvement, as well as a joint local area response on improving outcomes for children and young people with disabilities in Barking and Dagenham.</li> </ul>			
<b>Reason(s)</b>			
<p>The purpose of this report is to inform the Health and Wellbeing Board of the outcome of the joint Ofsted/Care Quality Commission (CQC) inspection of Barking and Dagenham's effectiveness in implementing the Special Educational Needs and Disability (SEND) reforms as set out in the Children and Families Act 2014.</p>			

**1. Introduction and Background**

- 1.1 Between 27 March and 31 March 2017, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of Barking and Dagenham, to judge the effectiveness of the area in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014. The inspection was led by one of Her Majesty's Inspectors from Ofsted, supported by a team of inspectors including an Ofsted Inspector and CQC children's services inspectors.
- 1.2 During the 5-day inspection, the inspection team sought the views and opinions of children and young people, their parents and carers. This was undertaken during visits to schools, early years settings and colleges and through meetings with individuals and groups. A webinar was also used by the inspectors to gather feedback from parents of children and young people with SEND in the local area.
- 1.3 Inspectors also visited a range of providers and spoke to leaders, staff and governors about how they were implementing the special educational needs reforms. Inspectors looked at a range of information about the performance of the local area, including the local area's self-evaluation. Inspectors met with leaders from the local area and a wide range of documentation and performance data across education, health and social care were reviewed as part of the inspection. A small number of Education, Health and Care Plans were also audited.
- 1.4 On 9 May 2017 HMI Ofsted sent Anne Bristow, the Deputy Chief Executive and Strategic Director for Service Development and Integration a draft inspection letter outlining the findings of the inspection, including some areas of strengths and areas for further development for factual accuracy checks. Senior Local Authority and CCG officers were provided with the opportunity to highlight factual inaccuracies in the draft letter, before its final publication. 2 inaccuracies were raised by the local area and agreed by Ofsted in the final report.
- 1.5 The local area received the final joint inspection letter from Ofsted and the CQC on the 21 June 2017. This letter details the inspectors' key findings and outcomes in a narrative of areas of strength and areas of development, rather than a specific grading. Barking and Dagenham's Local Area SEND Inspection letter is appended to this report.

## **2. Main Findings**

- 2.1 Overall, the outcome of Barking and Dagenham's inspection was positive. The inspection letter highlights many strengths across education, health and social care, in terms of the support that is offered to children and young people with SEND and their families. Inspectors praised partners' commitment to reform and effective implementation. The local area's governance and accountability were identified as strengths and inspectors praised the role of the Health and Wellbeing Board and elected members in holding leaders to account for improving outcomes in a local area which is rapidly changing. Collaboration between healthcare and local authority staff and personnel in settings, schools and colleges was also viewed as a significant strength. Strong relationships with providers were commended, which allow effective monitoring of the safety and wellbeing of children and young people.
- 2.2 In terms of development, the inspectors noted that insufficient numbers of parents and young people know about, or use, the *Local Offer* to find advice and help. Whilst the inspection noted that education, health and social care professionals

contributed to the local area self-evaluation with priorities identified, detailed targets and timescales are not incorporated into plans. Inspectors noted that there is a lack of clarity about how some aspects of services will be jointly commissioned.

- 2.3 An area for development has also been identified about the capacity in providing therapies such as speech and language, occupational and physiotherapy, due to issues with recruiting and training staff, which leads to delays in EHC plans. EHC plans themselves, it was reported, do not consistently benefit from appropriate input from health and social care. As a result, the detail of the support that children need and how this will be provided is, at times, insufficient. The level at which parents' and young people's views are considered is also variable. Some parents and young people said that they did not feel fully engaged in, or informed about, the process.
- 2.4 The low proportion of young adults who have learning disabilities in training and employment was also identified as an area for development. The local area has identified this and is taking the initiative by leading a project to support employers to understand how they can provide paid employment opportunities for young people. A strong feature of this work is the partnership with Barking and Dagenham College, which is starting to support young people to find employment.
- 2.5 The full inspection report, appended, details the findings across 3 categories; identifying need, meeting need, and improving outcomes.

### **3. Next steps**

- 3.1 In response to the findings of this inspection, an action plan is currently in development. The action plan will be brought to the Health and Wellbeing Board, and will seek to further improve the offer for children and young people with disabilities and/ or special educational needs in Barking and Dagenham.

### **4. Mandatory Implications**

#### **Joint Strategic Needs Assessment**

- 4.1 The 2016 JSNA identified that:
  - The proportion of children identified with special educational needs is lower in Barking and Dagenham than nationally.
  - There has been a downward trend in the number of children with special educational needs without statements
  - The numbers of children with severe disabilities is growing nationally
  - In Barking and Dagenham this means paying particular attention to our disadvantaged residents and our Asian and Black African communities because they have a higher prevalence of young disabled children

#### **Health and Wellbeing Strategy**

- 4.2 Responding to the findings of this SEND inspection will support the Board in improving the following key themes of the Health and Wellbeing Strategy:

improvement and integration of services, care and support, and protection and safeguarding.

## **Integration**

- 4.3 Not applicable.

### **Financial Implications** (completed by Katherine Heffernan, Group Manager – Service Finance)

- 4.4 This report informs the Board about the recent inspection – as such there are no financial implications arising directly out of this report. The Council and its partners are developing an action plan in response to the inspection. The financial implications of the plan will be assessed as part of its development. It is unlikely that there will be additional resources provided and so the actions will need to be funded from existing budgets through prioritisation.

### **Legal Implications** (completed by Lucinda Bell, Education Lawyer)

- 4.5 This report asks that members note and discuss the SEND inspection report and the current development of a multi-agency Local Area SEND Action Plan. No decision is required.
- 4.6 The legal context for this inspection are contained in the Care Quality Commission and Ofsted joint document “The Framework for inspecting local area in England under section 20 of the Children Act 2004” (the Act).
- 4.7 New duties on local areas regarding provision for children and young people with special educational needs and/or disabilities are imposed by the Act and amplified in regulations and in the statutory Special educational needs and disability code of practice: 0 to 25 years’. The duties came into force in September 2014.
- 4.8 Ofsted and CQC are required to carry out their inspection work in ways that encourage services they to improve, be user-focused and be efficient and effective in their use of resources. Inspectors will use their professional judgement to assess whether the overall evidence gathered causes them sufficient concern to recommend that a written statement of action be produced.

### **Patient/Service User Impact**

- 4.9 The effective response to the findings of the SEND inspection, detailed in Appendix A, will improve those services available to residents with special educational needs and disabilities.

### **Public Background Papers Used in the Preparation of the Report: None**

### **List of Appendices:**

**Appendix A:** Joint local area SEND inspection report

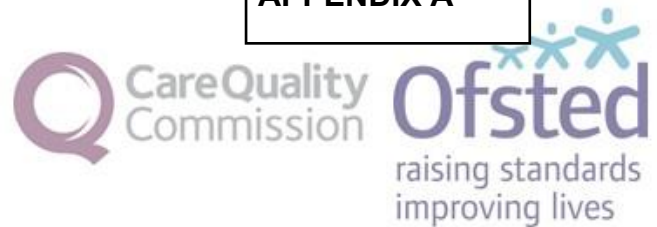
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**APPENDIX A**



21 June 2017

Mrs Anne Bristow  
Strategic Director, Service Development and Integration (Deputy Chief Executive)  
London Borough of Barking and Dagenham  
Town Hall  
1 Town Square  
Barking  
IG11 7LU

Mr Conor Burke, Barking and Dagenham Clinical Commissioning Group, Chief Officer  
Ms Joy Barter, Joint Local Area Nominated Officer  
Ms Vikki Rix, Joint Local Area Nominated Officer

Dear Mrs Bristow

### **Joint local area SEND inspection in Barking and Dagenham**

Between 27 March 2017 and 31 March 2017, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Barking and Dagenham to judge the effectiveness of the area in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014.

The inspection was led by one of Her Majesty's Inspectors from Ofsted, with a team of inspectors including an Ofsted Inspector and children's services inspectors from the Care Quality Commission.

Inspectors spoke with children and young people who have disabilities and/or special educational needs (SEND), parents and carers, and local authority and National Health Service (NHS) officers. They visited a range of providers and spoke to leaders, staff and governors about how they were implementing the special educational needs reforms. Inspectors looked at a range of information about the performance of the local area, including the local area's self-evaluation. Inspectors met with leaders from the local area for health, social care and education. They reviewed performance data and evidence about the local offer and joint commissioning.

This letter outlines our findings from the inspection, including some areas of strengths and areas for further improvement.

## Main findings

- All partners in the local area show a high level of commitment to implementing the reforms and to working together to best meet the needs of children, young people and their families. Where successful partnerships between education, health and social care are in place, they are making a positive difference to the timeliness and quality of provision to meet children's and young people's needs. These provide good models for the future developments needed.
- Governance is strong. Responsible elected members together with the Health and Wellbeing Board successfully hold leaders to account for improving outcomes in a local area which is rapidly changing. Leaders of healthcare services and the local authority understand the needs of the community and appropriate plans are in place to develop sufficient educational and healthcare provision through to 2020.
- A significant strength in implementing the reforms is the quality of collaboration between healthcare and local authority staff and personnel in settings, schools and colleges. Detailed analysis of information ensures that the local authority understands how well both pupils identified for special educational needs support and those eligible for education, health and care (EHC) plans are doing. These good-quality relationships are building capacity and developing the expertise necessary to meet children's and young people's needs.
- The local area involved parents at the initial stages of setting up the local offer. However, not enough parents know about or use it to find advice and help. Advocacy information and advice services (Barking and Dagenham Carers and Barnardo's) and 'Just Say', the parents' forum, provide much valued advice and support to families. The forum also works at a strategic level to influence how the reforms are implemented. Despite this, some parents do not have access to the information and support they need.
- Through the strong relationships established with providers both within the local area and where placements are made beyond it, leaders monitor the safety and well-being of children and young people. The regular review of the appropriateness of provision means that changes are made quickly when children and young people are considered to be at risk.
- Where the local area reviews specific aspects of provision, the views of young people and parents are effectively sought. For example, the Barking and Dagenham Youth Forum, which includes representatives who have special educational needs and/or disabilities, has presented to council members on the challenges of managing mental health issues. Parents have been specifically consulted on the improvement of short-break provision.

- Education, health and social care professionals have contributed to the local area self-evaluation. The findings of this inspection reflect the priority areas identified. Detailed targets and timescales are not incorporated into plans and there is a lack of clarity about how some aspects of services will be jointly commissioned. Consequently, it is difficult to know how well the local area is on track to achieve its aspirations for children, young people and their families.
- The capacity to provide therapies such as speech and language, occupational and physiotherapy is hindered by difficulties in recruiting and training staff who can deliver these services sufficiently to a population that has grown rapidly. Consequently, some EHC plans are delayed and some families spend too long waiting for the support they need. Healthcare funding has been allocated to the 2017/18 budget to recruit further staff to address these issues.
- EHC plans do not consistently benefit from appropriate input from health and social care. The detail of the support that a child needs and how this will be provided is, at times, insufficient. The level at which parents' and young people's views are taken into account is variable. Some parents and young people said that they did not feel fully engaged in, or informed about, the process.

### **The effectiveness of the local area in identifying children and young people's special educational needs and/or disabilities**

#### **Strengths**

- Processes for the identification of need are effective. They draw on parents' concerns and on school assessments which are moderated by the local authority. In the early years, healthcare and education draw on a range of information about children to identify when they have additional needs. Healthcare professionals recognise that further work is needed to improve take-up of the universal offer for assessments. When triggered, social care identification of need is effective and timely.
- Effective pathways are in place for the identification of needs as part of neonatal screening by midwifery services. Health visitors use nationally recognised tools to support identification of need during the assessment process, which is undertaken as part of the healthy child programme.
- The health visiting service offers families flexible ways of working to assist them in accessing the healthy child programme. For example, appointment times are offered outside standard daytime working hours to accommodate working families. Early notification of the one-year checks has also been introduced. These strategies have resulted in the increased uptake of the one-year checks and resulting early identification of need.

- The inclusion team provides detailed advice and training to all education providers regarding the identification of need. Identification is confidently made against the same benchmarks across the local area. The proportion of new EHC plans completed within the 20-week timeframe is well above the national average. Importantly, members of the EHC plan panel from education, health and social care are budget holders, so decision making is immediate and action is taken quickly.
- Additional scrutiny identifies any children and young people, either with SEND support or who have an EHC plan or statement, who require crisis support or who are at risk of exclusion. The placement panel, which meets fortnightly, effectively considers those who are at risk and, where necessary, makes rapid decisions about resources and provision to enable them to continue learning with the right support.
- Transition between different phases of education is well supported. Local area staff work closely with settings, schools and colleges to ensure that the handover of information is managed carefully. Special educational needs coordinators from a receiving school meet face to face with colleagues and children at review meetings. This ensures that they understand a child's or young person's needs and make appropriate provision ready for them to start the next stage of their education journey.
- Children looked after are offered fast tracking to healthcare appointments. The timeframe from initial referral to commencement of treatment is currently no more than four weeks. This includes specialist child and adolescent mental health services (CAMHS) intervention for children and young people placed out of the area.
- An identified practitioner works with children missing from education and those who are educated at home. The role allows for home visits to be undertaken to develop health care plans for children educated outside the school setting. Assessments undertaken are shared with the GP and the local authority. This process supports the identification of children and young people who are not at school and who have special educational needs and/or disabilities.
- Through the local area's responses to the reforms and increasingly collaborative working, the identification of need is more effective. While there is still more to be done, particularly to support older pupils in schools, the number of appeals resulting from dissatisfaction with assessments or plans has reduced year on year. It is well below the national average.

## Areas for development

- The speed of transition from statements to EHC plans has been below the national rate. Although this is now accelerating and the quality of identification of needs within the plans is improving, some children and young people still have to wait too long for their plans. Parents said the 'tell it once' principle of the SEND reforms is not well implemented in some instances. Some feel that they have to share their story too many times to get the help and advice they need.
- Except for the most vulnerable pupils, where identification is effective, social care needs are not regularly recognised or addressed in plans. This means that some children and young people and their families do not always receive the level of help and support they need.
- Healthcare professionals do not routinely review how their assessments are addressed in plans. This means that in some cases, the right actions and support are not in place. The lack of availability of therapist advice due to limited capacity means that some children's and young people's needs are not identified in a timely way. This leads to a delay in the provision of support and is a source of frustration to parents.
- Parents are unaware of personal budgets. They said that they do not have enough support to help them understand what they are for and how they can use them. In order to support parents in understanding some ways they can use the additional funding available to them, the local area is providing an online offer. Through this, parents are given a budget to purchase activities and resources for their children.
- There is a downward trend in meeting the 20-day initial health assessment targets. Where reasons are given for this, they relate to a lack of paediatrician availability and parents not attending appointments. The clinical commissioning group (CCG) and healthcare trust have identified these delays as unacceptable.
- Children who have sensory disorders receive no funding to access occupational therapy specialist services. This prevents them from making the progress they are capable of unless individual providers or parents purchase this expertise themselves.
- The health visiting service is not meeting targets for undertaking mandatory assessments at 12 months and at two years. This limits the ability to identify and assess children's needs, including of the most vulnerable groups.

## **The effectiveness of the local area in meeting the needs of children and young people with special educational needs and/or disabilities**

### **Strengths**

- The local area has an in-depth understanding of the quality of provision for children and young people who have special educational needs and/or disabilities. Future needs are analysed and plans to meet these are in place. The local area's vision for inclusion is lived through the investment it is making into new provision in partnership with providers, for example, with the new all-through and special school and the planned development of respite provision for children and young people with social, emotional and mental health needs at a primary school.
- The wide range of portage services is targeted effectively at supporting families with young children who have identified additional needs. Services are enhanced well where health visitors refer families to the service and work in partnership to secure children's well-being.
- In collaboration with parents, young people and professionals, leaders have implemented a 'preparing for adulthood' pathway which identifies the support and options available to young people between the ages of 14 and 25. This is helping to raise expectations for young people who have special educational needs and/or disabilities to achieve success and live fulfilling lives as valued members of their local community.
- The partnership with providers is very strong. Settings, schools and additional resource providers benefit from the local area's quality assurance processes. These maintain and improve the quality of provision, including compliance and safeguarding practice and procedures. The inclusion team works regularly with schools to analyse how well the needs of children and young people who have special educational needs and/or disabilities are met. Providers say that the local area responds rapidly with advice and resources when they raise concerns.
- The local area's comprehensive training offer, professional networks and conferences mean that education staff skills are continually updated. The impact of collaboration between staff in schools, and particularly the leaders in additionally resourced provisions, is considerable. Pupils' needs are met well and behaviour is managed effectively.

- An overwhelming strength of the provision for children and young people who have special educational needs is the quality and extent of additionally resourced provision. An increasing number of schools and colleges have additional specialist provision on site. The local area carefully monitors these providers and supports leaders and staff to share their expertise. Educational psychology support to them is well resourced. Children's and young people's views are taken into account and they benefit from good teaching and the increased understanding of their needs that these placements provide. Outreach provided by the provisions, for example, Hunter's Hall support for speech, language and communication, develops staff knowledge and understanding of particular needs across the local area, as well as supporting practitioners to improve their practice.
- The expertise within the area's special school also plays an important role in securing the quality of provision in the local area. It is used to develop provision through on-site and outreach staff training and through their engagement in the establishment and development of additional specialist provision. Links with the Riverside Bridge project are enhancing the capacity to meet the needs of children and young people with high-level needs.
- The information and advice services commissioned by the local area, Barking and Dagenham Carers and Barnardo's, provide effective independent guidance and support for parents when they need it. Parents value the help it gives them, particularly to deal with the challenges they face in understanding and managing their children's needs.
- 'Just Say', the parents' forum, is also valued by both parents and professionals. The forum's work with the local authority to develop policies that take account of parents' views and needs is effective, as are the face-to-face events and training opportunities they provide both centrally and at individual settings and providers.
- Where healthcare practitioners are fully engaged in education, health and care planning, their work is effective in enabling children and young people to achieve positive outcomes. For example, in one EHC plan, speech and language input provided clear support strategies which reflected the child's voice.
- Health visitors are trained in perinatal and infant mental health. The increased knowledge and skills gained from this training supports families who may be coping with the emotional impact of a diagnosis of increased need and vulnerability for their child.
- The Heathway Centre acts as a 'one-stop shop', providing support to families with children aged 0 to 18 years across the local area. The centre currently supports in excess of 1,700 families with children who have additional needs. When capacity allows, both speech, language and communication and occupational therapists provide advice as part of the core offer. An offer of 'plain communication' has also been developed to help improve children's communication skills before an assessment takes place.

- Learning disability provision based at Queen's Hospital is developing and strengthening transition processes for young people moving to adult services. Where young people have complex needs, planning starts early, sometimes when young people are as young as 12. Young people's and families' fears about transition are better addressed as a result.

### **Areas for development**

- The extent to which parents' views are taken into account when plans are made to meet their child's needs, and professionals from education, health and care work together, is variable and in some instances underdeveloped. Parents who face barriers to communicating easily with professionals and some who require access to a range of services do not receive the level of support they need.
- The quality of EHC plans is inconsistent. The processes put in place to secure a plan are effective, but contributions from professionals to create well-focused targets and to identify specialist help vary too much. This is sometimes because insufficient detail from specialist reports is included in the plans. As a result, there is a risk that children and young people do not receive the level of specialist support they need to enable them to do as well as they can.
- The level of knowledge and understanding of the SEND reforms is variable across healthcare practitioners. This means that their ability to support parents through established processes can be limited.
- Too few families are seen during the antenatal period by health visitors. This is a culmination of the lack of practitioner capacity and gaps in the administrative processes between organisations. The current position means that there is a risk that early identification of need might be missed and access to support is less timely.
- Post-diagnostic support on the autistic spectrum disorders pathway is not equitable. Access to support relies on a local charity to which parents make a financial contribution in order to gain access to help. This potentially limits the availability of support to the most vulnerable groups of children.



## **The effectiveness of the local area in improving outcomes for children and young people who have special educational needs and/or disabilities**

### **Strengths**

- The local area has set a clear aspiration for all providers to be judged by Ofsted to be good or better and for educational standards, including those of children and young people who have special educational needs and/or disabilities, to exceed those achieved across London. This is above the standards achieved nationally. Through a time of significant population change and growth, the proportion of good and better providers and the standards achieved by children and young people who have special educational needs and/or disabilities have improved.
- At the end of the early years, the effective work of agencies and settings means that the proportion of children identified as requiring SEND support and with an EHC plan reaching a good level of development has risen year on year. Parents receive effective support and advice at this early stage through the specialist providers and children's centres. The local area identifies and resources appropriate school placements and transition to these is managed carefully.
- The inclusion team analyses how well all pupils who have special educational needs and/or disabilities are achieving. Children's and young people's progress in reading, writing and mathematics is carefully tracked through school. While significant gaps between pupils' attainment and that of other pupils nationally remain, collated evidence shows that across the area, the majority of pupils are making good progress from their starting points.
- New initiatives are in place, for example, the location of health and well-being hubs in schools, the appointment of family liaison officers and training for staff in emotional well-being. These are supporting improvements in addressing children's and young people's social and emotional health and enabling them to remain in school and access learning.
- While a very small number of young people who have special educational needs and/or disabilities attain five A\*–C grades at GCSE, there has been a sharp increase in the proportion of pupils achieving five GCSEs at A\*–G.
- Almost all pupils identified as receiving SEND support move on to, and remain in, an education destination. The proportion of young people achieving a level 2 or level 3 qualification is increasing. This means that more young people are becoming suitably qualified to seek paid employment.
- Fixed-term exclusion rates, for children and young people identified as receiving SEND support, and those who have an EHC plan, are well below the national rates. Attendance rates have improved to be in line with national averages.

- The local area is working to improve how well it achieves local provision for local children and young people. Historically, placements have been made out of the area because there has been insufficient specialist support. In the last three years, the proportion of children and young people placed out of the local area has reduced by half because the provision and quality of specialist support have improved.
- The proportion of young adults in settled accommodation is well above the national average. This is because education, health and social care partners work very effectively to ensure that needs are met and appropriate provision to support young adults' transition to independence is made.
- The learning disability provision for children in the Queen's Hospital is recognised by families as a positive force in ensuring that their children have equal access to the services they need. Visual and written communication aids have been developed to help provide care to children living with autistic spectrum disorder. This promotes trust and improved communication between practitioners and patients. GP surgeries have been asked by the CCG to prioritise seeing children who have special educational needs and/or disabilities attending practices for clinical appointments. This is an example of an improvement initiated by parental feedback through the parents' forum.

### **Areas for development**

- Education, health and social care partners are not clear enough about the long-term intended outcomes of their work. The lack of shared targets means that it is difficult for all participants in delivering the reforms to be sure that they are sufficiently improving children's and young people's life chances and well-being.
- While some young people access a range of wider opportunities, which helps their social development, for example through the 'Ab Phab' youth club and 'The Vibe' youth centre, not enough parents and young people know about the range of opportunities available to them through the local offer.
- The proportion of young adults who have learning disabilities in training and employment is low. The local area has identified this and is taking the initiative by leading a project to support employers to understand how they can provide paid employment opportunities for young people. A strong feature of this work is the partnership with Barking and Dagenham College, which is starting to support young people to find employment.

Yours sincerely

Prue Rayner  
**Senior Her Majesty's Inspector**

<b>Ofsted</b>	<b>Care Quality Commission</b>
Mike Sheridan Regional Director	Ursula Gallagher Deputy Chief Inspector, Primary Medical Services, Children Health and Justice
Prue Rayner Senior HMI Lead Inspector	Elizabeth Fox CQC Inspector
Keith Tysoe Ofsted Inspector	

Cc: DfE Department for Education  
 Clinical commissioning group(s)  
 Director of Public Health for the local area  
 Department of Health  
 NHS England

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## HEALTH AND WELLBEING BOARD

5 July 2017

<b>Title:</b>	<b>Future Integrated Arrangements for the Delivery of Mental Health Social Work in Barking &amp; Dagenham</b>	
<b>Report of the Strategic Director for Service Development and Integration</b>		
<b>Open Report</b>	<b>For Information</b>	
<b>Wards Affected:</b> None	<b>Key Decision:</b> No	
<b>Report Author:</b> Mark Tyson, Commissioning Director, Adults' Care & Support	<b>Contact Details:</b> Tel. 020 8227 2875 Email: mark.tyson@lbbd.gov.uk	
<b>Sponsor:</b> Cllr Maureen Worby, Cabinet Member, Social Care and Health Integration, LBBD		
<b>Summary</b>		
<p>Alongside its wider transformation plans for care and support, the London Borough of Barking &amp; Dagenham commissioned a review of its Mental Health Social Care Services. This followed correspondence from the Chief Social Worker for Adults, Lyn Romeo, seeking assurances from statutory Directors of Adult Social Services that the appropriate statutory duties around adult mental health services were being satisfactorily discharged. The review report was completed in February 2017 and was received by the Deputy Chief Executive in March 2017.</p> <p>The Report recognised a number of areas of good practice in place in Barking and Dagenham's mental health services. However, alongside this, it raised some immediate concerns around compliance with safeguarding procedures, the stability of the workforce (the AMHP Service in particular), and some limitations with the Care Act compliance of the service. In overall summary, it was indicated that the distinctive value of social work did not have the opportunity to have the impact that it might within the current integrated arrangements for delivery of mental health services overall. This becomes particularly relevant, considering the changing ways in which the NHS and local authority deliver and commission mental health and related support.</p> <p>It was also recognised that the way in which the Council and its health partners approached integrated services had changed, with a more comprehensive locality-based approach is being developed under the BHR Integrated Care Partnership. Alongside this, the Council has initiated its new Community Solutions service for initial access to social care services alongside welfare, employment and housing advice. Finally, work is underway to rethink the future of employment and vocational support for this service user group. It was recognised that this was an opportunity to re-evaluate the place of mental health social care services in this new landscape.</p> <p>In her role as statutory Director of Adult Social Services, therefore, the Deputy Chief Executive took the decision to reinstate a direct management relationship with Mental Health Social Care Services. A temporary six-month extension to the Section 75</p>		

arrangement with NELFT is being negotiated to maintain the service for the delivery of the integrated service. With a date effective from 1 October 2017, a refocussed Mental Health Social Care Service will be in place, continuing to deliver under Council management, and within a strong partnership with NELFT.

This report provides a summary of the Review, the process being undertaken to establish the new service arrangements, and progress on first joint steps.

### **Recommendation(s)**

The Health and Wellbeing Board is recommended to:

- (i) Note the contents of this paper, the direction of travel and the rationale for the decisions taken;
- (ii) Propose any issues or steps that the relevant managers should consider when designing and implementing the new service model.

### **Reason(s)**

It is the statutory Director's role to ensure that resources are in place to deliver on the Council's statutory duties under the Care Act, the Mental Health Act, and other related legislation. Following concerns about the robustness of compliance with some of this legislation, the decision has been taken to reinstate a Council management line for this service. This presents opportunities to rethink the role of mental health social work, given recent developments in the partnership delivery of health and social care services. This report is an opportunity for Board members to indicate areas that they would like to see brought into scope, for consideration by the officers implementing the review.

The Council has set a vision of 'no-one left behind' as it sets out ambitious plans to grow the borough. Improving mental health social care outcomes, and promoting more open access to early intervention and prevention for mental health support, are key to ensuring that those with mental health problems are not excluded from the Borough's future growth.

## **1. Introduction and background**

- 1.1 The Review of the Mental Health Social Care offer in Barking and Dagenham was undertaken between October 2016 and January 2017, in order to support management in understanding the processes and quality of current services, with a particular focus on Social Care outcomes and how these are met through integrated multi-disciplinary teamwork, as well as through wider commissioning arrangements.
- 1.2 The Review Report was an options paper specifically written for the Council's adult social care management, detailing strengths and weaknesses of the current arrangements of the service. It was recognised that there are some areas of good practice in Barking and Dagenham. However, it also raised a number of areas that needed improvement, particularly in relation to meeting the Local Authority's statutory duties under the Mental Health Act 1983 (as amended 2007) and the

Care Act 2014. Concerns around compliance with Safeguarding processes were also cited. The report also highlighted need for a greater focus on social care outcomes, supported by a strong and stable workforce.

- 1.3 As a result of the report, the decision was made by the Council to end the integrate management arrangements governed by the Section 75 agreement and reinstate Council management of the service. As from 1 October 2017 the Social Work staff will be directly managed by the Council, with a new Head of Mental Health reporting to the Operational Director, Adults' Care & Support. This date provides a convenient point in time to align these new arrangements with the development of Community Solutions and a number of the other Council transformation developments, ensuring that the staff return to the Council and feel quickly part of the development of the new Council working arrangements.
- 1.4 This has required a considerable amount of planning work in a short space of time, which is currently underway. All parties – the Council, NELFT and the Clinical Commissioning Group as the commissioners of mental health clinical services – have asked that a joint risk assessment be drawn up in order to identify and manage the risks; this has been worked up in first draft by the Section 75 partners, and continues to develop.
- 1.5 Preliminary work has also commenced with regard to the development of a Joint Operational Policy between the Council and NELFT to govern the delivery of the service under the new arrangements.
- 1.6 A project team has been established to oversee the safe transition and to ensure close work between all partners to bring the new Mental Health Social Work Service into being.

## **2. Findings of the review of the Mental Health Social Care**

- 2.1 The headline findings of the Review included the observation that in many areas Barking and Dagenham already has a version of what good looks like in mental health services. There is evidence of many areas of good practice, local initiative and strengths across Adult Mental Health Services. The challenge is to make this sustainable with clear care pathways that reflect the priorities and direction of travel for the Local Authority and keep pace with rising demand and complexity.
- 2.2 Social Care outcomes are not as clearly articulated as Health Care outcomes in the current integrated arrangements. These Social Care outcomes are not addressed as a priority in the current arrangements and a shortfall in the delivery of the Local Authority Statutory functions is dealt with reactively.
- 2.3 During the course of the Review identified concerns around safeguarding and AMHP provision and staffing had to be immediately addressed. The AMHP Service had been on the Trust risk register for several years and also went onto the Council's Corporate Risk Register.
- 2.4 To address these issues the following recommendations were made:

## **Overall strategy**

- Implementation and development of the Joint Mental Health Strategy through effective channels and Senior Commissioning leadership.
- Stronger Council direct working relationship with users and carers of Mental Health Services and the voluntary sector to make progress on co-production and peer support and support a richer Voluntary Sector.
- A Strategy in place for addressing the mental health needs of the BME communities in Barking and Dagenham.
- An Implementation Delivery Plan to be drawn up that provides a framework for taking forward recommendations that are accepted by Senior Officers at LBBB from this Review.

## **Approved Mental Health Professional (AMHP)**

- Ensure that the Local Authority's statutory duties under the Mental Health 1983 (as amended 2007) and the Care Act 2014 are fully and effectively discharged and that the organisation and delivery of the AMHP Service is strengthened.

## **Role and function of social work in mental health services, and greater preventive intervention**

- Ensure that there is a stable critical mass of staff with sufficient experience and leadership and managerial input from LBBB within Mental Health Social Care. Further ensure that recruitment, retention and forward planning are given strategic consideration and embedded in operational practice.
- Mental Health Social Work identity, culture and practice to be reclaimed, rather than the Social Work staff undertaking the generic role of Care Management or the CPA role of Care Coordinator, as has been historically established in national care models, but not updated since the introduction of the Care Act.
- Agreement on reform of integration across statutory mental health services, to bring Social Work nearer to the front of the system and at the interface between primary and secondary care. This in part will require a clear pathway for Mental Health Social Care including involvement with Community Solutions and working to the 3 localities.
- Consideration of the Older Persons Mental Health Team being absorbed into the three Integrated Care locality teams.
- Focus on supporting people living with long-term conditions in the community.
- Further application of Enablement and Personalisation for improved prevention and recovery and promoting choice and control.
- Strong focus on prevention and earlier access to help for children and young people and protecting what is already working well for key vulnerable groups.

## **Safeguarding practice**

- Provide assurance that all Safeguarding referrals are properly dealt with and recorded. Continue the audit on the Safeguarding function.



### **3. Developing a new model of mental health social care delivery**

- 3.1 On 31 March 2017, the previously agreed Section 75 agreement lapsed, which had been authorised for signature by the Health & Wellbeing Board on 26 January 2016. The commissioning of the review was in response to the approaching endpoint of this agreement. In the absence of other decisions, therefore, the default position would have been to end the secondment of Council staff and return to Council management of the service.
- 3.2 However, in making the decision to restore Council management of mental health services, it was recognised that any such process needed to be managed carefully; therefore in confirming the end of the agreement a six-month extension to 30 September 2017 was proposed to allow the necessary planning work. The statutory Director of Adult Social Services is responsible for ensuring the Council's delivery against the statutory duties of the Care Act 2014 and the Mental Health Act 1983 (as amended), and having not been satisfied as to the level of compliance with that legislation, took the decision to reinstitute Council management in line with her delegation under Part 3, Chapter 1, Section 5.1(i) of the Council Constitution.

#### **Developing a model**

- 3.3 As from the 1 October 2017 the Social Care staff will be managed directly by the Council, with the emphasis on practising as social workers rather than focusing on the care coordinator role under the Care Programme Approach. There will be a need to address the current range and level of staffing and management.
- 3.4 A model is being developed to transform Mental Health Social Care. This will include a number of key elements, including:
- an Enablement function in keeping people out of hospital and supporting their successful discharge;
  - an Assessment function will be established with Community Solutions and working closely with the Trust's Access and Assessment Team;
  - an enhanced AMHP Service will be established; and
  - a Long Term Care Team will focus on support for those people in supported living and similar placements to support review and move-on.
- 3.5 In order to have this transition managed safely, a number of policies and procedures need to be in place including:
- an Implementation Plan has been drawn up in outline, to take the service through to the date of new management arrangements of 1 October 2017;
  - a longer-term Project Plan will include, and then pick up from the initial implementation plan, and establish a longer-term transformational journey for the service;
  - a Joint Operational Policy, or set of policies, will be developed together with NELFT and cover the ways in which the new service will deliver integrated care for service users and enhanced outcomes and the practicalities of how the new arrangements will work day-to-day;
  - the Joint Operational Policy will need to fit closely with a set of more detailed shared pathways, eligibility criteria (more closely fitted to the Care

Act vision of prevention, assessment and provision), and caseload management, which will deal with the different responsibilities of the partners in place of a more generic approach to care management across disciplines;

- these products, the implementation plan in particular, will be informed by a Joint Risk Assessment, which will be a joint product of NELFT and the Council, and to which the CCG has been invited to contribute, with the intention of ensuring that system risks are managed jointly across partners;
- a new Service Specific Information Sharing Agreement may need to pick up from the current draft in the Section 75 to reflect the new organisational arrangements;
- the structure will need to be described in a new set of organisational charts, which can then evolve as the service adapts to meet a longer-term vision;
- a Communications plan will support the initial transition of the service, with a deeper engagement plan then picking up the shaping and development of the longer-term vision for the service.

3.6 These need to be worked through systematically and cooperatively with our health partners and other stakeholders including users. The focus of user consultation will be on the longer-term vision, once the initial restabilisation of the service under Council management has been achieved. Together with the implementation of the new mental health strategy, the early establishment of Community Solutions, and the new proposals for vocational and peer support being pursued by both the Council and the CCG, there will be a rich opportunity to discuss with service users how the mental health system evolves to support them and others in the future.

3.7 Immediate work will take place to strengthen the management and leadership and development of the workforce, resolve IT issues, enhance the AMHP Service and have assurance around safeguarding and address duties under the Care Act and give some focus to improving Social Care outcomes.

3.8 Whilst the longer-term vision is to ensure that the localities are the base for delivery of these services, and that integrated working with NELFT is maintained, it will be necessary in the immediate weeks after the transition to emphasise the new local authority base that will be provided for staff. Whilst staff will have the flexibility to work alongside health colleagues, and this will be very much supported by the Council's core policies on flexible working arrangements, they will increasingly be encouraged to see their physical 'home' alongside other social care teams. Both partners to the change have committed to proactive management of the risk that this arrangement leads to poorer communication, silo-working and increased risk to complex service users. The assessment of the risk, and mitigations, is the subject of active dialogue between both provider organisations.

3.9 There will be a strong social care training and workforce development package in place for the social care staff, together with initial orientation into the 'new' Council and its working processes.

#### **4. Progress to date, scoping and managing risks**

4.1 Weekly meetings with NELFT are being established to work closely in partnership for current and future operational delivery, comprising the Mental Health

Transformation Lead for the Council and Assistant Integrated Care Director for NELFT, and other colleagues as required.

#### 4.2 In summary:

- Steering group meetings are being scheduled;
- Local authority task and finish meetings are scheduled;
- Development of a Joint Operational Policy between the Health and Social Care Partners has started;
- Development of a joint risk register has started and is subject to ongoing review;
- Actions to address areas of safeguarding and the support and structure of the AMHP service are being worked on;
- The AMHP incentive scheme is being taken forward;
- A staff development programme is being developed;
- Staff HR and IT issues are being jointly resolved.

#### 4.3 For the Board's information, the risks identified for mitigation thus far through the transition process are included in headline form below. These are a mixture of risks in the current arrangements that the transition will seek to resolve, risks of the transition process itself, and risks that may be increased, and therefore need to be mitigated, in any new twin-management arrangement.

##### **Accommodation**

An early decision as to the location of the social care staff is required to enable either co-location/suitable office accommodation to be provided on an ongoing basis post S75 disaggregation.

##### **Service user care management during transition**

The maintenance of partnership working between health and social care to ensure that service users, especially the most vulnerable, do not fall between gaps. Both organisations have plans in development to ensure that this is managed effectively.

##### **Information systems**

The need to ensure all LBBB Mental Health Social Care Staff have the equipment to ensure access to both Trust and LBBB information systems to resolve existing data collation and reporting issues within LBBB.

##### **Approved Mental Health Professional Service**

Replacement arrangements fail to provide sufficiency of AMHPs to deliver statutory functions as required under Mental Health Act.

##### **Lack of joint planning of service provision**

Avoiding a situation where unilateral service planning results in gaps in services that present risks to service users, carers and the community.

##### **Service changes lead to extended waiting lists/unsustainable workloads in care coordination**

The disaggregation of health and social care staff will require a joint workforce plan. NELFT currently has 19 social care staff working as care coordinators. Re

designating social care staff will impact on the delivery of care coordination and risk management.

### **Compliance with Care Act and other mental health and social care requirements**

The Council remains non-compliant in relation to the Care Act requirements and social care service provision and key deliverables

### **Agreement between partners**

Agreement to S75 disaggregation project plan and actions/timescale.

### **HR information**

Managing the transition of HR data of staff (leave, sickness, appraisal) to the Council's Oracle system effectively.

### **Reliance on locum social workers**

The social care service is currently highly dependent on temporary and expensive locum staffing to deliver the service, which will need managing through the transition process, and long-term resolution.

### **Staff and Management Morale**

Risk of repatriation to LA premises depleting morale of staff and managers, which could exacerbate staff shortages and poor recruitment and retention, for both parties.

## **5. Consultation**

### **Staff consultation**

- 5.1 Consultation has happened with staff on several occasions. Concerns and issues arising are being facilitated through the Communications Plan. Staff will continue to be engaged in shaping the issues to be addressed, in problem-solving and in developing solutions to the issues and risk mitigations identified.

### **Service users and carers**

- 5.2 A Steering Group has been set up and various stakeholder events are being planned including consultation with users and carers. Consultation with users needs to reflect the wider offer and stakeholders who may not have been engaged previously.
- 5.3 However, it is important to note that the stabilisation of the service is proceeding at pace, and the focus of service user and carer consultation and engagement will be on the longer term from 1 October 2017 onwards, when a stable management framework has been established for the new service.

### **Partners, including commissioning partners**

- 5.4 The Clinical Commissioning Group was given informal notice of the development shortly before the final decision was communicated to NELFT. They were formally notified at the same time as the formal correspondence to NELFT. In both instances, and then throughout, they have been invited to consider issues from

their perspective to feed into implementation planning. They continue to be part of the planning group to inform the transition.

- 5.5 The Council has agreed with the CCG to undertake a commissioning-specific review of the long-term direction of the joint service shortly, in order to identify wider system impacts and opportunities. This will be a development of the already on-going discussion between the CCG and the Council on mental health commissioning. In more general terms, a formal review point is proposed take place after 3 months and 6 months with partners following the establishing of the transformed service, and these conversations will again be informed by user and carer input.

## **6. Mandatory implications**

### **Joint Strategic Needs Assessment**

- 6.1 Barking and Dagenham has a population of almost 206,000 which is comparatively young, mobile and ethnically diverse. The population has grown 13.4% since 2001 and is expected to rise to 275,000 by 2037. Barking and Dagenham is densely populated and also has a deprived population in relation to other London Boroughs and English authorities. It is a disadvantaged population with poor outcomes. In the 2015 Indices of Multi Deprivation, LB Barking and Dagenham is the 9th most deprived Borough nationally and the 2nd most deprived Borough in London.
- 6.2 The population of Barking and Dagenham is diverse. Since 2001 the proportion of the population from a minority ethnic background has increased from 15% to 50%. This is predicted to increase to 62% over the next 25 years.
- 6.3 The population is young. There is the highest proportion of under 16's of anywhere in the UK (54,912). 10% of the population is aged 0-4 and that is a 50% increase since 2001.
- 6.4 The Strategy and Programme Team (LBBD) has just undertaken a Borough Equality and Diversity Strategy. The Strategy is aligned to the wider ambitions of the Local Authority.
- 6.5 In 2014/15 according to the JSNA, between 1097 and 1542 Adult Barking and Dagenham residents who were registered with GPs were on the severe mental illness (SMI) register. This is considered to be an underestimate and the Borough sees high levels of severe and enduring mental illness. Numbers in contact with Mental Health Services appears relatively low compared to other Boroughs.

### **Health and Wellbeing Strategy**

- 6.6 This Health and Wellbeing Strategy supports the following priorities in the Joint Health & Wellbeing Strategy:
- Increase the life expectancy of people living in Barking and Dagenham.
  - Close the gap between the life expectancy in Barking and Dagenham with the London average.
  - Improve Health and Social Care outcomes through integrated service.

6.7 In addition, there is a more detailed Mental Health Strategy that sets out how the partnership will meet the relevant aims of the Health & Wellbeing Strategy.

### **Barking and Dagenham Mental Health Strategy 2016 - 2018**

6.8 The Mental Health Strategy supports and aligns with the Council vision of 'One Borough; one Community; London's growth opportunity'. There are 3 corporate priorities: Encouraging Civic Pride; Enabling Social Responsibility; Growing the Borough. It provides a specific Barking and Dagenham perspective on the wider planning processes that are underway across North East London, as part of the development of the Sustainability and Transformation Plan for the area.

6.9 The vision for the Mental Health Strategy 2016 – 2018 is for people to be active citizens, to live a meaningful life and make positive contributions to the community that they are part of. Services and support must focus on promoting wellbeing and enabling people who have experienced a mental health problem to be independent, with more people choosing the support they want and a greater range of services to choose from; to support people to achieve their aspirations such as returning to work, living well in suitable accommodation and keeping active.

6.10 The Strategy is predominately focused on adults, but highlights the significance of promoting and protecting the emotional health and wellbeing of children and young people to prevent mental health problems in adulthood. Actions to do this are being taken forward through the Barking and Dagenham Children and Young People's Mental Health Transformation Plan, which includes consideration of improved transitions to adult services.

6.11 The Barking and Dagenham Mental Health Strategy promotes Community Solutions, which will be an early resolution and problem-solving service to help residents to become more self-sufficient and resilient. It is intended that Community Solutions will tackle the multiple needs of households in a joined-up way and at an early stage. It will comprise multi-disciplinary and multiagency teams that will collaborate closely with partners in the voluntary and statutory sectors to deliver early intervention and preventative support based in 3 localities.

6.12 The key theme of prevention runs throughout the Mental Health Strategy and the Borough's Prevention Approach is an inherent aspect of LBBD overall future ambition. The growing prevention agenda promotes the development of a more resilient community, where individuals are empowered and supported to take positive steps towards managing their own wellbeing.

6.13 The four priorities are:

- Priority 1: Preventing ill-health and promoting wellbeing;
- Priority 2: Housing and living well;
- Priority 3: Working well and accessing meaningful activities;
- Priority 4: Developing a new model of social support.

6.14 This fourth priority provides a focus on more creative, innovative ways to co-produce a new system of mental health care and support, including maximising

the benefits of creating a digital front door to advice and support. The role of Social Work and Social Care in this new model needs to be developed, to allow the particular skills and unique contribution of Social Workers to be used to their full benefit in creating a sustainable and responsive approach in the Borough.

- 6.15 The proposed next steps for the Mental Health Strategy 2016 - 2018 are as follows:
- Deliver upon the action plan, monitored and supported through the Mental Health Subgroup.
  - Establish and enhance links with other strategies to support the principle of parity of esteem for mental health.
  - Continue to develop the Mental Health Strategy 2016 - 2018 to align with and support the implementation of the Growth Commission and Ambition 2020 along with the NHS Five Year Forward View for Mental Health.
  - Completion of a suicide audit and the development of a local suicide prevention plan in line with Public Health England's on-going programme of work to support the government's suicide prevention strategy. The local plan will link with the Mental Health Strategy 2016 – 2018.
- 6.16 Integrated commissioning and provision within Barking and Dagenham and across the wider Health and Social Care system is at the heart of the Mental Health Strategy 2016 – 2018. The Strategy further confirms integration priorities that have been identified as part of the BHR system wide approach to Mental Health and developed through the work on devolution. It also reflects the mental health priorities identified as priorities within the work to develop the North East London Sustainability and Transformation Plan. These priorities have been developed to reflect the national Five Year Forward View for Mental Health, ensuring that there is a link through from nationally identified priorities through to borough and locality level delivery. The development of the Strategy has been supported through the Mental Health Subgroup of the Health and Wellbeing Board whose membership consists of a wide range of partner organisations from across the local Health and Social Care economy including Service Users representatives.
- 6.17 The content of the Better Care Fund revised plans for 2016/7 for the Borough takes into account the development of revised locality delivery networks based on population needs, which is at the heart of the transformation programmes. One of the work streams from the BCF Plan is to clarify the locality model based vision of the Mental Health Strategy and utilisation. Re-tendering is taking place for services to support people into employment and education in order to build resilience and wellbeing.

### **Integration**

- 6.18 The Chief Social Worker for Adults met with the Senior Managers and Adult Social Work staff at LBBDD in December 2016. She gave clear unequivocal messages. She promoted Social Workers as lead Professionals in ensuring personalised and integrated care and support for individuals, families and their communities. She

stressed the importance and discussed ways at looking at the recruitment and retention of staff and the need for leadership.

- 6.19 The duties under the Care Act were reiterated around assessment, eligibility, application of legislation, care planning etc. It was a positive visit, enabling reflection and dialogue around practice and providing context for the operation of the profession. Themes developed in recent Department of Health, the former Social Work College and Parliamentary Working Group Mental Health Guidance etc. (see References) were further articulated by the Chief Social Worker around the necessity to have strong Social Work identity and professional practice.
- 6.20 At face value, the ending of the Section 75 agreement integrated working between health and social care in Barking and Dagenham seems retrograde. However given the risks and shortcomings identified and the necessity of meeting statutory duties under the Care Act etc. there was a fundamental need to get back-to-basics and re-establish a strong social care offer with strong social care outcomes and transform to provide a more universal delivery.
- 6.21 However, the Council is firm in its intent to ensure that a strong partnership is maintained going forward. The landscape for the management of integrated activity has changed substantially in recent years. Through 2016 Barking & Dagenham, Havering and Redbridge set out to shape a proposal for an Accountable Care Organisation to take on all of health and social care activity. That case not being proven to partners' satisfaction at this point, increasingly the focus is on an alternative 'Accountable Care System', with deepened provider collaboration and outcomes-based contracts and incentives to drive joint activity across the system. This is a reduced focus on organisational integration, but sets a vision which is no less ambitious for joining up services across multiple organisations. For mental health, we want to re-establish the unique strength of mental health social work, but would nonetheless see it playing more strongly into these new joint working opportunities.

**Financial Implications** (completed by Katherine Heffernan, Group Finance Manager)

- 6.22 The impact of the review of the Mental Health Services has resulted in a requirement to invest in the service and ensure that the service is compliant in meeting its statutory duties under the Mental Health Act 1983 and the Care Act 2014.
- 6.23 The investment would include funding the project team established to oversee the transition, creating a new Head of Mental Health, additional staffing costs arising from the redesign of the new service, training and developing staff and various IT related costs. At present, these costs are being collated and the full cost is yet to be confirmed but is likely to be significant.
- 6.24 Based on the re-design required, these costs cannot currently be contained within the MH service's existing budget. Additional funding would be required to fund this investment from within other Social Care resources. It is assumed that a proposal would be put forward to utilise an element of the £4.385m additional social care funding allocated to the Council in the spring budget 2017 announcement, via the



integration and Better Care fund (BCF). Proposals for the use of this additional funding are also yet to be agreed.

- 6.25 This additional funding is not permanent and will be phased out over time. However it will be largely replaced by the Improved Better Care Fund and/or the ASC precept. Planning for future years' expenditure will need to include sufficient provision for the permanent increase in costs of the new MH service.

**Legal Implications** (completed by Dr Paul Feild, Senior Corporate Governance Lawyer, LBBD)

- 6.26 The Health and Social Care Act (2012) conferred the responsibility for health improvement to local authorities. In addition as a best value authority under the Local Government Act 1999 there is a duty on the Council to secure continuous improvement. The evidence cited in this report supports the view that there is a need for change in working between providers and practice to ensure the statutory responsibilities for mental health are the best they can reasonably be. The Health and Well-Being Board terms of reference establish its function to ensure that the providers of health and social care services work in their delivery in an integrated matter. These strategy proposals are in keeping with this committee's function.

### **Safeguarding**

- 6.27 A number of safeguarding issues arose during the course of the Review. As a result the NELFT safeguarding audit was undertaken from the beginning of December 2016 and led by the Quality Assurance and Safeguarding Adult Board Manager in Commissioning, Adults' Care & Support. He scrutinised a sample of cases together with the social care lead for mental health. The case audit process gave an overall positive view of safeguarding as proactive, after sustained work to improve recording and approach to safeguarding.
- 6.28 However, one of the main problems, as apparent from the outset, was that the actual enquiry information was recorded on the Health system RiO and not on the Local Authority system AIS. This had been raised as a concern repeatedly, and progress in addressing it in the integrated service had been limited. It is raised as an issue in the report in January 2016 which sought Board authorisation for the agreement of the Section 75. The Lead Social Worker needed to retrospectively retrieve information from RiO recorded for instance on CPA Reviews and Progress Notes, to put onto AIS. This was flagged as an issue of concern when the Section 75 arrangement was agreed by the Board in January 2016.
- 6.29 Nine cases looked at, as part of the audit, were not particularly Making Safeguarding Compliant (MSP) thereby raising a training issue around how people record or understanding the Procedures. No Mental Health cases were going beyond Strategy Meetings.
- 6.30 Recording was not explicit in following the multi-agency procedure (London Multi Agency Adult Safeguarding Policy & Procedures, 2015) that has been signed up to by both organisations. Examples of shortfall were recording who the SAM was, who the Enquiry Officer was, what outcomes from the process the adult wanted and whether these were achieved, did the person have capacity, how was risk recorded, the Safeguarding Conference and Plan based on the Adult's desired

outcomes, and Review and Closure giving details of how any ongoing risks will be managed etc. In the progress notes on RiO there was evidence from the audit sample of reasonable recording, within timescale with no outstanding alerts.

- 6.31 The Quality Assurance and Safeguarding Adult Board Manager has worked closely with the Social Work Lead and NELFT Managers in rolling out the audit tool and training up the Seniors and cascading to front line staff with a focus on making safeguarding personal.

### **Risk Management**

- 6.32 A number of risks are identified in the Mental Health Social Care Review. NELFT and LBBD are working closely together to provide a joint risk assessment and how to address these risks during a period of transition. NELFT and the CCG have asked for assurance about this being undertaken and the Local Authority are firmly committed to this.

### **Service User Impact**

- 6.33 Mental health Users in Barking and Dagenham made returns to the most recent Mental Health Adult Social Care Survey (2015/16). There were 45 respondents who were people with mental health issues, made up of 23 males and 22 females of whom 13 are black and 4 are Asian. 38 of the sample were aged 18-64 and the remaining 7 over 64. It is a comparatively small representation of the number of adults living with serious mental health problems in Barking and Dagenham and caution should be exercised about interpretation, but the information should still be given weight:

- Quality of life as a whole: 42% said it was satisfactory or poor
- Control over life: 86% reported some control,
- Care and support: 64% were very satisfied with their support. 2% were extremely dissatisfied.
- Clean and presentable in appearance: 14% of the mental health group reported a less than adequate view on their being clean and presentable
- Home: 9% were not comfortable or clean enough or not comfortable or clean at all.
- Safety: 7% of the sample did not feel safe.
- Advice and support: 26% found it not easy or difficult to get information about advice, support and benefits.

- 6.34 These are a reflection of what needs to be done in assuring that social care outcomes improve to achieve social inclusion and quality of life in a deprived borough like Barking and Dagenham.

## **7. Non-Mandatory Implications**

### **Crime and Disorder and Social Cohesion**

- 7.1 LBBD is seeking to be a pilot site for the Thrive London initiative. The Mental Health Foundation are leading on the community resilience work-stream for Thrive London, which is a Mayor of London's initiative due to be launched 4th July 2017. Thrive is a pilot programme designed for a whole community life-course approach

to improving mental health and preventing illness, addressing young people offending and promoting community cohesion. Evidence for the effectiveness of interventions can be seen from the Mental Health Foundation's work, such as Young Mums Together, peer work with children and young people, and tackling isolation of older people.

- 7.2 The Mental Health Foundation has produced a heat map of risk that shows the most disadvantaged boroughs of London. This includes Southwark and Lambeth where pilots are being established and potentially Barking and Dagenham- though we may be in phase 2 of the project in terms of longer-term involvement. Thames View was identified as a potential local estate to undertake a pilot project developing community cohesion. Evaluation of the work is through Warwick University and East London University.
- 7.3 In the coming months it is intended that the following actions are taken:
- The Mental Health Foundation will offer a training session to Members and officers on mental health prevention and provide a Borough wide development session on mental health, bringing together stakeholders.
  - The Mental Health Foundation will put forward a plan for carrying out an initial consultation session with the residents of Thames View and have an initial walkabout of the estate. The Mental Health Foundation will seek out longer term funding for potential work in LBBDD.
  - It is hoped to form an empowered peer led group at the heart of developments and promote community cohesion in Thames View.
- 7.4 This section should also be read in conjunction with the 'Customer Impact' section, below.

### **Property/Assets**

- 7.5 The intention is to jointly review locations of work to achieve the best solutions for strong partnership working and social care identity. However, the change of model and the closer alignment with the Council will require Council accommodation to be found for this service as its principal base, from which it will work out in localities. This will also pick up on working with Community Solutions and the 3 localities model.

### **Customer Impact**

- 7.6 By improving access routes to social care for mental health, the Local Authority will ensure that it meets its duty to assess under the Care Act 2014. The absence of focus on social care outcomes within adult mental health services has put the delivery of a social care offer at a disadvantage, relative to medical and health interventions.
- 7.7 For the London Borough of Barking and Dagenham's vision of 'no-one left behind' in a growing borough, this lack of assurance on the delivery of the social care functions has raised the prospect of mental health service users being disadvantaged in their ability to play an active part in society. Addressing this will

be core to the development of the new service focus, strategy and management arrangements. Service users will have the opportunity through consultation and engagement to inform the longer-term development of this thinking.

### **Contractual Issues**

- 7.8 The non-renewal of the Section 75 Agreement between NELFT and LBBB will take effect from 1st October 2017. A Memorandum of Understanding relating to partnership working will be drawn up with NELFT and also there is the opportunity afforded to develop an interim arrangement to smooth the change to new working approaches.

### **Staffing issues**

- 7.9 Staff have been met with regularly, before and after the Review. Their views have been taken into consideration and they are an important element in taking forward the planning and implementation of transformation of Mental Health Social Care. Regular meetings have also taken place with the AMHP workforce.
- 7.10 We have committed to being part of the Social Work for Better Mental Health Improvement Programme promoted by the Chief Social Worker for Adults. The initiative provides a framework for continuous improvement and practice excellence and includes several workshops for all Social Care staff. NELFT Managers will be invited to the 2nd session to look at supporting successful partnership working. It is also intended to invite the facilitator leads for the national programme to return and review the Service one year on.
- 7.11 A number of unresolved HR issues are being addresses along with improving access to the LBBB IT system and provision of laptops.
- 7.12 There has been an over reliance on use of locum Social Workers and locum AMHP's with recruitment and retention issues. This is being addressed through a package to make it more attractive for staff to come and remain in Barking and Dagenham and a strong induction and training and development programme being planned with HR. An AMHP incentive scheme for hard to fill posts has been agreed through the Workforce Board.
- 7.13 There is agreement to have a Head of Mental Health Social Work in place from 1st October 2017 along with Team Managers and more diverse roles such as Support Workers and Occupational Therapists, particularly for the Enablement and Move on Support functions. Social Care leadership and ownership is required to deliver a strong Social Care offer in Barking and Dagenham.

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

- The Role of the Social Worker in Adult Mental Health Services. The College of Social Work. Author: Ruth Allen, April 2014
- The NHS Five Year Forward View
- Distinctive, Valued, Personal: Why Social Care Matters, the Next Five Years, ADASS, March 2015
- All-Party Parliamentary Group on Social Work-Report of the Inquiry into Adult

- Mental Health Services in England Sept 2016
- Social Work for Better Mental Health-A Strategic Statement January 2016
  - Common Core Principles to Support Good Mental Health and Wellbeing in Adult Social -Care Skills for Care 2014
  - How are we doing? A self-assessment and improvement resource to help Social Care and Health organisations develop the role and practice of Social Workers in Mental Health. DOH January 2016
  - Letter from Lynn Romeo, Chief Social Worker for Adults, to Directors of Social Services re the Improvement Programme April 2017
  - NELFT/LBBD v2 2016 Section 75 Agreement
  - Better Care Fund Plans 2016-17 LBBD and Barking and Dagenham Clinical Commissioning Group
  - Making the Difference Together, Allen/Carr/Linde/Sewell 2017

**List of Appendices:**

- Appendix A** Review report  
**Appendix B** Communications Plan

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**LONDON BOROUGH OF BARKING AND  
DAGENHAM ADULT MENTAL HEALTH SOCIAL  
CARE REVIEW**

**February 2017**

**Richard Adkin  
External Reviewer**

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### SUMMARY

This Review of the Mental Health Social Care offer in Barking and Dagenham was undertaken between October 2016 and January 2017, in order to understand the processes and quality of current services, with a particular focus on Social Care outcomes and how these are met through integrated multi-disciplinary teamwork, as well as through wider commissioning arrangements.

The key findings of the Review were as follows:

1. In many areas Barking and Dagenham already has a version of ‘what good looks like’ in mental health. There is evidence of many areas of good practice, local initiative and strengths across Adult Mental Health Services. The challenge is to make this sustainable with clear Care Pathways that reflect the priorities and direction of travel for the Local Authority and keep pace with rising demand and complexity.
2. Social Care outcomes are not as clearly articulated as Health Care outcomes in the current integrated arrangements. These Social Care outcomes are not addressed as a priority in the current arrangements and shortfall in the delivery of the Social Care Local Authority Statutory functions are dealt with reactively.



3. During the course of the Review immediate concerns around Safeguarding and AMHP provision and staffing had to be immediately addressed. The AMHP Service was placed on the Trust risk register as red and the LBBB Corporate Risk Register

4. Implementing effective change will require:

- Implementation and development of the Joint Mental Health Strategy through effective channels.
- Ensure that the Local Authority's statutory duties under the Mental Health 1983 (as amended 2007) and the Care Act 2014 are fully and effectively discharged and that the organisation and delivery of the AMHP Service is strengthened.
- Ensure that there is a stable critical mass of staff with sufficient experience and leadership and managerial input from LBBB within Mental Health Social Care. Further ensure that recruitment, retention and forward planning are given strategic consideration and embedded in operational practice.
- Mental Health Social Work identity, culture and practice to be reclaimed, rather than the Social Work staff undertaking the generic role of Care Management or the Health role of Care Coordinator.
- Provide assurance that all Safeguarding referrals are properly dealt with and recorded. Continue the audit on the Safeguarding function.
- Agreement on reform of integration across statutory mental health services, to bring Social Work nearer to the front of the system and at the interface between primary and secondary care. This in part will require a clear pathway for Mental Health Social Care including involvement with Community Solutions and developments with GP's in particular.
- Consideration of the Older Persons Mental Health Team being part of the LBBB Integrated Care Management Team.
- Focus on supporting people living with long-term conditions in the community.
- Further application of Reablement and Personalisation for improved prevention and recovery and promoting choice and control.

- Stronger Council direct working relationship with Users and Carers of Mental Health Services and the Voluntary Sector to make progress on co-production and peer support and support a richer Voluntary Sector.
- Strong focus on prevention and earlier access to help for children and young people and protecting what is already working well for key vulnerable groups.
- A Strategy in place for addressing the mental health needs of the BaME communities in Barking and Dagenham.
- Revisit the Section 75 agreement that reflects meeting the needs of the Community of Barking and Dagenham and delivering the Local Authority's responsibilities under the Care Act.
- An Implementation Delivery Plan to be drawn up that provides a framework for taking forward recommendations that are accepted by Senior Officers at LBBDD from this Review.

### 1. INTRODUCTION

**1.1** The purpose of this Review is to understand the current Social Care offer, in the context of Barking and Dagenham residents experiencing or living with mental health issues and mental illness. The Review was commissioned by the London Borough of Barking and Dagenham and has mainly focused on Adult Services.

**1.2** The method of enquiry is described in the Terms of Reference (Appendix 1+2). It is based on an analysis of information from published documents; interviews with a sample range of stakeholders: including Service Users, Health and Social Care practitioners and managers, LBBDD Commissioners, Senior Managers of the Council, Barking and Dagenham Clinical Commissioning Group, Barking and Dagenham Public Health, North East London NHS Foundation Trust and the Voluntary Sector, and shadowing staff (see Appendix 3). In addition to interviews, I have also observed and participated in a number of meetings in the course of this Review, and made visits to several community sites in Barking and Dagenham where mental health and wellbeing services are delivered.

**1.3** This Review has focussed its enquiry, as it has progressed, more on the current Social Care offer and Social Care outcomes, since these are the areas the Council is accountable for, must lead upon and report to national government departments. These are the outcomes the Council must account for to the residents of Barking and Dagenham.

**1.4** Because of time constraints, there were some limitations to the scope of this Review. The focus was Adult Mental Health Social Care rather than a whole life course approach. Some providers did not engage, although I did obtain a sense of their views. I only undertook a desktop review of some areas like the Dementia Strategy and did not engage with Substance Misuse Services, Forensic Services, Learning Disability/Mental Health, GP leads, CAMHS and Young People's Services-All of which are crucial and are an integral part of the developing Mental Health Strategy.

**1.5** The integrated nature of operations in secondary mental health care sets a challenge in disaggregating Social Care outcomes and responsibilities from Health Care. There are strong arguments for looking at Social Care and Health Care as an integrated single arrangement. This is widely supported by national policy and across professional groups, including Social Work. These arguments were alive in Barking and Dagenham.

**1.6** In contrast, recent policy messages have come to prominence with the introduction of the Care Act 2014, where Councils must make arrangements using a single national threshold for access to Social Care provision, the duty to promote well-being in undertaking care and support functions, prevent or delay the need for care and support; and drive forward personalisation and safeguarding. In recent years, many Councils have come away from previous long-standing arrangements of seconding Social Care staff to Mental Health Trusts in response to other priorities, financial pressures, disengaged Social Care Staff, or poor provider Trust performance on Social Care outcomes.

**1.7** This Review has taken the issue of integration fully into account in getting under the skin of the local Social Care offer.

## **2. BACKGROUND**

### **Demography**

**2.1** Barking and Dagenham has a population of almost 202,000 which is comparatively young, mobile and ethnically diverse. The population has grown 13.4% since 2001 and is expected to rise to 275,000 by 2037. Barking and Dagenham is densely populated and also has a deprived population in relation to other London Boroughs and English authorities. It is a disadvantaged population with poor outcomes. In the 2015 Indices of Multi Deprivation, LB Barking and Dagenham is the 9<sup>th</sup> most deprived Borough nationally and the 2<sup>nd</sup> most deprived Borough in London.

**2.2** The population of Barking and Dagenham is diverse. Since 2001 the proportion of the population from a minority ethnic background has increased from 15% to 50%. This is predicted to increase to 62% over the next 25 years.

**2.3** The population is young. There is the highest proportion of under 16's of anywhere in the UK (54,912). 10% of the population is aged 0-4 and that is a 50% increase since 2001.

**2.4** The Strategy and Programme Team (LBBD) is currently undertaking a consultation process for an Equality and Diversity Strategy that will be produced by the Spring of 2017. The Strategy is aligned to the wider ambitions of the Local Authority.

**2.5** In 2014/5 according to the JSNA, between 1097 and 1542 Adult Barking and Dagenham residents who were registered with GPs were on the severe mental illness (SMI) register. This is considered to be an underestimate and the Borough sees high levels of severe and enduring mental illness. Numbers in contact with Mental Health Services appears relatively low compared to other Boroughs.

Always start with a strong opening line!

### **Barking and Dagenham Mental Health Strategy 2016 - 2018**

**2.6** The Mental Health Strategy supports and aligns with the Council vision of '*One Borough; one Community; London's growth opportunity*'. It provides a specific Barking and Dagenham perspective on the wider planning processes that are underway across North East London, as part of the development of the Sustainability and Transformation Plan for the area.

**2.7** The vision for the Mental Health Strategy 2016 – 2018 is for people to be active citizens, to live a meaningful life and make positive contributions to the community that they are part of. Services and support must focus on promoting wellbeing and enabling people who have experienced a mental health problem to be independent, with more people choosing the support they want and a greater range of services to choose from; to support people to achieve their aspirations such as returning to work, living well in suitable accommodation and keeping active.

**2.8** The Strategy is predominately focused on adults, but highlights the significance of promoting and protecting the emotional health and wellbeing of children and young people to prevent mental health problems in adulthood. Actions to do this are being taken forward through the *Barking and Dagenham Children and Young People's Mental Health Transformation Plan*, which includes consideration of improved transitions to adult services.

**2.9** The Strategy promotes Community Solutions, which will be an early resolution and problem-solving service to help residents to become more self-sufficient and resilient. It is intended that Community Solutions will tackle the multiple needs of households in a joined-up way and at an early stage. It will comprise multi-disciplinary and multiagency teams that will collaborate closely with partners in the voluntary and statutory sectors to deliver early intervention and preventative support based in 3 localities.

**2.10** The key theme of prevention runs throughout the Mental Health Strategy and the Borough's Prevention Approach is an inherent aspect of LBBB overall future ambition. The growing prevention agenda promotes the development of a more resilient community, where individuals are empowered and supported to take positive steps towards managing their own wellbeing.

**2.11** The four priorities are:

**Priority one: preventing ill health and promoting wellbeing**

**Priority two: housing and living well**

**Priority three: working well and accessing meaningful activities**

**Priority four: developing a new model of social support**

**2.12** This fourth priority provides a focus on more creative, innovative ways to co-produce a new system of mental health care and support, including maximising the benefits of creating a digital front door to advice and support. The role of Social Work and Social Care in this new model needs to be developed, to allow the particular skills and unique contribution of Social Workers to be used to their full benefit in creating a sustainable and responsive approach in the Borough.

**2.13** As part of the future design of the Council, Community Solutions will take a holistic approach to providing early intervention and support and will develop responses that will incorporate links to mental health support as required. The new Service will be developed to encourage self-help. The development of 3 Localities being initially rolled out from April 2017 will not directly include Mental Health Social Care per se at the outset, given the complexities of mental health provision and the challenge of establishing and stabilising a new model of delivery. There are 2 GP Federations in Barking and Dagenham. A new Disability all-age will be rolled out in Barking and Dagenham from April 2017.

**2.14** The proposed next steps for the Mental Health Strategy 2016 - 2018 are as follows:

- Deliver upon the action plan, monitored and supported through the Mental Health Subgroup.
- Establish and enhance links with other strategies to support the principle of parity of esteem for mental health.
- Continue to develop the Mental Health Strategy 2016 - 2018 to align with and support the implementation of the Growth Commission and Ambition 2020 along with the *NHS Five Year Forward View for Mental Health*.
- Completion of a suicide audit and the development of a local suicide prevention plan in line with Public Health England's on-going programme of work to support the government's suicide prevention strategy. The local plan will link with the Mental Health Strategy 2016 – 2018.

**2.15** Integrated commissioning and provision within Barking and Dagenham and across the wider Health and Social Care system is at the heart of the Mental Health Strategy 2016 – 2018. The Strategy further confirms integration priorities that have been identified as part of the BHR system wide approach to Mental Health and developed through the work on devolution. It also reflects the mental health priorities identified as priorities within the work to develop *the North East London Sustainability and Transformation Plan*. These priorities have been developed to reflect the national *Five Year Forward View for Mental Health*, ensuring that there is a link through from nationally identified priorities through to borough and locality level delivery. The development of the Strategy has been supported through the Mental Health Subgroup of the Health and Wellbeing Board whose membership consists of a wide range of partner organisations from across the local Health and Social Care economy including Service Users representatives.

### **Health and Wellbeing Strategy**

**2.16** This Strategy will further support the following priorities in the Joint Health & Wellbeing Strategy:

- Increase the life expectancy of people living in Barking and Dagenham.
- Close the gap between the life expectancy in Barking and Dagenham with the London average.

- Improve Health and Social Care outcomes through integrated services.

### **Barking and Dagenham Mental Health Voluntary Sector**

**2.17** Barking and Dagenham does not seem to have a strong Voluntary Sector fabric that puts it in a good position to support social inclusion. Unlike a number of other Boroughs it does not have much in the way of well-established community organisations that have a specific interest in mental health or directly support mental health Service Users. The 3<sup>rd</sup> Sector can also offer non-directive advice, information and signposting through the mainstream/universal services and resources, and to personal budgets to those adults who are eligible to purchase services and access to activities to protect and improve their wellbeing and assist recovery.

**2.18** The general Voluntary Sector provision in Barking and Dagenham is likely to remain places where unmet mental health need emerges, for example where individuals are seeking advice and assistance because of housing or welfare issues. This is particularly true of the BaME community. There seems to be a need to engage BAME and marginalised groups on cross-borough engagement events to identify key considerations for promoting and protecting the mental health and wellbeing of Black and Asian minority ethnic and other marginalised groups in Barking and Dagenham as there are indications of hidden mental health problems. Future mental health services for BAME and other marginalised communities could be commissioned through dedicated community-based support services delivered using: Information and Advice; Peer Support; Faith Groups; Community Networks; Self Management; Befriending and Social Inclusion.

**2.19** The contract for Healthwatch for Barking and Dagenham ends on 31<sup>st</sup> March 2017. This has been extended to the end of June 2017 as a contract will be procured for a local Healthwatch and put out for competitive open tender.

### **Public Health**

**2.20** Barking and Dagenham Public Health Team are located with LBBD Commissioning Team and provide good data and health intelligence that has informed the Mental Health Strategy, The spend directly on Mental Health is relatively low about 330k. There are Mental Health Promotion activities that are well regarded. For instance in October 2015 the London Borough of Barking and Dagenham (Public Health) re-commissioned Big White Wall to provide the Support Network to local residents. Residents via either postcode self-referral, or a

prescription referral from the IAPT service can access the Big White Wall. Since the initial launch in 2013 to 1st October 2016, Big White Wall has supported 1284 Barking and Dagenham residents, with 561 registering during the 2015/2016-contract year.

**2.21** The data below summarises the registrations, demographics and user activity over the 12-month contract period from 1st October 2015 to 1st October 2016.

- 69% of Barking and Dagenham members are female
- The largest proportion of members are aged 25-34
- 15% of members are 'lone parents' and 16% live 'alone'
- 37% of members are in 'full time employment' and 21% are 'unemployed'
- 57% of members heard about Big White Wall via the IAPT service

**2.22** Barking and Dagenham members make good use of the SupportNetwork. In the months between October 2015 and October 2016 the average active member in Barking and Dagenham logged in 11.4 times and viewed 131.4 pages. They are active in 'TalkAbouts' and creating 'Bricks', part of Big White Wall's art and writing therapies. On average members in Barking and Dagenham create 4.8 posts (either Bricks, Brick comments or TalkAbouts) and utilise various resources within 'Useful Stuff'.

**2.23** Public Health are supporting the development of the London Digital Mental Wellbeing to pilot a digital service that helps Londoners improve and maintain good mental wellbeing. It is based on research that too many people are suffering alone with common mental health. The Service will be rolled out in phases and investigate innovative ways of helping people online create a suite of unique digital products that continually evolve to meet needs. At the outset it will allow local people to:

- Assess their own mental health
- Get information about how to look after their own wellbeing and access support in their communities
- Help them connect with others - including mental health professionals.

This will all be available 24 hours a day seven days a week, and to be initially launched in May 2017.



**2.24** Going forward, there will need for clarity over the role Public Health play in relation to prevention for targeted mental health cohorts and for a stronger relationship with Commissioners. The JSNA is a key responsibility along with Health promotion but the impression gained was that more could be spent by Public Health more directly on Mental Health when there is such great need.

### Commissioning Arrangements

**2.25** Social Care Mental Health Commissioning arrangements for Adults with Mental Health issues are carried out by the Council. A Section 75 agreement is in place with NELFT for the operational delivery of the Local Authority functions. This Section 75 Agreement is monitored through a monthly meeting with Senior Officers from LBBB Commissioning and Operations and NELFT. Concern has been expressed that the Agreement needs more constructive challenge and a rewrite; that it preserves the status quo and does not address the rapid changes happening in the Borough. Changes particularly relate to cultural needs of the growing population or requirements to be delivered under the Care Act. In addition LBBB Commissioners have lead responsibility of developing a Strategy for Mental Health as well as a Market Position Statement. LBBB Commissioners must also take account of Social Care approaches and ensure that all commissioned services supply relevant mental health activity data, including those required for the Adult Social Care Outcomes Framework submission for Councils, with Adult Social Care Responsibilities. These are annual returns through which the Council's performance is measured.

**2.26** Nationally, Health and Social Care Services have been challenged to work closely to deliver more effective and joined up and affordable services. Under *the Sustainability and Transformation Plan (STP)*, Improvement Plans for the next five years are being developed in order to improve the health and wellbeing of the local community and tackle the growing demand for high quality health and care services. Within the North East London STP, Barking and Dagenham have developed into an Integrated Care Partnership with Havering and Redbridge.

**2.27** The content of *the Better Care Fund revised plans for 2016/7* for the Borough takes into account the development of revised locality delivery networks based on population needs, which is at the heart of the transformation programmes. One of the work streams from the BCF Plan is to clarify the locality model based vision of the Mental Health Strategy and utilisation. Re-tendering is taking place for services to support people into employment and education in order to build resilience and wellbeing. Several Senior Officers have echoed what is being recommended in the Mental Health Strategy about the need for Joint

Commissioning. *The Barking and Dagenham CCG Operating Plan 2017/9*, which does have major saving requirements confirms taking forward integrated mental health commitments. However, some Senior Officers expressed the view that overall locally there was a lack of aligned and joined up commissioning intentions.

### **Mental Health Adult Social Care Survey Return for 2015-6**

**2.28** Mental health Users in Barking and Dagenham made returns to the most recent Survey (2015/6). There were 45 respondents of people with mental health issues, made up of 23 males and 22 females of whom 13 are black and 4 are Asian. 38 of the sample were aged 18-64 and the remaining 7 over 64. It is a comparatively small representation of the number of adults living with serious mental health problems in Barking and Dagenham and caution should be exercised about interpretation, but the information should still be given weight:

- *Quality of life as a whole*: 42% said it was satisfactory or poor
- *Control over life*: 86% reported some control,
- *Care and support*: 64% were very satisfied with their support. 2% were extremely dissatisfied.
- *Clean and presentable in appearance*: 14% of the mental health group reported for less than adequate, for not being clean and presentable
- *Home*: 9% were not comfortable or clean enough or not comfortable or clean at all.
- *Safety*: 7% of the sample did not feel safe.
- *Advice and support*: 26% found it not easy or difficult to get information about advice, support and benefits.

These are a reflection of what needs to be done in assuring that User Social Care outcomes improve to achieve social inclusion and quality of life.

### **Barking and Dagenham Children and Young People's Mental Health Service**

**2.29** Most mental health problems have their origin in childhood, and half of all mental disorder first emerges before the age of 14 years and three quarters by the age of 25 years. Young people aged 12-25 years have the highest incidence and prevalence of mental illness across the lifespan. In contrast to physical health, which is at greatest risk at the start of life and in old age, mental illness vulnerability peaks at 18 years of age - just at the point where young people are moving into adulthood, and where, typically, service access arrangements change because of age boundaries and legal responsibilities.

**2.30** Mental health national policies set clear expectations around meeting the needs of young people, the importance of prevention, early help and intervention and a focus on key transitions is key to reducing the risk of young people developing longer-term mental health problems, with their significant impact on education, employment and quality of life. Transitioning to Adult Services in Barking and Dagenham has been reported as problematic, in spite of the same Mental Health Trust provider delivering CAMHS and Adult Services.

**2.31** Another important element of local young people mental health services is Early Intervention in Psychosis which has a good account, The family intervention rate is positive, which is important in relation to wellness and recovery. Currently the CAMHS Strategy has been recently signed off through the Health and Wellbeing Board. This Strategy is encompassed within the Joint Mental Health Strategy. It is intended for a Wellbeing Hub to be established for young People in order to have greater access and early intervention. There are a number of vulnerable groups that need to be reached. For instance *the Adult Psychiatric Morbidity Survey (September 2016)* undertaken by the National Centre for Social Research, highlighted that sexual violence, childhood trauma and pressures from social media were contributing to young women aged 16-24 being identified as a high-risk group.

### **3. ORGANISATION OF STATUTORY ADULT MENTAL HEALTH IN BARKING AND DAGENHAM**

#### **North East London NHS Foundation Trust**

**3.1** North East London NHS Foundation Trust (NELFT) provide a range of integrated community and mental health services for people in the London Boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest and community services in South West Essex. NELFT has an annual budget of £340m and provides care and treatment for a population of 2.5 million people. NELFT is predominantly not a Mental Health Trust and roughly 30% of NELFT work is around Mental Health.

**3.2** NELFT was inspected by the Care Quality Commission between the 4th-8th April 2016 and the Report was published in September 2016. CQC rated the Trust as “Requiring Improvement” and served a warning notice in relation to acute mental health wards and Children and Adolescent Mental Health Wards. Training in the Mental Health Act was found to be not part of mandatory training for staff and diversity information not routinely captured. The Trust was providing good access to physical care and was found to have good overall systems and processes for managing safeguarding children and adults at risk. Community Mental Health Services across the 4 Boroughs were rated as good for effectiveness, caring, responsive and well led. Safety in Community Mental Health Services required improvement.

**3.3** During the Review the Trust declared an Internal Critical Incident from the 10<sup>th</sup> to the 14<sup>th</sup> November 2016 when the mental health wards were closed to new admissions and the Section 136 Suite closed. With a bed availability of 99 beds there were 127 people needing an inpatient bed. There was an intense period of multidisciplinary work to support people in the community at risk of admission or discharge people back to residential accommodation or back home etc. The Trust is reviewing the entire acute care pathway and introduced a new escalation process for bed management. The Trust performs well in a number of areas in relation to other London Trusts such as crisis contact and follow- up and low admission rates. See Appendix for some performance comparisons from *the London Mental Health Dashboard-Summary Report December 2016*.

### **Mental Health Social Work**

**3.4** The workforce is made up of:

#### **Adults**

- 1 AMHP/Social Care Lead
- 3 Senior Social Workers
- 12 Social Workers
- 2 Support Workers
- 2 Admin Staff

#### **Older Persons**

- 1 Senior Social Worker
- 2 Social Workers
- 1 Community Case Worker

**3.5** 1/3 of the qualified staff are locums including 4 AMHP locums out of 8, and 2 of the 4 Seniors are locums. There is little role diversity in the range of staff e.g. there are no OT's undertaking a reablement function. The staff members are spread between Services Based predominantly in the Community Recovery Team and Home Treatment Team and Older Persons Team. There is only 1 locum worker in the Intake and Access Service. The staffing levels and seniority and range of staff does not compare favorably with similar London Boroughs like Southwark and Newham (see Appendix 4) where there is such provision as reablement programmes to support people coming out of hospital and prevent potential admissions and a universal offer to provide access and prevention. Staffing numbers though are difficult to quantify meaningfully until there is clarity, for example, around the role, organisation and duties of the Mental Health Social Care Service in Barking and Dagenham.

**3.6** The Older Persons Mental Health Team is managed by an experienced Health Manager who is a qualified Social Worker. Their remit includes the Memory Service, which also covers younger people. The Group Manager for Integrated Care Management signs off the personal budgets for this team. The view was expressed that that team members in the Older persons Mental Health Team did not feel part of the Local Authority.

**3.7** There are issues of recruitment and retention of qualified Social Work staff in Mental Health for LBBB and some sickness in the Team. There needs to be stronger Social Care Management arrangements and staffing in place, as the lead Social Worker currently reports to a NELFT Service Manager who has a wide span of predominantly health responsibilities. There is not a sense of key Social Care Outcomes, for instance around personalisation or Carers' assessments, employment, education and training for Users being embedded or given priority. Carers' assessments have dropped further in November 2016 and continue to fall. Social Care staff have collectively and individually strongly expressed dissatisfaction about the current secondment arrangements, though some have also expressed that they do not feel that they belong to Adult Social Care Social Care and that the Social Care direction has been handed over to the Trust. The roles of the Social Care staff are better described as that of a generic care coordinator function that is organised around Care management and the Care Programme Approach (CPA) rather than the professional role with protected title. There is a legacy of a period of 4 years where there was no Social Work lead until the current post holder came into post 2 years ago.

**3.8** There is a need for a Senior Social Care Manager to oversee the Social Care delivery and champion the profession and the needs of people and their families where there are Mental Health issues. There needs to be stronger experience of Mental Health delivery within the Local Authority. Input is needed from a Principal Social Worker for Adults, as are in place in a number of Authorities, to raise standards and provide focus of core social Work tasks.

Consideration also needs to be given to the role of Consultant Social Workers being developed and also succession planning. *The Think Ahead Programme* provides a fast track mental health Social Work scheme across the country. Several Authorities have committed to this scheme with a Consultant Social Worker/Practice Educator overseeing the work of the trainee Social Workers. It is positive that there is one Social Work student on placement.

**3.9** LBBB Target Operating Model sets out how Adults' Care and Support (AC+S) will be shaped going forward to 2020 in order to meet the needs of local people, and reflects key decisions made including the planned delivery of Community Solutions. The Model sets out a vision for AC+S, which is in line with Care Act requirements that Mental Health Social Care, should play a part in. This includes "making best use of valuable Social Work time" and envisages the introduction of Care Navigators and unqualified staff to release Social Work time. There is positive Senior Officer commitment within LBBB to transform Mental Health Social Care with a Social Care workforce also wanting to establish a stronger Social Care Offer.

### Options

**3.10** Some options options for reform are:

- a) Maintain the current arrangements with NELFT. However this does not address the necessary reform nor address the poor Social Care outcomes.
- b) Maintain presence in NELFT but the Social Care staff managed directly by a Social Care Group Manager, with consideration of Social Care staff not acting as generic care coordinators but working with those people who are assessed as being eligible for Social Care needs.
- c) Consideration to be given to the Older Persons Mental Health Team, given the small size of the Team and overlap, being assimilated within the LBBB Integrated Care Management Teams.
- d) Establish a Social Care base at least for the mid term, with staff directly managed within a robust Social Care Management structure with a strong commitment to the multidisciplinary partnership, integrated working and colocation particularly with NELFT; and to bring Social Work nearer to the front end of the system at the interface between primary and secondary care.

**London Borough of Barking and Dagenham Approved Mental Health Practitioner Provision**

**3.11** The AMHP service is managed by the London Borough of Barking & Dagenham Social Care/AMHP lead for all Social Care staff in the mental health teams within Barking and Dagenham i.e. Barking and Dagenham Recovery Services, Home Treatment Team, Older Adult Mental Health Team and Barking and Dagenham Access and Assessment and Brief Intervention Team. The AMHP Manager reports to the Assistant Integrated Care Director for Mental Health and Learning Disability Services. Both the Assistant Integrated Care Director and AMHP Manager take a lead role in operational and professional management of the Social Care workforce within Mental Health Services, All professional issues are further escalated through the Section 75 Executive Steering Group through key performance indicator reporting.

**3.12** The London Borough of Barking & Dagenham has a S75 Partnership agreement for North East London NHS Foundation Trust to coordinate the Out of Hours Emergency Duty Social Work Service for vulnerable adults, which includes people who may require assessment under the Mental Health Act within Barking and Dagenham. A North East London NHS Foundation Trust Manager oversees the day- to-day operational management of the Out of Hours service, however, the local AMHP Manager still retains the overall responsibility. The EDT Service covers the 4 Boroughs, Waltham Forest, Redbridge, Havering and Barking and Dagenham. Some people interviewed questioned whether the Service offered value for money but it is a challenging Service to run.

**3.13** The London Borough of Barking and Dagenham currently commission AMHP training through the North East London AMHP Consortium, who provide all pre-AMHP training, professional AMHP training and on-going refresher training. The training, which is a one-year programme, is subject to rigid entry requirements, including a pre-AMHP course, due to the intensity and complexity of the training that is operated at a Masters level. There are four AMHP places per year from the Consortium, but these have not been utilised fully by LBBDD. All AMHPs and trainees meet fairly regularly at an established AMHP forum. The forum invites guest speakers, chaired by the AMHP Lead and takes place every 6 - 8 weeks.

**3.14** The North East London NHS Foundation Trust, through the Section 75 agreement, operationally manages the Mental Health Social Care workforce. LBBDD Mental Health Social Work Staff are seconded and located into NELFT integrated teams in community mental health and other service settings since 2000, through a National Health Service Act 2006 Section 75 Agreement. North East London NHS Foundation Trust and London Borough of Barking & Dagenham have a bi-monthly staff engagement forum for all Social Care workforce within Mental Health Services.

**3.15** Access to legal and professional advice is supported by both the North East London NHS Foundation Trust and the London Borough of Barking & Dagenham. All staff have access to professional advice through the AMHP Manager and Assistant Integrated Care Director. Front line staff have access to the North East London NHS Foundation Trust's Mental Health Act Administrator and NELFT Social Work Professional Lead who supports Social Work across the organisation.

**3.16** In terms of context there is a national issue of shortfall in AMHP's and increase in demand. An NHS Digital Report (Nov 2016) reported that detentions under the Mental Health Act in 2015/6 were up 9% from the previous year with a significant 18% increase in NHS based Place of Safety. Community Care Research (Andy Nicholl September 2016) highlighted that AMHP Numbers dropped 7% from the period 2013/4-20115/6.

**3.17** In February 2016 the Chief Social Worker wrote to Directors of Adult Services to ensure that each Local Authority had "effective workforce management and succession planning to enable on-going sufficiency of AMHP's and good workload management." A report was sent to the Chief Social Worker giving an undertaking that the AMHP Service in Barking and Dagenham was fit for purpose. However effective workforce management and succession planning, to enable on-going sufficiency of AMHPs and workload management is a challenge. There are 10 AMHPs currently practising during daytime in London Borough of Barking and Dagenham. 7 are permanent staff and 3 are locums. A Community Mental Health Nurse undertook AMHP training but did not complete the training. Recruitment of qualified and experienced AMHPs into vacant social work posts, has presented a problem. In 2015 mental health services recruited into three vacant Social Work posts and one Senior Practitioner post. Whilst specifying on the person specification that AMHP qualification or willingness to train was essential, the Service was unsuccessful in securing qualified AMHPs at this recruitment event; instead four newly qualified Social Workers were recruited and joined Mental Health Services. All are subject to ASYE training and will be eligible for AMHP training in 2017.

**3.18** An Acute Crisis Assessment Team filters all Community requests for a Mental Health Assessment. However the Service appears to be too thin and vulnerable in terms of sustainability. The work is demanding and requires detailed working knowledge of the Mental Health Act/DoLS/the Mental Capacity Act/the Human Rights Act etc. There are obstacles like the forthcoming impact of the Crime and Justice bill, bureaucratic delay in gaining a Section 135 warrant from the Court for powers of entry, a need to book in Police involvement, ambulance delays (which is being addressed by the Trust) and no Section 12 Approved Doctor rota during the working day- meaning that the duty Section 12 Approved Doctor at Snaresbrook is called upon after hours by the day time AMHP's who have to work into the evening. The AMHP Manager has recently advertised a further 3 Social Work/AMHP



vacancies, which have arisen this year. The failure to recruit AMHPs into these posts has resulted in AMHP rota slot vacancies. There is a shortage of AMHPs and reliance on locums in Barking and Dagenham. The legal responsibilities of the Local Authority are detailed under Section 114 of the Mental Health Act 1983 (as Amended 2007).

**3.19** There is no central base or support for the AMHP Service in terms of coordination and administrative support, screening of referrals (Acute Crisis Assessment Team aside) and prioritising. A rota is distributed with first on call and back up and AMHPs receive referrals directly at their Team base. This is potentially isolating and non supportive of what is a key statutory function. Stronger managerial, administrative and consistent supervision is needed because of the extreme pressures. Recruitment and retention of AMHP staff is problematic. The AMHP Service was recently made Red on the Trust Risk Register, though a positive summary of AMHP delivery had been sent to the Chief Social Worker. Statutory provision was also put on LBBB Corporate Risk Register. Too many trainee AMHPs have not moved on to practising as an AMHP. The current AMHPs are dissatisfied with their caseload and the amount of sessions on the rota.

**3.20** As part of the Review, the Reviewer shadowed the AMHPs on duty and spent time at the Community Mental Health Team. Access to AIS was limited on site and did not seem part of Practitioner practice. The AMHP information folder needed updating systematically and comprehensively particularly given the number of AMHP locums. Overall a radical review is needed on this statutory provision, as there are risks around the Local Authority meeting its statutory obligations and risks around recruitment and retention of key staff.

### Options

**3.21** There is a need for a stronger core structure for the day-time AMHP Service i.e. Managerial leadership and availability and support availability, administrative back up screening referrals and a core central base. Consideration needs to be given to the following:

- Increase full time cover of AMHPs on the rota to reduce burden of rota'd AMHPs.
- Reduce the current caseload of AMHPs.
- Attract more AMHPs with a positive support offer e.g. the Think Ahead Scheme. This could include health professionals training to be AMHPs who would need a small financial incentive and support of the Trust to operate as AMHP.

- Establish a central base as soon as is practical, with Admin and Management Support with proactive screening and prioritising taking place for the statutory AMHP provision.
- Formally raise with NELFT the non-availability of a daytime rota for a Section 12 approved Doctor.

### Visit by the Chief Social Worker

**3.22** Lyn Romeo (the Chief Social Worker for Adults) visited, presented to and met with the Senior Managers and Adult Social Work staff at LBBB on 8<sup>th</sup> December 2016. She promoted Social Workers as lead Professionals in ensuring personalised and integrated care and support for individuals, families and their communities. She stressed the importance and ways at looking at the recruitment and retention of staff and the need for leadership. The duties under the Care Act were reiterated around assessment, eligibility, application of legislation, care planning etc. It was a positive visit, enabling reflection and dialogue around practice and providing context for the operation of the profession. Themes developed in recent Department of Health, the former Social Work College and Parliamentary Working Group Mental Health Guidance etc. (see References and Appendix) were further articulated by the Chief Social Worker.

**3.23** The Older Persons Mental Health Social Workers attended the visit by the Chief Inspector but unfortunately there was no attendance or awareness of the event by the Adult Mental Health Social Workers or Managers. This was a missed opportunity.

### Residential Care

**3.24** There are currently around 104 people from Barking and Dagenham living with longer-term severe mental illness in residential and nursing care. 87 are in Borough and the remaining are out of borough placements. There was a major review programme 2 years ago with the setting up of a Review team to look at the appropriateness and cost of all the placements. There was a budget overspend, and the budget has now been brought under control. This process has been overseen and monitored by the RAMP Panel. Some members have reflected that there could be more positive risk taking with people moving on. There is good input in some provision with STAR Floating Support Workers. LBBB Commissioning are developing a stronger pathway where there is a gap for step down and step up. Feedback from Users at 2 Units were very positive about the support that they had received throughout their pathway towards recovery.

**3.25** In terms of Delayed Transfer of Care the figures remain strong and performance is above target. This is in contrast to other Borough areas using the Goodmayes Unit. The Brokerage Team, on the Adult Integrated System, now records all placements. LBBDCommissioning is considering a remodeling of Mental Health Supported Accommodation and Floating Support. Prior Information Notices have gone out to the market to ascertain whether the proposed plan is deliverable and to gauge providers' responses in relation to price and service delivery models.

### **Safeguarding**

**3.26** At the early stages of the Review there was no assurance via the Section 75 Meeting or meeting with the AMHP/Social Care Lead for Mental Health that Safeguarding Processes were compliant. There had been a recent crisis when there were only 2 SAMS in the Adult Mental Health Service before several Senior Workers were reactively rushed through training.

**3.27** A deep dive audit of Safeguarding Practice had been organised via Corporate Services but failed to produce a Report earlier in 2016. The NELF safeguarding audit was undertaken from the beginning of December 2016 and lead by the Quality Assurance and Safeguarding Adult Board Manager for Adult Social Care LBBDC, scrutinising a sample of cases with the Social Care Lead for Mental Health.

**3.28** One of the main problems, as apparent from the outset, was that the actual enquiry information was recorded on the Health system RiO and not on the Local Authority system AIS. The Lead Social Worker needed to retrospectively retrieve information from RiO recorded for instance on CPA Reviews and Progress Notes, to put onto AIS. 9 Cases looked at, as part of the audit, were not particularly Making Safeguarding Compliant (MSP) thereby raising a training issue around how people record or understanding the Procedures. No Mental Health cases were going beyond Strategy Meetings. There was a high proportion of NFA's. One case recorded as NFA in reality was taken through actual enquiry to closure with actions carried out and multi agency involvement. It was just incorrectly recorded as NFA.

**3.29** Recording was not explicit in following the multi agency procedure (see Appendix 5 *London Multi Agency Adult Safeguarding Policy & Procedures, 2015*) that has been signed up to by both organisations. Examples of shortfall were recording who the SAM was, who the Enquiry Officer was, what outcomes from the process the adult wanted and whether these were achieved, did the person have capacity, how was risk recorded, the Safeguarding Conference and Plan based on the Adult's desired outcomes, and Review and Closure giving details of how any ongoing risks will be managed etc. In the progress notes on RiO there was evidence from the audit sample of reasonable recording, within timescale with no

outstanding alerts. The Quality Assurance and Safeguarding Adult Board Manager will work closely with the Social Work Lead rolling out the audit tool and training up the Seniors and cascading to front line staff with a focus on making safeguarding personal. The Quality Assurance and Safeguarding Adult Board Manager will be attending the February NELFT Management Meeting.

**3.30** AiS IT system will be replaced by Liquid Logic in the future and may offer greater interconnectivity between the Health and Social Care systems; but the current arrangements around safeguarding practice are muddled and flawed. NELFT currently do not have the resources to input onto both systems.

### **Budget**

**3.31** From the outset the Review is not about making savings but reviewing to gain a stronger Social Care offer. The Adult Mental Health Social Care budget comprising of assessment and care management staff costs; residential contracts; direct payments and personal budgets etc. As of October 2016 some of the key total net sums by Cost Centre are:

Mental Health Support £2,232,400

Older Persons CMHT £175,270

MH Commissioned Services £303,300

MH Vocational Support Services £110,900

Home Treatment/Crisis Resolution £160,340

Community Mental Health Team £659,960

Assertive Outreach £96,510.

**3.32** Investment was made in the last 2 years to review all residential placements and cost effectiveness. The budget overspend has been brought under control by the reviews along with a strong Members' and Senior Officer steer and maintained through the RAMP Panel and commissioning of new Services. Some work is needed on a Section 117 Policy (duty to provide Aftercare) and establishing comprehensively and accurately who is on the S117 Register that sees people coming off S.117, as this is a potential significant financial liability for the Local Authority and CCG. If Choice and Control and personalisation take up was alive in Barking and Dagenham there would be potential further cost pressures.

## **4. FINDINGS**

**Some Layering**

**4.1** The method of service development over a number of years appears to a degree to have been ad hoc, in the absence until recently of an overarching jointly developed mental health and wellbeing strategy. There has been an accumulation of services with comparatively little decommissioning. There is a large operational Trust structure across all client groups covering a large population, which is positive in addressing parity of esteem and whole life course, but this is weaker on the Council's Borough-wide focus and delivery of Social Care outcomes for mental health.

**4.2** The mental health system is complex to navigate and does not provide a clear, integrated pathway for users, families, primary care or other key professionals, e.g. GP's. There is a risk that layering behaviour continues.

**Section 75 Arrangements**

**4.3** Robust governance assurance is necessary and this must be sustained. This can be provided through an agreed joint strategy; clear commissioning intentions and resource allocation; routine senior officer contact; annual review against performance, and routine performance reporting against Social Care outcomes, including personalisation, safeguarding, Carers' assessments, and the demand and performance of AMHP and other services. Clear recovery and mitigation if Social Care outcomes are not achieved, are required. The Section 75 Meetings do not fully address the challenges. Without this governance assurance process, tensions are likely to arise when new policy must be acted on (e.g., implementation of Care Act 2014 or potential initiatives from the London Mayor's Office such as the *Thrive Initiative*) or when previous resource levels cannot be sustained.

**Integration**

**4.4** There is support across Barking and Dagenham, particularly by NELFT and the CCG, for an integrated mental health offer. There is a desire by the Local Authority to improve the benefits of the integrated arrangements. Service Users in Barking and Dagenham have said they wanted care and support to come from as few places as possible and this care and support to be coordinated.

**4.5** The advantages of an integrated Health and Social Care offer are presented as the single pathway to secondary care services; the durability of existing work practices over time;

good professional inter-disciplinary relationships and information flow; informal learning; relaxing of professional boundaries, allowing Social Care work to be undertaken by nursing colleagues around personalisation. An argument was made that integration has worked for the benefit of the larger Social Care agenda in Barking and Dagenham, through the influence of Social Workers' contribution to multidisciplinary working and there were warnings from Health Senior Officers on any potential impact of disaggregation.

**4.6** Other advantages of integration were presented as being better than the alternative. This was based on people's previous experiences and concerns about potential adverse consequences if an alternative approach were implemented. It included concerns about the double-running of assessment processes and information systems in Health and Social Care, which appears to go against government-sponsored guidance; more distant staff working relationships, with potential for professional disagreement and discord if a 'task-based' work focus were established; the risk of Users and families falling through gaps in delivery; and the reaction of NELFT as a large health provider. While there was support for integration, the quality of existing arrangements was generally agreed as requiring improvement.

**4.7** The Social Care offer was perceived as subsumed into the larger and more dominant health delivery priorities at the Trust. There needed to be a better balance of Social Care and Health care goals and outcomes, so that Social Care could be reclaimed in integrated teams, consistent with LBBD's vision for Social Care. Many stakeholders struggled to understand what Social Care outcomes were.

**4.8** There were other views, particularly from the Local Authority Senior Managers and front line Mental Health Social Care Staff that the sum of benefits currently derived from integration were intangible and hard to define. It was also hard to recognise the Social Care elements of current integration arrangements. Social Work was not in the foreground of work with Service Users and their families on initial assessments. The current arrangements were perceived to be a medical model and health orientated. Concerns were expressed that some Trust colleagues appeared annoyed when Social Care needs were raised; and that the scope of Social Care was narrowly defined as consisting of either residential care *or* a personal budget.

### **Partnership with Community Voluntary Sector**

**4.9** Good working relationships are vital in the context of significant welfare reforms and their impact on people and families living with severe mental health difficulties. Voluntary sector organisations spoke of their desire for a partnership with the Council, but felt that their potential contribution was not valued.

**Personalisation**

**4.10** Because of the current location of Barking and Dagenham Adult Mental Health, there is an assumption that everyone in secondary care mental health is eligible for a Social Care Service. This is different from the eligibility test applied in other Adult Social Care Services. A second working assumption that follows is that, to apply and be assessed for a personal budget, the person must be open to a secondary care team. Given the number of people registered with Barking and Dagenham GPs with severe mental illness who are not open to secondary care, this puts this group at an unequal disadvantage. Non compliance within the Care Act eg around non assessment, when there is eligibility to be assessed, exposes the Local Authority to risk of legal challenge for failure to assess and failure to address the requirements to deliver strong Social Care outcomes and deliver prevention and wellbeing for Barking and Dagenham citizens.

**4.11** There was a sense of frustration expressed by Senior Officers in the Local Authority that there had been a significant training and development programme lead by the respected specialist, Ian Winter, 2-3 years previously, that had produced some sound publications but the training had not embedded or maintained within the Mental Health Social Care Workforce.

**5. REFLECTION****What would good look like?**

**5.1** In many areas Barking and Dagenham already has a version of this, but a refocus is needed to strengthen prevention and early intervention etc. The focus needs shifting if it is to remain relevant and fit for purpose.

**Signs of safety**

**5.2** The Social Care offer must have strong signs of safety. These must be evident and understandable at key points in the person's journey to recovery. For example at the point of transition for those leaving care, because of the increased risk of experiencing poor mental health alongside a complex set of changes.

**5.3** Hospital, nursing and residential care are all intermediate steps in managing crisis and making a good mental health recovery. One of the main ways to contain the high costs associated with these services is to improve outcomes around resettlement into ordinary community living with or without support. The current reality is that, already, most people living with significant longer-term mental health conditions live in the community and not institutional settings. Previous consultations have received a clear message from Users that they want to manage crisis without returning to hospital. NELFT, until the recent episode, had a good track record locally of managing their bed numbers and making community follow up.

**5.4** The experience of Service Users reported in research and guidance and Carers spoken with suggest that they believe an unequal share of risk falls to them outside institutional settings. This will be especially important to those being resettled into the community with long-term conditions, with potential to provide confidence to weather crisis without recourse to hospital.

**The Social Care offer is accessible, clearly articulated and advertised and straightforward.**

**5.5** For Mental Health Service Users, their Carers, families and supporters, the Social Care offer is not clear. It is mainly located in a complex secondary care system. It is hard to pick out the Social Care elements clearly in the mix.

**5.6** Local Voluntary Sector partners want to make personalisation work in Barking and Dagenham, but struggle with its requirements, are not clear on the criteria applied for a personal budget payment; and the logistical difficulties of forming group activities using personal budget payments.

### **Social inclusion**

**5.7** Social inclusion is entirely consistent with Council's intention. This is an important Council issue in relation to making progress in enabling social inclusion become a reality for the most vulnerable citizens with long-term mental health conditions, living well in the community and beyond intermediate institutional settings.

### **Social Work to the front of the system and into Locality Teams**



**5.8** Social Work is the core discipline for Social Care; it is regulated, practised and supervised as a distinct, professional discipline. To be most effective in integrated, multi-disciplinary settings, it must retain its distinct professional identity and be located where this can have greatest benefit. To have greatest benefit, Social Work needs to be positioned at the front of secondary care mental health settings rather than deep within it, so that it is integrated into baseline, preliminary assessments. Unless this happens, it is increasingly difficult to introduce it later to promote social change and development.

## **Positives**

**5.9** There are a number of strengths in the system.

- The Resource Allocation Management Panel (RAMP) is well run and a good example of LBBB Housing, LBBB Commissioning, NELFT (Health and Social Care) working well together as partners with collaborative understanding and sharing in challenging and complex situations. Actions are acted upon from the Panel with an update at the next meeting. Care packages, placements, personal budgets have all been brought in within budget.
- I observed effective working that placed Users at the heart of the process, with positive user feedback, of resettlement work being undertaken by LBBB Commissioning with NELFT input.
- The Suicide rate is one of the lowest in London and the delivery of the Suicide Prevention Strategy, which is being updated, has had in part contributed to this rate.
- The CCG commission NELFT to deliver Talking Therapies as part of the IAPT provision which has a good reputation with positive outcomes though some professionals have commented that the Service needs to target more BAME referrals.
- The Care and Support Hub is funded by LBBB Council and offers information and advice about care and support services for anyone in the Borough who is over 18 and thinks they need some help to live independently. It is also for people who are caring for someone. The website is designed to help people find information about care and support, and search for local groups, activities and services. There is a link page for Mental Health that encourages accessing Services via the person's GP. It is a recognized and well-respected Service which had 6,000 sessions recorded for November 2016.

- The Big White Wall, along with SuppotNetwork and the planned London Digital Wellbeing, provide access and support to a relatively younger range of people who would not necessarily engage with Services.
- The Memory Service is respected with timely and reflective practice.
- The Carers' Centre, with limited funding, is providing much needed services. For instance they run a Peer Support Group for Carers of people with mental health problems, and also provide advocacy, signposting and information and support for Young Carers.

**5.10** These are all fit for purpose, show good examples of innovation and are forward thinking, anticipating some of the issues Barking and Dagenham have and will face.

### **Three interconnecting areas**

**5.11** The Barking and Dagenham Joint Mental Health Strategy has the purpose to set direction and commitments, predict and shape, and reduce a reliance on being reactive. The Health and Wellbeing Board have signed off the Strategy. The Strategy is in its infancy and needs strong Senior Commissioning leadership to take forward wider partnership working and the aspirations of the Strategy.

**5.12** The absence of a focus on Social Care outcomes within Adult Mental Health Services puts the delivery of a Social Care offer at a disadvantage in relation to Health. This introduces several problems, including lack of assurance to London Borough of Barking and Dagenham and limiting the opportunities to mental health Service Users to become full citizens.

**5.13** Making delivery fit for purpose i.e. having strong signs of safety, social inclusion and opportunity, community not institutional site for intervention, prevention agenda, and moving in the direction of parity of esteem between mental and physical health from a Social Care perspective.

### **Challenges**

**5.14** The current challenges are:

- Same or increasing demand, with smaller resource envelope going forward, requires a rethink of supply and capacity.

- To protect what's good and what works and change what is less effective, mainly as a result of repositioning in the integrated arrangement.
- The opportunity for improvement with cost reduction, is in having better community support for long-term conditions replacing institutional living and stronger prevention, earlier intervention, greater accessibility and better transitions.
- Direct negotiation with the health provider is required in order to seek agreement on reordering the sites of integration, whilst maintaining strong partnership and reformed integration.
- The reordering of integration will reveal that there is shortfall at an operational level in Social Care Leadership in Mental Health and potentially a shortfall in a stable workforce and over reliance on locums.
- Resetting the working relationship with local Voluntary Mental Health Sector through commissioning and operations management, because of the value and skills these partners can bring into new supply arrangements around personalisation, peer support and safe environments.

## 6 RISKS

Issue	Description	Mitigation	Risk Rating
<b>6.1 Relationship with the CCG</b>	Implementing the Review will test durability of partnership between the Council and the CCG in relation to delivering change involving a large strategic provider.	Meet with CCG to review recommendations and seek their support in making integration reforms. These are consistent with CCG objectives, since it brings Social Work to the front of the primary care-secondary care interface in the management of complex care.	<b>Medium</b>
<b>6.2 Negative response from the MH Trust</b>	NELFT may perceive integration reform as a threat to its interests and to the running of safe service delivery and incurring extra costs. There may be resistance and limited capacity for change.	Direct negotiation by Council with MH Trust seeking full partnership on integration reform in the context of reviewing the Section 75 agreement and CCG supporting this. NELFT realigning their structures in line with locality developments.	<b>High</b>
<b>6.3 System homeostasis</b>	System Reform introduces disruption to an already changing landscape (including presentation by the Trust to the CCG of additional health costs as a result of reform) and impact of other London Boroughs that NELFT work with. There could be challenges around Information	Communication of mental health strategic direction through a worked-up Joint Mental Health Strategy.  An Implementation/Delivery Plan is required to order and manage pace of change and with a Reference Group including CCG, MH	<b>Medium</b>

	sharing and risk if the process is not managed collaboratively in partnership.	Trust, Voluntary Sector and Primary Care and Service Users and Carers.	
<b>6.4 Mental Health Social Care Budget</b>	Reform must be achieved within context of further significant Council budget reduction at a time of the impact of austerity and a challenging financial climate. Successful take up of personal budgets and direct payments will bring additional cost pressures	Budget saving must be achieved. This Review is not intended to be part of a cost saving exercise. An area of cost reduction is potentially in accommodation, which is currently being reviewed and Section 117 liability.	<b>Medium/ High</b>
<b>6.5 Unmet need</b>	Despite benefits of system reform to bring about better user outcomes, there is unlikely to be sufficient resource capacity to address unmet need and rising demand.  The hidden needs of the BaME Communities should be better identified and addressed.	Presence in the development of working more closely with GP's and Community Solutions as a route to developing fuller understanding of local community and neighbourhood resources, so that these can be deployed to support wellbeing, prevention and recovery and also identify gaps.	<b>Medium</b>
<b>6.6 Social work skill set and leadership and staffing levels</b>	Funding will be required to strengthen Social Care leadership and staffing levels and ensure stability.  Reform will be reliant on workforce deployment based on the relevant knowledge, process, skills and experience at the right points in the service system.	The Implementation/Delivery Plan needs to include a review of current skills set to support improved outcomes around reablement, personalisation, community crisis support, AMHP Service, Safeguarding, family interventions and Carers' assessments and primary care interface. A strong workforce-training plan will be needed.	<b>Medium/High</b>

## 7. RECOMMENDATIONS

**7.1** These recommendations are intended to enable the Council and its partners to focus on strengthening the local Mental Health Strategy; reform integration; make stronger arrangements with providers around mental health service delivery; and to stimulate further service innovation around co-production and peer support. The overall purpose to be achieved is that more Barking and Dagenham people have good mental health and tenure in the community in its broadest sense.

**7.2** It is recommended that the Council:

- Implement and develop with NHS Barking and Dagenham CCG the Joint Mental Health Strategy providing Senior Commissioning leadership.
- Renegotiate with the Mental Health Trust the sites of integration and the deployment of seconded Social Care workforce, within the defined resource envelope, towards the front of secondary care and at the interface with primary care.
- Give consideration to the Older Persons Mental Health Team becoming part of the LBBB Integrated Care Management Services.
- Maintain a strong commitment to proactive partnership working with NELFT.
- Bring focus to bear on supporting people living with long-term conditions in the community, through closer work with for example LBBB Housing Team and assurance around reablement and crisis support in partnership with the Mental Health Trust.
- Strengthen User and Voluntary Sector working relationships.
- Address the immediate priority “back to basics” findings in this Review around the AMHP Service/Safeguarding/Staffing retention and leadership and implementing the Care Act.

**7.3** The key findings of the review were as follows:

- 1** In many areas Barking and Dagenham already has a version of ‘what good looks like’ in mental health. There is evidence of many areas of good practice, local initiative and strengths across Adult Mental Health Services. The challenge is to make this

sustainable with clear Care pathways that reflect the priorities and direction of travel for the Local Authority and keep pace with rising demand and complexity.

- 2 Social Care outcomes are not as clearly articulated as Health Care outcomes in the current integrated arrangements. These Social Care outcomes are not addressed as a priority in the current arrangements and shortfall in the delivery of the Social Care Local Authority Statutory functions addressed reactively.
- 3 During the course of the Review immediate concerns around Safeguarding and AMHP provision and staff recruitment and retention have had to be prioritised for robustly being addressed.

#### 7.4 Implementing effective change will require:

- Implementation of the Joint Mental Health Strategy through effective channels. Consideration needs to be given to strengthening the Mental Health Sub Group and have some facilitated sessions at the outset to map out the firm development of the Strategy ambition. The Mental Health Sub Group should be Senior Commissioner-led given the scale, complexity and importance of the task.
- Ensure that the Local Authority's statutory duties under the Mental Health 1983 (as amended 2007) and the Care Act 2014 and other key legislation are fully and effectively discharged.
- Ensure that there is a critical mass of staff with sufficient experience and leadership and managerial input within Mental Health Social Care. Strengthen recruitment, retention and forward planning and strengthen the Social Care identity. There is a need for a comprehensive training and learning programme to support the skilling of staff to undertake the required roles and to promote team development. The workforce needs to be valued and be stable.
- Stronger championing of Mental Health delivery and ownership and direction from within the Local Authority.
- Provide assurance that all Safeguarding referrals are properly dealt with and recorded. Continue the audit on the Safeguarding function. Resolving the impasse of recording on 2 different IT systems, which are not integrated.

- Agreement on reform of integration across statutory mental health services, and to bring Social Work nearer to the front of the system and at the interface between primary and secondary care.
- Be party at an early stage to the development of locality provision for instance with GP's and a universal offer through Community Solutions.
- Focus on supporting people living with long-term conditions in the community.
- Stronger application of Reablement and Personalisation for improved prevention and recovery.
- The Council to have more direct working relationship with Mental Health Users and the Voluntary Sector to make progress on co-production and peer support and support a richer Voluntary Sector.
- Strong focus on prevention and earlier access to help for children and young people and protecting what is already working well for key vulnerable groups.
- A Strategy developed for addressing identifying and meeting the mental health needs of the BaME Communities in Barking and Dagenham.
- Revisiting the Section 75 agreement with NELFT that reflects meeting the needs of the Community of Barking and Dagenham and delivering the Local Authority's responsibilities under the Care Act.
- The Local Authority moving towards integrated commissioning with the CCG.

### Way Forward

**7.5** An Implementation Plan is required that takes forward accepted recommendations from the Review within a prescribed timetable. Immediate concerns around Safeguarding, AMHP Provision, staff recruitment and retention, level of staff provision, composition of staff group, and strengthening Senior Social Care Leadership should as a priority be immediately addressed. Stronger forward planning is needed and a refocus of delivering a transformed personalised Mental Health Social Care offer under the Care Act.

**Richard Adkin January 2017**



**8. SOURCES AND REFERENCES**

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17. NELFT /LBBD v2 2016 Section 75 Agreement.
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23. The Adult Psychiatric Morbidity Survey (September 2016).
24. NHS Digital Report (Nov 2016) Detentions under the Mental Health Act 2015/6.
25. London Mental Health Dashboard 2015/6.

**9. APPENDICES**

1. Terms of Reference
2. Background brief note re Review
3. People interviewed and Meetings attended etc.
4. Staffing Levels-LBBD and sample of similar Local Authorities
5. Care Act-Safeguarding summary
6. Key themes from BASW paper
7. London Mental Health Dashboard 2015/6-some key points

**Appendix 1****LB BARKING AND DAGENHAM MENTAL HEALTH REVIEW  
TERMS OF REFERENCE****1. Background**

The London Borough of Barking and Dagenham is responsible for the quality of mental health social care outcomes for the local authority area, including meeting its statutory requirements, The Council must be assured that appropriate safeguarding arrangements are in place for all residents. The Council must ensure sufficient and tangible social care value for LBBD residents from the investment the Council makes in meeting local mental health needs.

A review of the current social care offer for mental health social care, primarily for Adults, has been commissioned by the Council and is being undertaken to understand the processes and quality of current services and ensure that this is consistent with the direction of travel of the Local Authority. There will be a particular focus on social care outcomes, such as safeguarding and personalisation, and how these outcomes are met through integrated multi-disciplinary teamwork in partnership with North East London NHS Foundation Trust, as well as through wider commissioning arrangements.

With the introduction of the Care Act 2014, Councils must make arrangements to use a single national threshold for access to Social Care provision. A Social Care approach is at the heart of the Care Act 2014 with the core principles of promoting wellbeing through prevention, reduction and delay in the need for higher levels of intervention, support and care and stronger mobilisation of individual, family and community capability.

There is a backdrop of immense financial challenges in local government particularly at this point in time, but no overall savings are being sought in the Review and in the transformation of the Social Care offer.

### **2. Principles of Mental Health Social Work Practice and Role**

The College of Social Work (*The Role of the Social Worker in Adult Mental Health Services- Dr. Ruth Allen April 2014*) have articulated five key areas of practice that frame the function of social care delivery. The role categories are:

- Enabling citizens to access the statutory social care and social work services and advice to which they are entitled, discharging the legal duties and promoting the personalised social care ethos of the local authority.
- Promoting recovery and social inclusion with individuals and families
- Intervening and showing professional leadership and skill in situations characterised by high levels of social, family and interpersonal complexity, risk and ambiguity.
- Working co-productively and innovatively with local communities to support community capacity, personal and family resilience, early intervention and active citizenship.
- Leading the Approved Mental Health Professional Workforce.

### **3. Scope of the Review**

*To review the opportunities available to improve the local offer to LBBB residents by:*

- Reviewing the current operational model and the extent to which it meets safeguarding and social care needs through delivering mental health social care outcomes;
- Reviewing current commissioning arrangements and the extent to which these meet strategic priorities in relation to delivering mental health social care outcomes;
- Reviewing value for money in relation to LBBB's expenditure in relation to mental health.

### **4. Key areas of focus of the Review**

*The focus of the Review will include:*

- Considering the Section 75 Agreement with North East London NHS Foundation Trust for the operational delivery of integrated statutory mental health services and the deployment of social work skills.
- Reviewing the effectiveness and priorities of the Section 75 Agreement in discussion with Barking and Dagenham Clinical Commissioning Group in achieving broader mental health partnership commissioning arrangements.
- Looking at Safeguarding practice and governance arrangements and lessons learnt from serious incidents.
- Reviewing transitions into Older Persons Mental Health Services and Children and Young People's transitions into Adult Mental Health Services.
- Considering the interfaces between Adult Mental Health, Substance Misuse Services, Housing, Complex Need and CLDT, particularly in relation to supporting people with a Dual Diagnosis.
- Ensuring that there is alignment with other Council and Partnership Developments for instance Community Solutions, reorganisation of clusters, Barking and Dagenham Ambition 2020 Programme etc.
- Looking at the provision and retention of LBBD AMHP's and the relationship with the Out of Hours Service. Giving consideration to the over representation of Black and Minority Ethnic groups being formally detained.
- Assessing quality of the current LBBD mental health and accommodation system, including nursing care, residential care, supported living, supported housing and community-based floating support services and its effectiveness in managing crisis and supporting tenure and wellbeing in the community.
- Articulating and looking at the effectiveness of key social care outcomes such as personalisation, carers' assessments, employment etc. and considering the current thresholds for engagement with the Mental Health Social Work resource, and the potential benefits of increasing community and preventive support.
- Determining Care Act compliance around a range of areas including prevention, early intervention and access and thresholds, wellbeing and promoting co-production with users and carers.
- Reflecting on the development of the Voluntary Sector for stronger and safer communities and BaME provision.

## 5. Governance

### Sponsorship:

Tudur Williams- Operational Director: Adult's Social Care | Service Development & Integration

Mark Tyson- Commissioning Director, Adults' Care and Support.

### Overview of Review:

Tudur Williams Operational Director: Adult's Social Care | Service Development & Integration

### Undertaking of the Review:

Review Co-ordination and Project Management: Richard Adkin.

## 6. Methodology

*Views to be sought from key stakeholders, including:*

- Service users, carers, families and their advocates;
- LBBD mental health practitioners
- Barking and Dagenham CCG;
- North East London NHS Foundation Trust
- Other Council Departments, including Housing
- Senior officers in LBBD Social Services and Elected Members
- Other key stakeholders e.g. Healthwatch and the Voluntary Sector.

*Analysis of performance data in relation to mental health social care outcomes, including benchmarking where possible.*

*To take account of previous reports, including, JSNAs and, Barking and Dagenham Mental Health Strategy 2016-8;*

*Impact of legislative and national and local policy change including The Care Act 2014 implementation, the NHS “5 year Forward View”, ADASS “Distinctive, Valued, Personal-Why Social Care Matters-The Next 5 Years” and Parity of Esteem.*

*Relevant background papers eg BASW paper-“Report of the Inquiry into Adult Mental Health Services in England BASW All-Party Parliamentary Group on Social Work September 2016” and “Social Work for better mental health” DOH 2016.*

### **7. Key Review outcomes**

To advise the Council on key risks and recommend how these may be mitigated.

To advise on gaps in meeting needs in relation to safeguarding and social care.

To make recommendations on improving the LBBB mental health social care offer.

To provide assurance that there is sufficient social care resource in terms of quantity and quality and located where it can most effectively be delivered.

To provide assurance that LBBB is meeting its statutory duties under the Mental Health Act 1983 (as amended 2007) as well as the Care Act 2014.

### **8. Reporting timetable**

17<sup>th</sup> October 2016-Completion of Review Date.

Week 1-Brief introductory background paper agreed.

End of Week1-Draft Terms of Reference- and agreed with Sponsors beginning of week 2.

Weeks 2-7 - Interviews, visits, policy and report reading etc.

Week 8 - Initial Report drafting, analysis and checking out lines of enquiry.

Week 9 - (Week beginning 12<sup>th</sup> December 2016)-Draft Paper to the Operational Director.

Week 11/12 - Finalised paper to the LBBB Management Board.

**Richard Adkin 27th October 2016**

Appendix 2

**LB BARKING AND DAGENHAM ADULT SOCIAL CARE MENTAL HEALTH REVIEW**

The London Borough of Barking and Dagenham is responsible for the quality of mental health social care outcomes for the local authority area, including meeting its statutory requirements, The Council must be assured that appropriate safeguarding arrangements are in place for all residents. The Council must ensure sufficient and tangible social care value for LBBDD residents from the investment the Council makes in meeting local mental health needs.

A review of the current social care offer for mental health social care, primarily for Adults, has been commissioned by the Council and is being undertaken to understand the processes and quality of current services and ensure that this is consistent with the direction of travel of the Local Authority. There will be a particular focus on social care outcomes, such as safeguarding and personalisation, and how these outcomes are met through integrated multi-disciplinary teamwork in partnership with North East London NHS Foundation Trust, as well as through wider commissioning arrangements.

With the introduction of the Care Act 2014, Councils must make arrangements to use a single national threshold for access to social care provision, the duty to promote well-being in undertaking care and support functions, prevent or delay the need for care and support.

An important part the Review is meeting and hearing the views of staff, and key partners and stakeholders such as users and carers.

An initial draft report will be produced for the Operational Director of Adults Care and Support.

I have a number of years experience working in Mental Health at a senior level in Social Care, Health, The Voluntary Sector and Regulation and will be undertaking the Review commencing on 17<sup>th</sup> October 2016 for 3 days a week.

I look forward to hearing from you.

**Richard Adkin**

Social Care Mental Health Review Coordinator-LBBDD

07930 462149 (m)

[Richard.Adkin@lbbd.gov.uk](mailto:Richard.Adkin@lbbd.gov.uk) (email)

19<sup>th</sup> October 2016



Appendix 3

**STAKEHOLDER ORGANISATIONS, GROUPS AND PARTICIPANTS MET IN RELATION TO THE  
REVIEW**

**Users** of mental health services in Barking and Dagenham

Rowney Road residents

Knights Close residents

**LBBB**

Cllr. Worby-Portfolio Holder Social Care, Adults and Children and Health Integration and Leisure.

Anne Bristow-Strategic Director/Deputy Chief Exec

Tudur Williams-Operational Director Adults Care and Support LBBB

Mark Tyson-Commissioning Director LBBB

Louise Hider-Principal Commissioning Manager

Michael Fenn-Integrated Commissioning Manager

David Millen-LBBB Commissioner Lead

Stefan Liebrecht- Service Manager Adults

Cathie Kelly-Integrated Commissioning Manager

Lewis Snell Drake- Integrated Commissioning manager

Andrew Hagger-Health and Social Care Integration Manager

Glen Oldfield –Equalities Lead

Angela York-Intake Manager

David Murray-Project Director Interim Solutions

Gordon Hastie-Quality Assurance and Safeguarding Adult Board Manager ASC

**LBBB/NELFT**

Kevin Sole-Assistant Integrated Care Director LBBB/NELFT

Olu Oye-Bamgbose-Social Work Lead LBBB/NELFT

LBBB AMHP's

LBBB-Mental Health Social Work Staff

**NELFT**

Melody Williams- Director of Integrated Services (B and D)

Jenny Redpath-Service Manager Older Adults Mental Health

**CCG**

Sharon Morrow-Chief Operating Officer LB Dagenham CCG

Sarah De Sousa-Deputy Chief Operating Officer

**Public Health**

Sue Lloyd-Consultant Public Health

Michael Williams-Senior Public Health Commissioner

**Voluntary Sector**

Lorraine Goldberg-Carers in Barking and Dagenham

**Meetings**

Section 75 Executive Steering Group Mental Health-attendance at 2 meetings

Resource Allocation Management Panel X 2 involving Housing, NELFT, LBBB

Mental Health Sub Group

Visit by the Chief Social Worker for Adults, Lyn Romeo, to meet the LBBD Social Workers and Senior officers. 8/12/16

Meeting with LBBD AMPH Group

Meeting with Mental Health Social Workers-Older Persons and Adult

Meetings with Safeguarding Team and NELFT x2 re concerns around safeguarding

Health and Wellbeing Board 31/1/17

Shadowing AMHP Service- day with Duty AMHP's and Community Mental Health Team  
18/1/17

## Appendix 4

## MENTAL HEALTH SOCIAL CARE STAFFING LEVELS IN COMPARATIVE LONDON BOROUGHES

LB Newham Population 332,800	
Service Manager	1
Principal Social Worker	1
Team Managers	4
Admin	4
Practice Managers	3
Senior Practitioners	7
Social Workers	20
Senior Support Workers/enablers	2
Specialist Support Worker (No Recourse)	1
Support Workers / Enablers	13
<b>Total</b>	<b>56</b>

LB Southwark Population 308,900	
Assistant Director (16)	1
Service Development Manager (14)	1
Service Manager (14)	1.6
Team Manager (12)	4
Deputy Manager (11)	3
Advanced Practitioner (11)	4
Social Worker (10)	15
Occupational Therapist (10)	6
Business Manager (8)	1
Assistant Practitioner (8)	4
Business Support Officer (6)	3
Apprentice (4)	1
<b>Total</b>	<b>44.6</b>

In addition-Substance Misuse Team is now integrated with Mental Health Adult Social Care Principal Social Worker for Adults also supports staff development.

<b>LB Barking and Dagenham Population 202,000</b>	
Joint Assistant Integrated Care Director-NELFT/LBBD	0.5
Lead Social Worker	1
Senior Social Workers	4
Social Workers	14
Community Case Worker (OP)	1
Support Workers	2
Admin Staff	2
<b>Total</b>	<b>24.5</b>

**Adults and Older Persons MH - LBBD**

Based predominantly in the Community Recovery Team and Older Persons Team with only 1 Social Worker in Intake and Access Service and Home Treatment Team

- 1 AMHP Lead and Social Care Lead
- 3 Senior Social Workers
- 12 Social Workers
- 2 Support Workers
- 2 Admin staff

Older Persons:

- 1 Senior Social Worker
- 2 Social Workers
- 1 Community Care Worker

1/3 qualified staff are locums including 4 AMHP locums out of 8 AMHP's and 2 of the 4 Seniors are locums.



## Appendix 5

## The Care Act - Care and Support Statutory Guidance (updated October 2016)

<https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>

**Care Act Guidance 2016 on roles & responsibilities:**

**14.10** - The Care Act requires that each local authority must:

- Make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect and if so, by whom.
- Co-operate with each of its relevant partners (as set out in section 6 of the Care Act) in order to protect the adult. In their turn, each relevant partner must also cooperate with the local authority.

**Local Authority's role in carrying out enquiries**

**14.78** - The purpose of the enquiry is to decide whether or not the local authority or another organisation, or person, should do something to help and protect the adult. If the local authority decides that another organisation should make the enquiry, for example a care provider, then the local authority should be clear about timescales, the need to know the outcomes of the enquiry and what action will follow if this is not done.

**14.81** - Professionals and other staff need to handle enquiries in a sensitive and skilled way to ensure distress to the adult is minimised. It is likely that many enquiries will require the input and supervision of a social worker, particularly the more complex situations and to support the adult to realise the outcomes they want and to reach a resolution or recovery. For example, where abuse or neglect is suspected within a family or informal relationship it is likely that a social worker will be the most appropriate lead. Personal and family relationships within community settings can prove both difficult and complex to assess and intervene in. The dynamics of personal relationships can be extremely difficult to judge and rebalance. For example, an adult may make a choice to be in a relationship that causes them emotional distress which outweighs, for them, the unhappiness of not maintaining the relationship.

**14.82** - Whilst work with the adult may frequently require the input of a Social Worker, other aspects of enquiries may be best undertaken by others with more appropriate skills and knowledge. For example, health professionals should undertake enquiries and treatment plans relating to medicines management or pressure sores.

**When should an enquiry take place?**

**14.93** – Local Authorities must make enquiries, or cause another agency to do so, whenever abuse or neglect are suspected in relation to an adult and the local authority thinks it necessary to enable it to decide what (if any) action is needed to help and protect the adult. The scope of the enquiry, who leads it and its nature, and how long it takes, will depend on the particular circumstances.

**Who can carry out an enquiry?**

**14.100** – Although the Local Authority is the lead agency for making enquiries, it may require others to undertake them. The specific circumstances will often determine who the right person is to begin an enquiry. In many cases a professional who already knows the adult will be best person. They may be a Social Worker, a housing support worker, a GP or other health worker such as a community nurse.

The local authority retains the responsibility for ensuring that the enquiry is referred to the right place and is acted upon. The Local Authority in its lead and coordinating role, should assure itself that the enquiry satisfies its duty under s.42 to decide what action (if any) is necessary to help and protect the adult and by whom and to ensure that such action is taken when necessary. In this role if the Local Authority has asked someone else to make enquiries, it is able to challenge the body making the enquiry if it considers that the process and/or outcome is unsatisfactory.

**London Multi Agency Adult Safeguarding Policy & Procedures, 2015:****Role of the Local Authority:**

The Local Authority should decide early on in the process who is the best person/organisation to lead on an enquiry. The local authority retains the responsibility for ensuring that the enquiry is referred to the right place is acted upon. If the local authority has asked someone else to make enquiries, it is able to challenge the organisation/individual making the enquiry if it considers that the process and/or outcome are unsatisfactory. In exceptional cases, the Local Authority may undertake additional enquiry e.g., if the original fails to address significant issues.

The information in some referrals may be sufficiently comprehensive that it is clear that immediate risks are being managed, and that the criteria are met for a formal s42 enquiry. In other cases some additional information gathering may be needed to fully that the three steps are met. Decisions need to take into account all relevant information through a multi-agency approach wherever possible, including the views of the adult taking into consideration mental capacity and consent (see best practice). The degree of involvement from the local authority will vary from case to case, but at a minimum must involve decision making at the conclusion of the enquiry about what actions are required, ensuring data



collection is carried out, the quality assurance of the enquiry has been undertaken. The manager acting in the role of the SAM at the time makes the decision on how the enquiry is progressed.

**4.3.4 Role of the Enquiry Officer:**

An enquiry officer is responsible for undertaking actions under adult safeguarding. In some instances there is a lead Enquiry Officer supported by other staff also acting as enquiry officers, where there are complex issues or additional expertise is required. The lead enquiry officer will retain responsibility for undertaking and co-ordinating actions under s42 enquiries.

**4.3.5 Role of Safeguarding Adults Manager (SAM):**

The Safeguarding Adult Manager is the member of staff who manages, makes decisions, provides guidance and has oversight of safeguarding concerns that are referred to the Local Authority. In the majority of cases, unless it is safe to do so each enquiry will start with a conversation with the adult at risk. The SAM should ensure if conversations have already taken place and are sufficient. The adult and/or their advocate should not have to repeat their story.

In many cases staff/organisation who already knows the adult well maybe best placed to lead on the enquiry. They may be a housing support worker, a GP or other health worker such as a community nurse or social worker. While many enquiries will require significant input from a Social Care practitioner, there will be aspects that should and can be undertaken by other professionals.

## Appendix 6

**BASW Paper-“*Report of the Inquiry into Adult Mental Health Services in England-BASW All-Party Parliamentary Group on Social Work, September 2016*”****Key themes from the BASW paper considered in this Report**

- Impact of austerity on people’s vulnerability and mental health.
- Putting co production and personalised support at the heart of the mental health system.
- Service systems are becoming more complex, fragmented and harder to navigate.
- The role and identity should be developed as “Social Worker” rather than “Care Coordinator”.
- Early intervention, flexibility around transitions, tackle social determinants of mental health problems.
- Focus on work with Carers and families.
- Respond more cogently to dual diagnosis.
- Address inequalities around access.
- Stronger workforce planning and a greater need to look after the valued workforce.
- Innovative integration needs to be progressed (but is not defined). Local solutions promoted.
- CCG’s need to be delivering on bed and detention reductions.

**Appendix 7****London Mental Health Dashboard-Summary Report December 2016****Some Key Points.****NHS Barking and Dagenham****North East London NHS Foundation Trust**

The Comparator is with the 9 London Mental Health Trusts and 32 London Clinical Commissioning Groups:

The data for Barking and Dagenham shows that people in contact with Mental Health Services is below the London average for Barking and Dagenham.

The percentage of people completing the GP patient survey who report a long-term mental health problem was by far the lowest of the London Boroughs.

IAPT referrals were below average but the percentage of IAPT referrals who entered treatment within 28 days of referral was the highest for London.

The Community Contacts by specialist Mental Health Community Teams per 100,000-registered population was above average.

Percentage of Service Users on CPA in employment was average.

Percentage of Service Users on CPA in settled accommodation was well above average.

Admissions to inpatient care was below average and average under the Mental Health Act.

Women accessing perinatal community services was 200 which is far the highest of the 32 London CCG's –with average perinatal admissions.

The Dementia diagnosis rate is below average and the rate measures the number of people on Dementia registers against the estimated prevalence in that area.

NELFT figures for the Boroughs it serves are stronger on community contacts, Crisis Resolution and Home Treatment contacts.

NELFT have by far the lowest Adult Acute beds per 100,000 registered population and lowest acute admissions and length of stay and low Adult Acute total staff per 10 beds.

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Communication Plan-Implementing LBBD Mental Health Social Care Review

Audience/ Meeting	Frequency/ dates	Type	Purpose	Owner
Task and Finish Group (MH)	Fortnightly	Internal Project Sponsor Group Oversight	Provide oversight Agree the model of delivery for Mental Health Social Care Co-opt Legal/HR/Finance Leads etc	Operational Director Adults and Social Care
Partner Advisory Meeting	Workshop	Wider Partnership Meeting	Senior Multi Agency meeting including NELFT/Vol Sector/CCG/Users/Housing/C and F/Public Health. To promote wider partnership, communication etc. Connection with Mental Health Strategy and locality developments	Programme Manager (Care and Support) MH Design Lead
Staff	Series of workshops	Full staff member meetings/ workshops	Involve staff and update staff in transformation Training and Development and ownership of model Formal Consultation with staff members AMHP Service reconfiguration Social Work for Better Mental Health Programme	Programme Manager (Care and Support) MH Design Lead Dr. Karen Linde (DOH)
Portfolio Holder/ Strategic Director	As requested	Signing off + Briefings	Sign off the Review and the proposed Implementation Plan. Updates on progress of the project Agreement of actions eg Informing Senior Partners of intentions Governance to Cabinet and Health and Wellbeing Board (6 <sup>TH</sup> July 2017)	Programme Manager (Care and Support) MH Design Lead
LBBD/CCG/ NELFT Communication group	To be established in late Summer 2017	Communication by Partners	Communication to Users/Carers/GP's/Stakeholders  Clear message re changes of practice, access, location etc. when finalised and manage expectations from October 1 <sup>st</sup> 2017 when the transformed model is rolled out.  Information Page on Council Website	Programme Manager (Care and Support) MH Design Lead
Service Users and	Consultation	Users / Carers	Briefing and Focus Groups-BME Groups, Carers, Users, Dual Diagnosis Users, Healthwatch	Programme Manager (Care and Support)

Audience/ Meeting	Frequency/ dates	Type	Purpose	Owner
Stakeholders				MH Design Lead
Steering Group and Sponsor Group	Monthly	Senior Leads Meeting	Developing the Implementation Plan and Partnership whole systems working Section 75 termination. CCG/NELFT/LBBD PID	Director of Commissioning/ Operational Director Adults
NELFT	Regular Ops Meeting	Partnership and Integration Meeting	Initial Meeting Director of Commissioning/Operational Director Adults re working together. Drive forward integration, partnership, collocation, shared understanding and practicalities of delivery, caseloads, eligibility, roles and responsibilities. Information sharing and migration.	Programme Manager (Care and Support) MH Design Lead. Implementation Project Manager, Social Care Lead
Stakeholder Events	Series of 1 off workshops	Stakeholder Engagement	Communication of how people and teams access the Service and what is the offer.  1). Joint NELFT/Local Authority event for Health and Social care staff re joint work, transfers and related issues 2) GP/CCG event re access and model 3) LBBD event-Housing, Children’s Services, Adult Social Care 4) Open events for Users, Carers, 3 <sup>rd</sup> Sector, partners	Programme Manager (Care and Support) MH Design Lead
Locality Development Meeting	weekly		Taking Forward the 3 Localities from October 1 <sup>st</sup> 2017	Head of Integration
Joint Mental Health Strategy		Steering Group	Take forward the Joint MH Strategy	Director of Commissioning
Thrive	Initial Meeting May 2017	Pilot Project Initiative	Potential Mayor of London Initiative to tackle deprivation and promote community cohesion and wellbeing	Portfolio Holder and Senior Officers Mayor of London’s Office MH Foundation

Richard Adkin 6<sup>th</sup> June 2017

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## HEALTH AND WELLBEING BOARD

5 July 2017

<b>Title:</b> Procurement of Integrated Adult and Young People Substance Misuse (Drug and Alcohol) Services	
<b>Report of the Cabinet Member for Social Care and Health Integration</b>	
<b>Open Report</b>	<b>For Decision</b>
<b>Wards Affected:</b> All	<b>Key Decision:</b> Yes
<b>Report Author:</b> Sonia Drozd, Strategic Manager Substance Misuse, Adults' Care & Support, Service Development and Integration	<b>Contact Details:</b> Tel: 020 8227 5455 E-mail: <a href="mailto:sonia.drozd@lbbd.gov.uk">sonia.drozd@lbbd.gov.uk</a>
<b>Accountable Director:</b> Mark Tyson, Commissioning Director, Adults' Care and Support.	
<b>Accountable Strategic Director:</b> Anne Bristow, Strategic Director, Service Development and Integration	
<p><b>Summary:</b></p> <p>Substance misuse (drug and alcohol) is defined as intoxication by or regular excessive consumption of and/or dependence on psychoactive substances, leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs (including alcohol when used in combination with other substances). Drug or Alcohol misuse can have a major impact on people's life chances and significant impact on health services, crime and community safety and is an important contributor to adult and children's social care needs</p> <p>London Borough of Barking and Dagenham (LBBD) currently have contractual provisions in place for the delivery of a range of young people and adult drug and alcohol service treatment services by different service providers across the Borough. These services play a key role in promoting recovery and reducing the harm caused by alcohol and drug misuse which are a significant cause of health inequalities in Barking and Dagenham.</p> <p>The provisions are currently made up of 4 adult services and 1 young people service with a total spend of circa £2.3m per annum;</p> <ul style="list-style-type: none"> <li>• Community Alcohol Service- £409,883 per annum</li> <li>• Horizon service- £339,631 per annum</li> <li>• Recovery management Service &amp; Prescribing service - £1,082,015 per annum</li> <li>• Intuitive Recovery Programme £30,000 per annum</li> <li>• Subwize Young People's Service £302,643 per annum</li> </ul> <p>All the contracts are due to expire on 31<sup>st</sup> March 2018 with the exception of the Young People service contract which is due to expire 30<sup>th</sup> November 2017; there are no provisions within the contracts for extensions.</p> <p>This report seeks approval for the Council to proceed with the procurement of an integrated</p>	

substance misuse service under two contracts (adults and young people).

It is proposed that going forward, the services will be delivered as two distinct services;

- Lot 1: Young People's Integrated substance misuse service
- Lot 2: Adults integrated substance misuse service

The young people's service contract (Lot 1) will be awarded to the successful provider for a period of 5 years and 4 months (3 years and 4 months initially with the option to extend for a further 2-year period). The adult's service contract (Lot 2) will be awarded to the successful provider for a period of 5 years (3 years initially with the option to extend for a further 2-year period).

Streamlining the system will enable the council to make efficiencies and ensure improved outcomes for service users.

### **Recommendation(s)**

The Health and Wellbeing Board is recommended to:

- (i) Agree that the Council proceed with the procurement and award the contract for the provision of an integrated substance misuse service for adults and young people respectively in accordance with the strategy set out in the report; and
- (ii) Delegate Authority to the Strategic Director of Service Development and Improvement, in consultation with the Director of Public Health, Chief Operating Officer and the Director of Law and Governance, to award the contracts for the provision of an integrated substance misuse service for adults and young people respectively to the successful bidder in accordance with the strategy set out in this report.

### **Reason(s)**

The procurement exercise will ensure compliance with the Council's Contract Rules and EU Legislation and ensure continued service provision beyond the contract end dates.

The new services would support the Council's priority of enabling social responsibility, through improving access to healthcare, protecting the vulnerable and encouraging people to take responsibility for their health and wellbeing. It would also contribute to the Council's commitment to borough growth by supporting those with substance misuse problems into employment.

## **1. Introduction and Background**

- 1.1 Substance misuse (alcohol and drugs) is a cause of considerable harm to the health and wellbeing of Barking and Dagenham residents. In Barking and Dagenham, it is estimated that there are currently over 1,000 individuals who use opiates and/or cocaine and over 7,000 people using cannabis according to the National Crime Survey for England and Wales and 2011 census population figures.

In addition, it is estimated that about one in five of the adult population in Barking and Dagenham are hazardous alcohol drinkers (drinking over the recommended 14 units per week), with nearly 6,000 of them drinking sufficient amounts to be harmful to their health.

- 1.2 The Psychoactive Substances Act was introduced in May 2016. The Act is a legislative initiative aimed at banning psychoactive substances, and has been introduced in order to prevent the continued manufacturing of 'legal highs'. Locally, it is known that Nitrous Oxide (laughing gas) and Spice (synthetic cannabis) the main substances used by young people that engage with the young people's drug project.
- 1.3 LBBD has also set up an addiction to medicine treatment pathway to support those individuals who are either prescribed pain killers or purchase them over the counter and have subsequently become dependent on them. Drug and alcohol use has a significant impact on health services, crime and community safety and is an important contributor to adult and children's social care needs.
- 1.4 The Barking and Dagenham Substance Misuse Strategy (2016-2020) sets out the Borough's vision for improving the health and wellbeing of residents and reducing the impact of substance misuse on the wider community by 2020. The Strategy identifies a number of objectives which will underpin commissioning plans and other agreements, to work in partnership, in order to make the greatest impact across the health and criminal justice system. In line with the visions of Ambition 2020, the commissioning of substance misuse services need to be less traditional and more efficient and innovative in order to maximise the positive impact for Barking and Dagenham residents.
- 1.5 LBBD currently commission a range of open access and specialist services that enable people who misuse drug and/ or alcohol to access treatment and work towards recovery. There are currently four separate contracts for different substance misuse services providing adult drug treatment including prescribing, structured drug programme, adult alcohol treatment and young people's substance misuse support in the borough. The services are namely:

Community Alcohol Service	£409,883 per annum
Horizon service	£339,631 per annum
Recovery management Service & Prescribing service	£1,082,015 per annum
Intuitive Recovery programme	£30,000 per annum
Subwize Young Peoples Service	£302,643 per annum

- 1.6 Referrals into the services come through different means including self-referral, Criminal Justice Services, General Practice or other local authorities. The aim is to target behaviours and drug/ alcohol use, reduce usage and other consequences and improve the overall health of the individual and therefore the borough.
- 1.7 **The Adult Drug Treatment Service** is the first point of contact for any adult over 18 years who requires support, advice or treatment for a drug issue. Individuals are assessed for their needs and a recovery plan devised. Many people will require stabilisation prior to reducing their drug use, therefore the initial assessment will include identifying need around housing, health and family and friends. This service also includes a clinical service providing substitute medication to heroin users (such

as Methadone or Buprenorphine – also known as Subutex). Prescriptions are issued onsite with consumption supervised at contracted pharmacies.

- 1.8 LBBDD has set up an addiction to medicine treatment pathway to support those individuals who are either prescribed pain killers or purchase them over the counter and have subsequently become dependent on them. Drug and alcohol use has a significant impact on health services, crime and community safety and is an important contributor to adult and children's social care needs.
- 1.9 Those individuals that have been arrested for particular crimes will be drug tested at the police station for Class A drugs. Drug workers assess the individual and refer into the adult drug treatment service if appropriate. They will also support adult drug users through the court process and advocate on their behalf for community sentences with treatment requirements attached. Individuals that are due to be released from prison will be contacted in preparation for return into the community.
- 1.10 **The Adult Structured Drug Treatment Programme** is a day programme for individuals who are stable in their recovery journey and are ready to engage in more intensive group therapy. Counselling is also offered for those who require it.
- 1.11 **Community Alcohol Service-** The adult alcohol service provides advice, support and treatment for those individuals who require interventions around their alcohol use. Individuals are offered a variety of integrated and efficacy based interventions and specialised community support to assist a service user through their issues to achieve their intended goal of controlling their alcohol use. The modalities include pharmacological detox and various structured talking therapies that can include whole family counselling. Maintenance of an individual's time within the service can include interest groups such as arts, relaxation and gardening. St Luke's provides support for an individual to empower themselves for life beyond the Service with CV support, and internet access to help a service user attain employment or education.
- 1.12 **Subwise Young Peoples Service** -The young people's substance misuse service is a service aimed at young residents who are looking for advice and support around issues of substance misuse. The staff attend school assemblies and organise workshops and one to one sessions to highlight the negative effects of using drugs and alcohol. They also provide therapeutic interventions to children who have witnessed their parents or carers abusing substances. this service is key to the continuation of the preventative work that has been delivered in the borough to ensure that the next generation of substance misusers are dramatically reduced. Working with children who have been directly affected by someone using substances will equip them with the life skills they need to go onto live a healthy lifestyle. Educating young people through interactive workshops and assemblies to dispel myths around drugs and alcohol alongside other healthy relationship messages will ensure young people have the tools to make informed choices. Confidential one to one sessions are also offered to those young people who would prefer advice and support bespoke to them.
- 1.13 The Psychoactive Substances Act was introduced in May 2016. The Act is a legislative initiative aimed at banning psychoactive substances, and has been introduced in order to prevent the continued manufacturing of 'legal highs'. Locally, it is known that Nitrous Oxide (laughing gas) and Spice (synthetic cannabis) are the

main substances used by young people that engage with the young people's drug project.

- 1.14 In the last year, outcomes for drug and alcohol treatment have improved and the services in scope of this procurement strategy form a key part of the drug treatment pathway and are key to sustaining and building on this improvement. During 1<sup>st</sup> August 2015 to 31<sup>st</sup> July 2016, 1337 individuals engaged in adult drug and alcohol services and 297 successfully completed their treatment and did not return in 6 months. For opiate/heroin treatment Barking and Dagenham is the 8<sup>th</sup> highest performing borough for successful completions. The young people's substance misuse service had 88% (N=106) individuals leave the service in a planned way compared to the London average (82%) during 1<sup>st</sup> July 2015 to 30<sup>th</sup> June 2016 with cannabis and alcohol the most prevalent substances used.
- 1.15 LBBD's priorities for the drug and alcohol treatment system are to improve recovery outcomes and ensure the treatment pathway meets the changing needs of the population of drug and alcohol users. This includes:
- Supporting clients with different patterns of drug and alcohol use (i.e. meeting the needs of the increasing number of users of novel psychoactive substances and alcohol);
  - Increasing uptake of treatment for people, including young people who misuse drugs and alcohol;
  - Supporting the treatment system to better promote recovery in the opiate using population;
  - Developing more flexible and personalised services, with a greater emphasis on community based programmes.
- 1.16 The alcohol service and adult structured drug treatment contracts have been extended to fall in line with the ending of the adult drug treatment contract on 31<sup>st</sup> March 2018.
- 1.17 The young people's substance misuse contract will expire and has no scope for further extension, therefore it is expected that this part of the contract will commence sooner on 1 December 2017.
- 1.18 It is anticipated that through commissioning an integrated substance misuse service, pathways for entry into and within the treatment system will be simplified. Service users will be able to access any aspect of the service without having to be re-assessed or change keyworker or provider. This will improve retention and therefore successful completions and ensure better outcomes for service users.
- 1.19 Robust KPI's will be within the service specification including those that are monitored through Public Health England. The expectations will be that performance will always be within the top quartile of our partnership group across England. Where there is evidence that performance is declining, appropriate monitoring measures will be put in place to support the provider with improving outcomes.
- 1.20 Total contract value in last Financial Year was £2.3m and estimated spend over last three years is circa £6.9m. The funding is mainly from the Public Health grant and £110k is from Mayor's Office for Police and Crime (MOPAC). Our intention is to

deliver efficiencies (circa 200k per annum across the entire treatment pathways). Through the re-modeling of the drug and alcohol treatment pathway to a new model of integrated working will help deliver this.

- 1.21 By transferring the existing different services into an integrated service, this will reduce the capital and organisational costs of multiple providers as well as reducing duplication of provision and focusing service provision on current need. This new model makes more effective and efficient use of resources through promoting collaborative and partnership working.
- 1.22 As a result of re-modelling the substance misuse services there will potentially be a saving of approximately £200k per year. By including the Intuitive Recovery programme (£30k) and combining the group element of the horizon service will save on management costs and potentially premises. This will potentially be a saving of £1m over five years.
- 1.23 The proposed approach will also deliver a treatment service that is better integrated with primary care and has a greater focus on psychosocial interventions; provide the best outcomes for service users and enabling the service to better support the Council's strategic priorities for substance misuse treatment.
- 1.24 Re-commissioning the services described above brings together the specialist clinical expertise required, to ensure a focus on integrated care and provide expert support across the treatment pathway. It will enable the council to ensure it is meeting the complex needs of people with drug and alcohol problems and ensure that there is specialist expertise in drug and alcohol treatment that can be used flexibly across the system. It will support the management and integration of care for people with drug and alcohol problems in primary care.
- 1.25 Given that the young people's substance misuse service contract will expire sooner (30th November 2017) than the adult's substance misuse services (31st March 2018), it is recommended that the two be procured as separate lots in the same procurement exercise at the same time with the expectation that the young people element will start earlier on 1st December 2017.

## **2. Proposed Procurement Strategy**

### **2.1 Outline specification of the works, goods or services being procured.**

Core elements of the service delivered are:

#### **Lot 1: Young People's Integrated substance misuse service**

- Preventing young people in Barking & Dagenham from developing substance misuse and criminal careers and provide early interventions to those young people at risk of substance misuse and offending behaviour.
- Reducing the level of substance misuse related problems and achieve improvement in health, social, psychological, legal, welfare and life chances of young people who are vulnerable through use of illicit drugs and/or alcohol and hidden harm.

## **Lot 2: Adults integrated substance misuse service**

- Drug services: the core interventions will include prescribing, psychosocial interventions; education, training and employment support, hepatitis screening and support into blood borne virus (BBV) treatment and peer mentoring. The new service will be responsive to changing trends and have a skilled workforce that will work collaboratively with key stakeholders on a wider range of cross cutting themes.
- Alcohol services - the service will continue to provide alcohol services such as hospital liaison nurses, older people and alcohol services, community detoxification, and core alcohol interventions. The service will generate efficiencies in wider health services including through diverting alcohol users from A&E and hospital admission and reducing ambulance call outs.
- The proposed service model will respond to the needs of families through early identification and prevention work prior to reaching crisis. Specialists will work alongside family services and lead or contribute to joint needs assessments.
- The service will maintain a focus on hidden harm and prevention work with provision of bespoke training.
- The new model will also work with local criminal justice agencies by sharing intelligence and supporting the case management of offenders on integrated offender management programmes. Preventing residents of Barking & Dagenham from developing substance misuse issues and criminal careers and provide early trauma based interventions to those individuals at risk of substance misuse and offending behaviour.
- Reducing the level of substance misuse related problems and achieve improvement in health, social, psychological, legal, welfare and life chances of residents who are vulnerable through use of illicit drugs and/or alcohol and hidden harm.
- A specialist treatment service for people with drug and/or alcohol problems who have additional complex needs around mental health, offending or other health issues. The service will also deliver in-reach prescribing service to the direct access gateway service for people with substance misuse problems

The service model and specification will be reviewed prior to tender issue. Providers will be requested in their tender response to propose how to best deliver the services with room for innovation

### **2.2 Estimated Contract Value, including the value of any uplift or extension period.**

**Lot 1: Young People's Integrated substance misuse service**- Estimated cost of £1,600,000 for the 5-years and 4 months

**Lot 2: Adults integrated substance misuse service** -Estimated cost of £9,000,000 for the period of 5 years

The funding is mainly from the Public Health grant and £110k per annum from Mayor's Office for Police and Crime (MOPAC).

It should be noted that given the uncertainty over the future of the Public Health Grant, if the decision is taken to procure services over a five-year period, the contracts will need to contain appropriate termination clauses if Public Health funding ceases. The new agreements will include a clause allowing the Council early termination of this service should the grant funding which pays for the service be reduced or withdrawn

### **2.3 Duration of the contract, including any options for extension.**

#### **Lot 1: Young People's Integrated substance misuse service**

5 years and 4 months (3 years and 4 months initially with the provision to extend for a further 2-year period) from 1st December 2017 to 31<sup>st</sup> March 2023

#### **Lot 2: Adults Integrated substance misuse service**

5 years (3 years initially with the provision to extend for a further 2-year period) from 1st April 2018 to 31<sup>st</sup> March 2023.

Contract extensions will be based on performance related quality measures and delivery of key outcomes. This is considered the option which will lead to the Council obtaining best value for money and will provide a stable and supportive environment for service users.

### **2.4 Is the contract subject to (a) the (EU) Public Contracts Regulations 2015 or (b) Concession Contracts Regulations 2016? If Yes to (a) and contract is for services, are the services for social, health, education or other services subject to the Light Touch Regime?**

The contract is subject to the (EU) Public Contracts Regulations 2015 and as a health contract is subject to the Light Touch Regime. Because the estimated value of the contract is higher than the set threshold (currently EUR 750,000), it needs to be opened up to competition and be advertised in the Official Journal of the European Union (OJEU) as required by the Regulations.

### **2.5 Recommended procurement procedure and reasons for the recommendation**

The procurement will be undertaken using the competitive procedure with negotiation process under the Public Contract Regulations 2015 and will be advertised in the Official Journal of the European Union (OJEU) and Contracts Finder as required by the Regulation. This approach will allow the council to work with interested parties to design the service. This approach is more flexible and allows for more tailored and innovative specifications and solutions to be developed against an overall service model, key outcomes and performance indicators developed by commissioners.

There are several advantages to this, the opening up of the development of the specification with potential bidders will allow bidders to draw on their experience and knowledge to ensure that a bespoke solution is created for LBBD. Many



bidders will have experience of delivering such services elsewhere and will be well placed to work with commissioners to design a high-quality service model.

At this stage, therefore, it is not possible to articulate the detailed configuration of the new services, as the competitive procedure procurement with negotiation process itself will help in the design of this. Bidders would be required to put in a bid for the provision of either Lot 1 (Young People) or Lot 2 (Adults) or both Lot 1 and Lot 2.

Through the competitive procedure with negotiation, commissioners will work with the bidders to identify economies of scale for delivery. That is, some elements of the services may need to be delivered in one location, whereas others could be delivered at several locations.

The procurement approach will aim to stimulate the market to deliver innovative new service models, with strong clinical governance that will improve quality and outcomes for service users and release further cost savings.

The procurement timetable is as follows (this will be shorter for the young people's service):

<b>Activities/ Tasks</b>	<b>Date</b>
Issue PIN for Expression of Interests	May 2017 (tbc)
Market Engagement Event	Early June 2017 (date tbc)
Prepare Tender Documents (Conditions, Specification, ITT, TUPE etc)	By 23 <sup>rd</sup> June 2017
Issue contract notice /ITT (Allow min 6 weeks for tender document to be returned)	10 <sup>th</sup> July 2017
Deadline for clarifications	18 <sup>th</sup> August 2017
Return Tenders	25 <sup>th</sup> August 2017
Tender Evaluation	29 <sup>th</sup> August – 29 <sup>th</sup> September 2017
Negotiation and Final Tender return	2 <sup>nd</sup> October – 20 <sup>th</sup> October 2017
Final Tender Evaluation	23 <sup>rd</sup> October – 10 <sup>th</sup> November 2017
Prepare contract award report and get approval	13 <sup>th</sup> to 24 <sup>th</sup> November 2017
Provisional Award (notify successful/ unsuccessful Tenderer's)	27 <sup>th</sup> November 2017
Standstill Period	28 <sup>th</sup> November – 8 <sup>th</sup> December 2017
Final award	11 <sup>th</sup> December 2017
Service Mobilisation including potential TUPE transfers	Dec 2017 -March 2018
Contract commencement	1st December 2017 – young people substance misuse treatment 1st April 2018 – adult substance misuse treatment

## **2.6 The contract delivery methodology and documentation to be adopted.**

The Council's standard terms and conditions contract will be used for the delivery of the contract. A no fault termination clause will be included in the contract allowing notice to be given by the Council for early termination. This allows increased flexibility should a significant change in service provision be required.

Service performance will be monitored through a series of Key Performance Indicators (KPIs) as detailed in the service specification that includes quantitative and qualitative data, service user feedback and activity on outstanding action plans reviewed at quarterly meetings.

## **2.7 Outcomes, savings and efficiencies expected as a consequence of awarding the proposed contract**

Investing in drug treatment optimises an individual's social capital. There is a significant and growing body of evidence showing that investing in the prevention and treatment of drug and alcohol misuse improves social, physical, human and recovery capital. Delivery of the service will reduce on-costs to Council by £2.50 per £1 invested.

As individuals recover from their addiction or problem use they increase their ability to access education, training and employment, sustain appropriate housing, commit fewer crimes and improve relationships often reconnecting with their families and gain positive social networks.

The impact of not investing in this will result in a negative impact on individuals, families and the community increasing costs to health and social care systems, criminal justice systems and increases demands on the welfare benefits system. A comprehensive review and re-procurement of the treatment system to operate under a new model that delivers recovery focused services in a more streamlined and cost-effective way will benefit substance misusers, their families and the local community. It will also mean that significant savings will be achieved with minimal impact to recovery outcomes.

Our intention is to deliver efficiencies (circa 200k per annum across the entire treatment pathways). Through the re-modelling of the drug and alcohol treatment pathway to a new model of integrated working will help deliver this. The potential savings will be realised by eliminating significant duplication within the currently system. By transferring the existing different services into an integrated service, this will reduce the capital and organisational costs of multiple providers as well as reducing duplication of provision and focusing service provision on current need. This new model makes more effective and efficient use of resources through promoting collaborative and partnership working

## **2.8 Criteria against which the tenderers are to be selected and contract is to be awarded**

The services are complex and work with people who are vulnerable with complex needs around substance misuse and mental health so quality, partnership working and safety are key considerations. It is proposed that a Quality/Price split of 40:60 is

used in the assessment of tenders, with the quality assessment being broken down into: service model – namely, creating change, access, managing complex partnerships and clinical pathways, and delivering health outcomes; clinical governance and quality assurance; social value, including training and research. For this service there is a clear need to drive major innovation in quality of services as well as costs

The scope of the contract will be published beforehand including the minimum requirements, award criteria and their weightings, and this will not be changed during the negotiation process. The whole process will be fully documented.

The first stage is advertisement and the conduction of an initial tender stage. After the evaluation of initial tenders, a decision will be made whether to award the contract to one of the bidders based on the outcome of the evaluations, or to negotiate on an equal treatment basis with the bidders who meet the criteria after evaluation.

If the decision is to conclude the negotiations all the bidders will be informed and a common deadline to submit any new or revised tenders will be set. Negotiation dialogue would only be to improve the bids, and not be on the fundamentals of the service. At the end of this process (which may include a best and final offers stage), the contract will be awarded to the supplier with the most economically advantageous tender using the award criteria in the procurement documents.

## **2.9 How the procurement will address and implement the Council's Social Value policies**

The Council's social value responsibilities are taken through its vision: One borough; One community; London's growth opportunity. Through the re-procurement of the contracts, the Council will ensure service continuity that meets the needs of the local population who misuse drug and alcohol and their families.

In line with the visions of Ambition 2020, the commissioning of substance misuse services need to be less traditional and more efficient. Early intervention to support those that have been affected by substance misuse is imperative to prevent the next generation of problematic drug and alcohol users.

It would also contribute to the Council's commitment to growth by supporting those with substance misuse problems into employment.

The Council will work with the provider to seek to identify local opportunities for apprenticeships, training and recruitment for Barking and Dagenham residents.

## **3. Options Appraisal**

### **3.1 Option 1 – Do Nothing**

This option is not viable because the Council needs to commission services for young people and adults who misuse drugs or alcohol. Having no service in place may lead to the deterioration in individuals' health and circumstances and for some may result in death. This could also lead to an increase in health and social care costs and an increase in crime. Reduction or cessation of these services would

affect the performance against substance misuse Public Health Outcomes Framework (PHOF) indicator.

### **Option 2 – Undertake competitive procurement process as current provision (that is 4 adult and 1 young people’s separate drug and alcohol services)**

#### **Advantage**

- The procurement exercise will ensure compliance with the Council’s Contract Rules and EU Legislation and ensure continued provision of drug and alcohol services to local residents beyond the contract end dates

#### **Disadvantage**

- Limited efficiencies to be made as there will be increased management costs, five contracts to manage and therefore increased costs to authorities in terms of legal, commissioning and contracting, risk of duplication of services, does not take account of sustainability

### **Option 3: Undertake competitive procurement process for an integrated Adult and Young People service (preferred option)**

#### **Advantages**

- The procurement exercise will ensure compliance with the Council’s Contract Rules and EU Legislation and ensure continued provision of drug and alcohol services to local residents beyond the contract end dates
- Performance management will be more efficient as there will be just two contracts to manage, communication will be easier as only dealing with two providers, easier to promote locally.
- Service users will be able to access any aspect of the service without having to be re-assessed or change key worker or provider. This will improve retention and therefore successful completions and ensure better outcomes for service users.
- By transferring the existing different services into an integrated service, this will reduce the capital and organisational costs of multiple providers as well as reducing duplication of provision and focusing service provision on current need. This new model makes more effective and efficient use of resources through promoting collaborative and partnership working.
- The service delivery model meets the identified need for alcohol service, new drug trends addressed, takes service user and wider partnership feedback into consideration, creates more equitable and sustainable service for our populations, increases choice, clarifies pathways.

#### **4. Waiver**

4.1 Not applicable.

## **5 Equalities and other Customer Impact**

- 5.1 Service continuation would ensure that services for people who misuse alcohol and/or drugs remain available and are accessible to service users across the full range of gender, ethnicity, age, faith, disability, sexuality and all protected characteristics. There is scope in the longer term to have a positive effect on equalities through the commissioning of more flexible models of service delivery to better meet the needs and preferences of different groups within the population.

## **6. Other Considerations and Implications**

- 6.1 **Risk and Risk Management** - Failure to maintain service would cause significant harm to residents of the borough who are recovering from alcohol/ drug misuse, their families, as well as the general population. If the service were to terminate, there would be no pharmacological (alcohol detoxification medications, substitute prescribing) or psychosocial (counseling, key working and day programmes) interventions available across the borough for people who misuse drugs and alcohol. This would undoubtedly result in an excessive consumption of drugs and alcohol across the borough. This in turn would impact upon the level of ambulance call outs, hospital admissions, drug/alcohol related deaths and levels of crime and anti-social behavior.
- 6.2 **TUPE, other staffing and trade union implications** - Eligible staff currently employed in the service will, in the event of change in service provider, transfer their employment to the new provider under the Transfer of Undertakings (Protection of Employment) Regulations.
- 6.3 **Safeguarding Children** - Substance use presents a range of behaviours that pose a risk to the individuals themselves and others around them, and can give rise to a range of safeguarding concerns, including domestic violence. The borough's systems for reporting and investigating both adult and child safeguarding concerns have established links to drug and alcohol services, and the borough recognises the need for commissioning interventions to continue to foster these links, and provide training for those involved in safeguarding. All agencies commissioned to work with adults and young people are aware of LBBB safeguarding procedures and must adhere to incident reporting as part of their contractual obligations
- 6.4 **Health Issues** - The proposal is in line with the outcomes and priorities of the joint Health and Wellbeing Strategy. The award of the contract should further enhance the quality of and access to substance misuse service in the borough. The proposal will have a positive effect on our local community.
- 6.5 **Crime and Disorder Issues** - Substance misuse impacts on many areas of crime and disorder including anti-social behaviour and offending behaviour. By commissioning services that prevent people from using substances and supporting those that are using in a problematic way will support the Partnership in reducing offending behaviour. Those individuals that are drug tested positive for Class A drugs in police custody will be compelled to engage in drug treatment.
- 6.6 **Property / Asset Issues** - The proposal will have a neutral impact upon the property or assets.

## **7. Consultation**

7.1 In line with Council procedure the following have been consulted with:

- Statutory Proper Officer – Director of Public Health
- Strategic Director Service Development and Integration
- Group Manager Finance Adults and Community Services
- Legal Services
- Corporate procurement
- Councillor Maureen Worby- Portfolio holder for Adult Social Care and Health
- Procurement Board

7.2 Consultation activity is also being planned from June 2017 in order to effectively engage with people with substance misuse problems, their families and other key stakeholders on the proposed service model and ensure there are opportunities to influence and shape the new service.

## **8. Corporate Procurement**

Implications completed by: Adebimpe Winjobi, Senior Procurement and Contracts Manager

8.1 This report is seeking approval to procure a contract for the provision of an integrated drug and alcohol the service for young people and adults as two separate lots. The service being procured falls within the description of services covered by the Light Touch Regime under the Public Contracts Regulations 2015. As the estimated value of the contract is higher than the set threshold (currently EUR 750,000), it needs to be opened up to competition and be advertised in the Official Journal of the European Union (OJEU) as required by the Regulations.

8.2 In keeping with the EU procurement principles, it is imperative that the contract is tendered in a competitive way and that the process undertaken is transparent, non-discriminatory and ensures the equal treatment of bidders.

8.3 The procurement will be undertaken using the competitive procedure with negotiation process under the Public Contract Regulations 2015. This approach will allow the councils to work with interested parties to design the service. It is more flexible and allows for more tailored and innovative specifications and solutions to be developed against an overall service model, key outcomes and performance indicators developed by commissioners and will provide best competition to get best value for money for the Council and will be compliant with the Council's Contract Rules and EU Regulations.

8.4 Corporate procurement will provide the required support to commissioners throughout the entire process.

## **9. Financial Implications**

Implications completed by: Katherine Heffernan, Group Manager - Finance

- 9.1 The current substance misuse services for adults and young people are funded predominantly through the Public Health Grant. For 2016-17, the grant provides a funding contribution of £2.866m for substance misuse services, of which £2.187m relates to services which will be included in the procurement of the integrated adult substance misuse service and the young people substance misuse service. Additional funding of £0.110m is received from The Mayor's Office for Policing and Crime (MOPAC), which also contributes towards the cost of the adult drug treatment services that will be incorporated into the contractual arrangements for the new integrated service.
- 9.2 With the intention to commence a new 5-year contract for the adult substance misuse service on 1 April 2018 and the young people substance misuse service on 1 December 2017, a proportion of both contract periods would fall within the ringfence conditions of the Public Health Grant. Public Health England recently announced that the ringfenced Public Health Grant would continue until the move to Business Rates Retention in April 2019. The cost of the new contracts could be contained within the overall Public Health budget until 31 March 2019. After this date, funding for non-mandatory Public Health services cannot be guaranteed. However, the new contractual arrangements will allow for the termination of the service prior to the completion of the 5-year contract period, should funding for the services no longer be available.

## **10. Legal Implications**

Implications completed by: Bimpe Onafuwa, Contracts and Procurement Solicitor

- 10.1 This report is seeking approval for the procurement of two separate contracts for the provision of Integrated Substance Misuse Services for Adults and for Young People.
- 10.2 The Light Touch Regime (LTR) would be applicable to this procurement as the services fall under the social and other specific contracts described in Schedule 3 of the Public Contracts Regulations (the PCR). In line with this regime, the PCR requires that contracts with a value above the current threshold of €750,000 (£589,148) be opened up to competition and be advertised widely enough for interested bidders to be aware of the procurement. The value of the Integrated Substance Misuse Services contract is estimated to be above the LTR threshold, and as such it needs to be tendered as required by the Regulations.
- 10.3 This procurement also has to be procured in line with the Council's Contract Rules which require contracts with a value of £50,000, or more, to be advertised and opened up to competition.
- 10.4 Procurement of this contract has to show equality in the treatment of bidders, transparency, as well as fairness in order to be compliant with the principles of the PCR and the Contract Rules. The proposed timetable, advertising media and evaluation criteria noted in the procurement strategy are indications of a compliant exercise.

10.5 The law and Governance Team are available to provide legal advice during this tender process.

**Public Background Papers Used in the Preparation of the Report:** None.

**List of appendices:** None.



## HEALTH AND WELLBEING BOARD

5 July 2017

<b>Title:</b> Contract for the Provision of a Three-Borough Integrated Sexual Health Service	
<b>Report of the Cabinet Member for Adult Social Care and Health</b>	
<b>Open Report</b>	<b>For Decision</b>
<b>Wards Affected:</b> All	<b>Key Decision:</b> Yes
<b>Report Author:</b> Matthew Cole Director of Public Health	<b>Contact Details:</b> Tel: 020 8227 3657 E-mail: <a href="mailto:matthew.cole@lbbd.gov.uk">matthew.cole@lbbd.gov.uk</a>
<b>Accountable Divisional Director:</b> Matthew Cole, Director of Public Health	
<b>Accountable Director:</b> Anne Bristow, Strategic Director Service Development and Integration	
<p><b>Summary:</b></p> <p>The commissioning of Genitourinary Medicine (GUM) and Contraception Sexual Health Services (CaSH) are mandatory services for Local Authorities. The services are designed so that residents can attend as open access service for the screening and treatment of Sexually Transmitted Infections (STI). This open access requirement results in financial uncertainty for Local Authorities as the level of activity is unpredictable.</p> <p>In Barking and Dagenham an Integrated Sexual Health Service (ISHS) is currently provided by Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT) at a cost £1,590,000 per annum (an activity-based contract that is capped at a value of £1,590,000 p.a). In effect, the Council is charged according to the actual level of activity, up to the £1.59m maximum). The contract is due to expire on 30th September 2017 but there is provision in the contract for a further 1 year extension.</p> <p>London Borough of Barking and Dagenham (LBBB) in partnership with the London Boroughs of Havering (LBH) and Redbridge (LBR) is undertaking a Three- borough procurement of the ISHS with LBBB leading the procurement exercise on behalf of the other two boroughs.</p> <p>This report presents a procurement strategy to extend the current contract for the provision of the ISHS for a year from 1<sup>st</sup> October 2017 until 30<sup>th</sup> September 2018 and undertake the procurement of a Three-borough ISHS operating between Barking and Dagenham, Havering and Redbridge (BHR) commencing 1<sup>st</sup> October 2018 for a period of 5 years initially with the option to extend for a further three-year period on an annual basis at the sole discretion of the Councils.</p> <p>The contract for the delivery of the new service will be a multilateral contract developed by LBBB legal team, it will have a stipulated notice period and will also include a clause to enable variations to be made if the financial position changes prior to the end of the contract.</p>	

## **Recommendations**

The Health and Wellbeing Board is recommended to:

- (i) Approve that the Council extend the contract for the provision of the Integrated Sexual Health Service (ISHS) currently provided by Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT) for a period of 1 year from 1 October 2017 until 30 September 2018;
- (ii) Approve that the Council proceed with the procurement of a new three-borough ISHS commencing 1 October 2018 for a period of 5 years initially with the option to extend for a further 3-year period on an annual basis in accordance with the Council's Contract Rules; and
- (iii) Delegate authority to the Strategic Director for Service Development and Integration, in consultation with the Director of Public Health, Cabinet Member for Social Care & Health Integration, Chief Operating Officer and Director of Law and Governance, to award a 5-year contract to the successful bidder for the provision of an Integrated Sexual Health Service from 1 October 2018 to 30 September 2023 with the option to extend for a further 3-year period on an annual basis.

## **Reason(s)**

The 1 year contract extension to BHRUT will ensure service continuity during the procurement process.

The procurement exercise will ensure compliance with the Council's Contract Rules and EU Legislation and ensure continued provision of sexual health services to local residents beyond the contract end date of 31 September 2018.

## **1. Introduction and Background**

- 1.1. Under the Health and Social Care Act 2012 local authorities have a duty to secure the provision of open access services for contraception and for testing and treatment of sexually transmitted infections (STIs) for their residents. This is mandatory and entails the key principles of providing services that are free, confidential, open access and not restricted by age.
- 1.2. The term 'open access' refers to the fact that such services are available to anyone requiring treatment, irrespective of their personal characteristics, place of residence or GP registration, without referral. This accessibility requirement impacts on the ability of all Councils to predict service demand and manage the budget effectively. This therefore results in financial uncertainty for Local Authorities as the level of activity is unpredictable.
- 1.3. Sexual ill health is not equally distributed within the population. Strong links exist between deprivation and STIs, teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), teenagers, young adults and black and minority ethnic groups. Similarly, HIV infection in the UK disproportionately affects MSM and Black Africans. Some groups at higher risk of

poor sexual health face stigma and discrimination, which can influence their ability to access services

- 1.4. A Three-borough (Barking & Dagenham, Havering and Redbridge) competitive procurement exercise undertaken for the service in January 2014 and subsequent negotiated procedure to obtain fresh tenders in early 2015 were both unsuccessful. The exercise was unsuccessful due largely to previous requirement to establish Tiers 1 to 3 service in each borough, the service operating from multiple sites in each borough and a proposal to embed chlamydia screening service into the ISHS. These requirements collectively made the received bids unaffordable
- 1.5. As a result of this, the Health and Wellbeing Board on 8th September 2015 approved to waive the requirement to tender in accordance with the Council's Contract Rules and a direct award of a 1 year contract from 1st October 2015 to 30th September 2016 with the option to extend for a further 2 year period on an annual extension basis to Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT) for the provision of an Integrated Sexual Health Service (ISHS).
- 1.6. The service currently provided by BHRUT delivers an integrated service which brings together all sexual and reproductive services, GUM and HIV testing at a cost of £1,590,000 per annum (an activity-based contract that is capped at a value of £1,590,000 p.a. In effect, the council is charged according to the actual level of activity, up to a maximum of £1,590,000 for the year). The contract will expire on 30th September 2017 and the council will utilise the contract extension period provision in the contract to ensure service continuity during the procurement of a new Three-borough ISHS. The London.
- 1.7. Following the award of the contract in October 2015, commissioners have worked with the provider BHRUT to undertake and complete a review of the following areas of service provision:
  - Review of existing staffing, management and operational arrangements and costs
  - Review service delivery costs to ensure competitive tariff rates, benchmarking costs with other comparator services /areas, taking account of national / Pan-London tariff guide prices and local factors such as population data, demand and market forces and application of tariff deflators
  - Analyse patient trends including clinic attendance and flows; review first appointment to follow-up ratios and activity including failed appointments and repeat attendances
  - Review the current service delivery model and existing care pathways to identify opportunities to move Family Planning, HIV screening and LARC activity to primary care where appropriate.
- 1.8. Following the completion of the service reviews, commissioners with support from BHRUT have remodelled current operations and service provision to ensure that it achieves improved outcomes for service users and continue to offer value for money. BHRUT working with the Council deliver the local prevention and demand management strategy for sexual health, by signposting service users to sexual health services in primary care and options for self-management including home testing.

## **Service Relocation**

- 1.9. The Council's commissioned open access GUM, contraception and reproductive service provided by BHRUT consists of;
  - Two Level 3 (specialist) hubs (Queen's Hospital and Barking Community Hospital); they provide a comprehensive range of GUM and family planning services.
  - Two Level 2 spokes providing testing and 'uncomplicated' (low risk or non-invasive) contraception services in the community (Oxlow Lane and Vicarage Field health centres).
- 1.10. In order for the service to be financially viable and to achieve some efficiency savings, BHRUT proposed the closure of a number of sites and the consolidation of services at Barking Hospital. These include a proposed relocation of GUM clinics at Vicarage Field and Oxlow Lane Health Centres to Barking Hospital from January 2017. To this end, BHRUT agreed a 5% efficiency saving on the contract value from 1<sup>st</sup> January 2017.
- 1.11. The consolidated service at Barking Hospital support service users by providing access to a wider range of sexual health services (including specialist Level 3 provision) under one roof:
  - All main methods of contraception – including emergency and long acting reversible contraceptives (LARC)
  - Pregnancy testing and referral for termination (abortion) services
  - Cervical screening
  - Chlamydia, HIV and all sexually transmitted infections screening and treatment
  - Psychosexual counselling for impotence and other sexual health conditions.
- 1.12. For LBBB, legal advice was sought as to the necessity of a consultation exercise, it was advised that no consultation was deemed necessary because the changes to the service for LBBB residents are minimal. The service relocation plan was also presented to and agreed by the local Health & Adult Services Select Committee (HASSC).

## **London Sexual Health Transformation Programme (LSHTP)**

- 1.13. The London Sexual Health Transformation Programme (LSHTP) was designed to work in partnership with local authorities across London to deliver a new commissioning model for open access sexual health services. These include Genitourinary Medicine (GUM), services for the screening and treatment of Sexually Transmitted Infections (STIs) and Sexual and Reproductive Health Services (SRH) (community contraceptive services).
- 1.14. The aim of the programme is to design, agree and procure a system that will deliver measurably improved and cost effective public health outcomes, meet increasing demand and deliver better value. There are three main strands to the programme:
  - Integrated sexual health tariff and pricing strategy

- E-services/home testing
  - Sub-regional re-procurement of face-to-face/clinic provision
- 1.15. The programme was set up with the specific aim to reduce costs for sexual health care across the capital, specifically GUM services through innovation, service redesign, demand management and pricing strategy. The continued growth of activities has led to further collaboration amongst London commissioners to manage growth and contain escalating costs. To this end, LSHTP has been exploring alternative provisions to the traditional service models of GUM, directing patients with no symptoms away from the costly clinical environment to lower cost service options.
  - 1.16. The LSHTP has been working on a new set of prices for London known as the London Integrated Sexual Health Tariffs (ISHT) that reflects more accurately the interventions provided by GUM and Contraceptive Services than the current attendance based tariffs. A rigorous due diligence process confirmed that significant savings can be achieved across London through implementation of ISHT. Further audit has been carried out to try and ensure that the financial risk to commissioners is minimal. There is now broad agreement across London that ISHT will be the payment mechanism for sexual health services from 1 April 2017.
  - 1.17. Currently a local attendance based tariff is agreed with BHRUT for the delivery of the ISHS for LBBB residents. During the contract extension period and before the commencement of the procurement process, commissioners will shadow ISHT to understand the direct impact of implementation and extent of savings that can realistically be achieved.
  - 1.18. The business case for developing an on-line sexual health service that supports signposting and self-testing of STIs has been agreed by participating boroughs and a London wide procurement is being undertaken by LSHTP. Although LBBB is not currently participating in the London online service procurement at this stage however, it is a named authority on the tender documents in order to retain the right to purchase the service should it wish to do so in future. LBR and LBH are currently part of the procurement, therefore LBBB are looking to joining the e-service when the new contract commences in order to ensure consistency in service delivery across BHR and deliver cost savings through channel shift.
  - 1.19. The LSHTP Board agreed that the procurement and commissioning of sexual health services is led on a sub-regional basis allowing for Local Authorities to determine the most appropriate procurement process. All participating local authorities have identified the need to develop models that will allow them to meet increasing demand within decreasing resources.
  - 1.20. This is a key driver for BHR boroughs to come together to jointly commission a more joined up and seamless service to residents, while achieving potential savings, economies of scale and enhancing quality. The proposed approach for the three boroughs is to commission a Three-borough ISHS commencing on 1<sup>st</sup> October 2018.

### **Three-borough Integrated Sexual Health Service**

- 1.21. Historically the ISHS has been commissioned as a Three-borough Barking, Havering and Redbridge service (although based on individual borough contract), and the current provider BHRUT have indicated that the service will not be financially viable if commissioned as a single borough service and is unlikely to attract market interest if put out to procurement.
- 1.22. There is evidence from sexual health commissioning across the country and from previous arrangement that a jointly commissioned service, albeit with local variation to meet specific local priorities, gives greater scope for cost efficiencies in relation to provider overheads, particularly in relation to some of the more complex clinical leadership
- 1.23. To this effect, the 3 boroughs Directors of Public Health with local sexual health commissioners attended a workshop organised by LBBB on 1st November 2016 to discuss the future procurement of the service, at the end of the workshop, it was agreed that the three boroughs will jointly procure a Three-borough ISHS with LBBB leading the procurement on behalf of the other 2 boroughs. This arrangement will require a Memorandum of Understanding (MoU) between all 3 boroughs to be drawn up by LBBB and agreed and duly signed by all. The MoU will describe the arrangement including the re-charge mechanism, setting out clear roles and responsibilities of each party along with their obligations.
- 1.24. The delivery of the service will be based on a multilateral contract developed by LBBB legal team. The contract will have a stipulated notice period and also include a clause to enable variations to be made if the financial position changes prior to the contract end. LBBB legal services and Corporate procurement are closely involved in the work and will provide continued support and advice throughout the process.
- 1.25. The contract will have a greater focus on prevention and innovation which will mean a shift from the traditional model of face-to-face consultations to a model where online booking, online triage and self-sampling (where service users are sent testing kits in the post and return a sample to the provider for testing) become more prominent. This will allow consultant time to be carefully managed and targeted to focus more on acute care with dual trained nurses (trained to deliver both contraception services and genito-urinary medicine) providing a significant element of the general care. This move to a more modern and efficient model of service delivery is in line with changes being made nationally by other local authorities and will enable the Council to continue to deliver services within a reduced budget envelope.
- 1.26. Upon the successful procurement and award of the Three-borough contract, LBBB, LBR and LBH will enter into a collaborative agreement with a lead authority (to be agreed) to lead on the effective contract management of the new service for the duration of the contract.
- 1.27. This report was presented to the BHR Joint Commissioning Board at its meeting on 8<sup>th</sup> May 2017. It is the expectation of commissioners that the Board will support with engagement with primary care colleagues in the delivery of

contraceptive services in primary care and identifying premises for the provision of the service across the three boroughs.

## **2. Proposed Procurement Strategy**

### **2.1 Outline specification of the works, goods or services being procured.**

This report presents a procurement strategy that will commission an Integrated Sexual Health Service (Genitourinary Medicine Services GUM and Sexual and Reproductive Health (community contraceptive) services (SRH) operating between BHR, with the new service commencing 1<sup>st</sup> October 2018.

The service will deliver an evidence based Integrated Sexual Health Service that meets national guidance and fulfils the Council's duties. It will be open access to all (universal) in line with statutory requirements and the national specification issued by the Department of Health,

It is anticipated that the specification for the service would deliver scope for better balancing capacity of the new service to achieve the following:

- Improving the LBB's sexual health outcomes in relation to the incidence of sexually transmitted infections.
- Reducing the incidence of late diagnosis of HIV.
- Improving access and availability of contraception and reducing unwanted pregnancies.
- Stronger leadership in relation to reducing teenage conceptions and improving outcomes for teenage parents and their children.
- Improved links between sexual health services and other commissioned services working with young people and adults at particular risk of poor outcomes, e.g. substance misuse, mental health and public health nursing service
- Improving sexual health and related outcomes for vulnerable groups: Children, young people and vulnerable adults through effective partnerships with schools, colleges, health, police and other statutory early help and children and family services.
- Protecting the vulnerable from risk of infection, unwanted pregnancy, freedom from sexual exploitation, abuse, inappropriate relationships and freedom from female genital mutilation.
- More effective engagement of communities at significantly increased risk of HIV infection in effective screening programmes that will protect them and others from the poor outcomes associated with late diagnosis of HIV

### **2.2 Estimated Contract Value, including the value of any uplift or extension period.**

**Contract Extension 1<sup>st</sup> October 2017- 30<sup>th</sup> September 2018- £1,510, 500** (an activity-based contract that is capped at a value of £1,590,000 per annum less 5% efficiency savings. In effect, the council is charged according to the actual level of activity, up to a maximum of £1,590,000 for the year less 5% efficiency savings)

**New 8-year (5+1+1+1) Three-borough Contract 1<sup>st</sup> October 2018- 30<sup>th</sup> September 2026-** Estimated contract value is £31,880,000 (breakdown for each

borough for 8 years is LBBD £12,800,000, LBR £7,080,000 and LBH £12,000,000

The estimated cost is based on individual borough spend in the past 3 years and this is expected to reduce as the plan is to shift contraceptive services to primary care.

The current service contract is currently commissioned as an activity contract based a locally tariff capped up to the value of £1,590,000 per annum less 5% efficiency savings, following the completion of the LSHTP an integrated sexual health tariff has been developed, work is currently being undertaken by commissioners to examine the use of the tariff to inform the decision as to whether a block contract or activity based or a mixture of both is the most appropriate to achieve value for money and quality for the new procurement.

The service will be funded from the Public Health Grant.

### 2.3 **Duration of the contract, including any options for extension.**

**Contract Extension-** 1 year 1st October 2017- 30th September 2018

**New Three-Borough contract** – 8 years (5 years initially with the provision to extend for a further 3 year period on an annual basis at the sole discretion of the Councils) from 1st October 2018 to 30th September 2026.

### 2.4 **Is the contract subject to (a) the (EU) Public Contracts Regulations 2015 or (b) Concession Contracts Regulations 2016? If Yes to (a) and contract is for services, are the services for social, health, education or other services subject to the Light Touch Regime?**

The contract is subject to the (EU) Public Contracts Regulations 2015 and as a health contract is subject to the Light Touch Regime. Because the estimated value of the contract is higher than the set threshold (currently EUR 750,000), it needs to be opened up to competition and be advertised in the Official Journal of the European Union (OJEU) as required by the Regulations.

### 2.5 **Recommended procurement procedure and reasons for the recommendation.**

The procurement will be undertaken using the competitive procedure with negotiation process under the Public Contract Regulations 2015. This approach will allow the councils to work with interested parties to design the service. This approach is more flexible and allows for more tailored and innovative specifications and solutions to be developed against an overall service model, key outcomes and performance indicators developed by commissioners.

There are several advantages to this, the negotiating the delivery of the specification with potential bidders will allow bidders to draw on their experience and knowledge to ensure that a bespoke solution is created for BHR. Many bidders will have experience of delivering such services elsewhere and will be well placed to work with commissioners to design a high-quality service model.



At this stage, therefore, it is not possible to articulate the detailed configuration of the new services, as the competitive procedure procurement with negotiation process itself will help in the design of this.

Through the competitive procedure with negotiation, commissioners will work with the bidders to identify economies of scale for delivery. That is, some elements of the services may need to be delivered in one location, whereas others could be delivered at several locations.

The procurement timetable is as follows:

<b>Activities/ Tasks</b>	<b>Date</b>
Issue PIN for Expression of Interests (Allow minimum 15days before issuing contract notice)	July 2017 (tbc)
Market Engagement Event	Early September 2017 (date tbc)
Prepare Tender Documents (Conditions, Specification, ITT, TUPE etc)	By 29 <sup>th</sup> September 2017
Issue contract notice /ITT (Allow min 6 weeks for tender document to be returned)	16 <sup>th</sup> October 2017
Deadline for clarifications	24 <sup>th</sup> November 2017
Return Tenders	30 <sup>th</sup> November 2017
Tender Evaluation	1 <sup>st</sup> December 2017-12 <sup>th</sup> January 2018
Negotiation	15 <sup>th</sup> January -2 <sup>nd</sup> February 2018
Final Tender Return	28 <sup>th</sup> February 2018
Final Tender Evaluation	1 <sup>st</sup> -23 <sup>rd</sup> March 2018
Prepare contract award report and get approval	26 <sup>th</sup> March -25 <sup>th</sup> May 2018
Provisional Award (notify successful/ unsuccessful Tenderer's)	29 <sup>th</sup> May 2018
Standstill Period	30 <sup>th</sup> May – 10 <sup>th</sup> June 2018
Final award	11 <sup>th</sup> June 2018
Service Mobilisation including potential TUPE transfers	11 <sup>th</sup> June -30 <sup>th</sup> September 2018
Contract commencement	1 <sup>st</sup> October 2018

## **2.6 The contract delivery methodology and documentation to be adopted.**

For the contract extension- The contract document will be a Deed of Variation, to vary the termination date of the contract.

For the new Three-borough contract- The Public Health Services Contract is the form of contract to be used. The contract will have annual break clause allowing notice to be given by the Councils for early termination. This allows increased flexibility should a significant change in service provision be required.

The management responsibility for the contract lies with Public Health and the contract will be managed in line with the contract management plan to be agreed by the 3 commissioning boroughs.

Service performance will be monitored through a series of Key Performance Indicators (KPIs) as detailed in the service specification that includes quantitative and qualitative data, service user feedback and activity on outstanding action plans reviewed at quarterly meetings. A number of KPIs are set nationally by the Department of Health (DoH) and these are in line with the PHOF, others are set locally to reflect local priorities as determined by the needs assessment. In addition, sexual health services are monitored by two national datasets. GUMCAD (Genitourinary medicine activity dataset) is the dataset for STI testing and treatment and SHRAD (Sexual health and reproductive activity dataset) is the dataset for contraception. All services are required to report into these systems.

## **2.7 Outcomes, savings and efficiencies expected as a consequence of awarding the proposed contract.**

The outcome expected as a consequence of awarding the proposed contract is to improve the sexual health of the population across the borough by building an effective, responsive and high quality sexual health service, which effectively meets the needs of our local community and offers a range of high quality, needs-led services which will target those most vulnerable in our boroughs.

The outcomes we wish to achieve for LBBD residents are to:

1. Reduce unwanted pregnancies, including teenage pregnancies
2. Reduce harm from STIs and HIV
3. Reduce inequalities in sexual health
4. Fulfil our statutory duty to provide open access services for contraception and for testing and treatment of sexually transmitted infections

There is an opportunity to negotiate a new tariff-based pricing model with the successful provider over the life of the contract. Although the tariff model is expected to deliver some cost efficiencies, the very nature of this on-demand service may impact on the ability to achieve these savings.

It is recognised nationally that spending money on sexual health services can save significant amounts of money further down the line to both health and non-health (including local authority) services. The report 'Unprotected Nation 2015' commissioned by the Family Planning Association shows the potential

impacts of a reduction in access to services. It illustrates that nationally a 10% reduction in access could result in the total cost of unintended pregnancies and STIs increasing from £69.092 billion to as much as £77.750 billion over the period 2015 – 2020. A significant portion of this increase (circa £7.2 billion) would relate to non-health costs such as social welfare, housing and education.

## **2.8 Criteria against which the tenderers are to be selected and contract is to be awarded**

It is proposed that a Quality/Price split of 80/20 is used in the assessment of tenders. For this service, there is a clear need to drive major innovation in quality of services. The use of the London-wide tariff means all providers will use the agreed price for the set of intervention in the provision of the service therefore there will be no competition in the service cost.

The quality assessment being broken down into: service model – namely, creating change, access, managing complex partnerships and clinical pathways, and delivering health outcomes; clinical governance and quality assurance; social value, including training and research.

The scope of the contract will be published beforehand including the minimum requirements, award criteria and their weightings, and this will not be changed during the negotiation process. The whole process will be fully documented.

The first stage is advertisement and the conduction of an initial tender stage. After the evaluation of initial tenders, a decision will be made whether to award the contract to one of the bidders based on the outcome of the evaluations, or to negotiate on an equal treatment basis with the bidders who meet the criteria after evaluation.

If the decision is to conclude the negotiations all the bidders will be informed and a common deadline to submit any new or revised tenders will be set. Negotiation dialogue would only be to improve the bids, and not be on the fundamentals of the service. At the end of this process (which may include a best and final offers stage), the contract will be awarded to the supplier with the most economically advantageous tender using the award criteria in the procurement documents.

## **2.9 How the procurement will address and implement the Council's Social Value policies.**

The Council's social value responsibilities are taken through its vision: One borough; One community; London's growth opportunity.

Through the award of the contracts to the providers, the Council will ensure service continuity that meet the needs of the local population, including provision of information, advice and support on a range of issues, such as sexually transmitted infections (STIs) testing and treatment, Chlamydia screening, HIV Testing, contraception, relationships and unplanned pregnancy.

In terms of the service contract, we will work with the provider to seek to identify local opportunities for apprenticeships, training and recruitment for residents.

### **3. Options Appraisal**

#### **3.1 Option 1: Do Nothing**

This option is not viable because the Council is mandated to provide open-access, accessible and confidential contraceptive and sexually transmitted infections (STIs) testing & treatment services for all age groups in the borough. Withdrawing services to support residents at this preventative and health protection level will result in further investment being required in relation to health and social care costs associated with unplanned pregnancies and the more expensive provision of care for those with long term health conditions such as HIV.

It is important that appropriate contractual arrangements are put in place locally to cover such services, to ensure compliance with national clinical guidance, minimise risk and ensure value for money. The nature of sexual health services is such that, should appropriate services not be available in Barking and Dagenham, a larger number of residents will access services in neighboring authority areas and the Council will still be required to pay for the provision of these services but will have limited influence on the quality or cost.

#### **3.2 Option 2: Procure as a single Borough Service**

Going out to market just for a LBB service was considered but rejected on the basis that it would not offer the same opportunities for economies of scale (thereby maximising value for money) that a Three-borough tender across BHR would offer. There would also be the risk that the market would focus on the larger procurement and that there would be little interest in a Barking and Dagenham only procurement. As most BHR residents currently access service from the same provider, there would be the added risk of a Barking and Dagenham only procurement destabilising BHR provision if it were not part of the same procurement.

#### **3.3 Option 3: Extend the current contract for a year and undertake a competitive process for a Three-borough service (preferred option).**

The extension of the current integrated sexual health service contract for a 1 year period and procure a Three-borough service is the preferred option. There is evidence from sexual health commissioning across the country and from previous arrangement that a jointly commissioned service, albeit with local variation to meet specific local priorities, gives greater scope for cost efficiencies in relation to provider overheads, particularly in relation to some of the more complex clinical leadership. This is a key driver for BHR boroughs to come together to jointly commission a more joined up and seamless service to residents, while achieving potential savings, economies of scale and enhancing quality

The procurement exercise will ensure compliance with the Council's Contract Rules and EU Legislation and ensure continued provision of sexual health services to local residents beyond the contract end date of 31<sup>st</sup> September 2018. The Council is able to fulfil its legal obligation to its residents by having an open access sexual health service they will have no need to go elsewhere for treatment which will lower the council none contracted spend.

#### **4. Waiver**

4.1 Not applicable.

#### **5 Equalities and other Customer Impact**

5.1 The local authority will be providing an open access, universally provided Integrated Sexual Health Service that will meet the need of the whole population. The service allows for targeted provision for those parts of the population that have greater sexual health needs, these will include but not limited to; men who have sex with men. Young people, black African community, transgender communities.

5.2 This service will be open to anyone who is in the area and who wishes to access sexual health services. The service will be designed and specified to meet the needs across the population, including of people with protected characteristics, and they will be equally open to the general population on equal terms. New web based portal/access point, including access to self-sampling kits for sexually transmitted infections, have the potential to provide an alternative to GUM clinic attendances for people who are asymptomatic, and may also reach people who may previously not have used clinic services. It will be important that web-based services meet standards for accessibility.

#### **6. Other Considerations and Implications**

6.1 **Risk Assessment** - A detailed risk assessment is at Appendix 1.

6.2 **TUPE, other staffing and trade union implications** - Eligible staff currently employed in the service will, in the event of change in service provider, transfer their employment to the new provider under the Transfer of Undertakings (Protection of Employment) Regulations.

6.3 **Safeguarding Children** - The provider has in place the necessary safeguarding protocols, in line with Council Policy and applies the Frazier Guidelines and Gillick Competency where a young person is under 16.

6.4 **Health Issues** - The proposal is in line with the outcomes and priorities of the joint Health and Wellbeing Strategy. The award of the contract should further enhance the quality of and access to sexual health service in the borough. The proposal will have a positive effect on our local community.

#### **7. Consultation**

7.1 In line with Council procedure the following have been consulted with:

- Statutory Proper Officer – Director of Public Health
- Strategic Director Service Development and Integration
- Group Manager Finance Adults and Community Services
- Legal Services
- Corporate procurement
- Councillor Maureen Worby- Portfolio holder for Adult Social Care and Health
- Procurement Board

## **8. Corporate Procurement**

Implications completed by: Adebimpe Winjobi, Senior Procurement and Contracts Manager

- 8.1 The contract for the integrated sexual health service was awarded for an initial term of one year, commencing on 1<sup>st</sup> October 2015 with an option to extend the service provision on a '1 plus 1 year basis', at the sole discretion of the Council. The contract was extended until 30<sup>th</sup> September 2017 and the Council now wishes to exercise that option and extend the contract with the current provider for a further period of one year until 30<sup>th</sup> September 2018.
- 8.2 The Council's Contract Rules allow contract extensions on the basis that there is budgetary provision; value for money can be clearly demonstrated; and there is a provision stipulated in the Notice and/or original contract for an extension. This report clearly demonstrates that the Integrated Sexual Health Service contract meets the requirements for extensions.
- 8.3 This report is also seeking approval to procure a contract for the provision of the service. The service being procured falls within the description of services covered by the Light Touch Regime under the Public Contracts Regulations 2015. As the estimated value of the contract is higher than the set threshold (currently EUR 750,000), it needs to be opened up to competition and be advertised in the Official Journal of the European Union (OJEU) as required by the Regulations.
- 8.4 In keeping with the EU procurement principles, it is imperative that the contract is tendered in a competitive way and that the process undertaken is transparent, non-discriminatory and ensures the equal treatment of bidders. The procurement will be undertaken using the competitive procedure with negotiation process under the Public Contract Regulations 2015.
- 8.5 This approach will allow the councils to work with interested parties to design the service. It is more flexible and allows for more tailored and innovative specifications and solutions to be developed against an overall service model, key outcomes and performance indicators developed by commissioners and will provide best competition to get best value for money for the Council and will be compliant with the Council's Contract Rules and EU Regulations.
- 8.6 Corporate procurement will provide the required support to public health throughout the entire process.

## **9. Financial Implications**

Implications completed by: Katherine Heffernan, Group Manager – Finance

- 9.1 The 2016/17 budget for integrated sexual health services (universal genitourinary medicine and family planning services) is £1,560,500. The annual BHRUT contract is an activity-based contract that is capped at a value of £1,590,000 p.a. The council is charged according to the actual level of activity, up to a maximum of £1,590,000 for the year. The contract commenced in October 2015, for a period of one year, with the option to extend for a further two years, on an annual extension

basis. The contract extension from 1 October 2017 to 31 September 2018 will straddle two financial years, 2017-18 and 2018-19.

- 9.2 A cash reduction in the Public Health Grant allocation to the council, as announced by the Department of Health in February 2016, will see a reduction of 2.5% in 2017/18 and 2.6% in both 2018/19 and 2019/20, which equates to over £400,000 per annum. In order to address the reduction in public health funding and the anticipated increase in demand for services, an efficiency savings plan was negotiated with BHRUT of 5% in each year of the contract period from October 2016 onwards. The new service design that commenced in January 2017 should allow for these efficiency savings to be achieved.
- 9.3 On 9 March 2017, Public Health England announced that the ringfenced Public Health Grant would continue, until the move to 100% Business Rates Retention in April 2019. The contract extension from 1 October 2017 to 30 September 2018 falls within the period where the ringfence remains in place, ensuring that Public Health Grant must fund Public Health related services. The cost of the contract extension will be contained within the overall Public Health budget at this time.
- 9.4 The new Three-borough contract will commence on 1 October 2018, for a period of eight years, through a five-year contract with the option to extend each year on an annual basis, for a period of three years. It is estimated that the cost of the contract for the eight-year period will be £12,800,000. Most of the contract term will fall outside of the ringfenced period, where funding will transfer to Business Rates Retention instead. There is the risk that services that were protected by the ringfenced Public Health Grant may not be guaranteed funding after the move to Business Rates Retention. However, sexual health services are mandatory for local authorities with the responsibility for Public Health, and it can therefore be assumed that the contract costs will be contained within future budgets.

## **10. Legal Implications**

Implications completed by: Bimpe Onafuwa, Contracts and Procurement Solicitor

- 10.1 This report is seeking approval to extend the term of the contract for the Provision of Integrated Sexual Health Services. This contract is currently provided by the Barking Havering and Redbridge University Trust.
- 10.2 Clause 57.1 allows for contract extensions in instances where there is budgetary provision, where value for money can be demonstrated and where there is an extension provision in the contract. As detailed in the report, there is a clause in the contract which permits an extension. Provided the other two requirements noted above can be demonstrated, the Law and Governance Team do not see a reason why the current contract cannot be extended for a further year.
- 10.3 This report is also seeking permission to undertake a procurement exercise in respect of a new contract for the provision of Integrated Sexual Health Services commencing in October 2018. It is proposed that the new contract will be procured by the London Borough of Barking and Dagenham (the Council) on behalf of the London Boroughs of Havering (LBH) and Redbridge (LBR).

- 10.4 Section 102 of the Local Government Act 1972 makes provision for councils to establish joint committees with other local authorities to discharge their functions. In line with this piece of legislation, the Council is able to undertake the procurement on behalf of itself, LBH and LBR.
- 10.5 This report further provides details the proposed strategy for procuring the contract. Although this service is a health service which falls within the Light Touch Regime, due to its value (approximately £31,880,000), the contract has to be procured in line with the EU procurement principles. The exercise therefore has to demonstrate equality in the treatment of bidders, transparency, as well as fairness in order to be compliant with the principles of the PCR and the Council's Contract Rules. The proposed timetable, advertisement medium and evaluation criteria noted in the procurement strategy are indications of a compliant exercise.
- 10.6 The law and Governance Team are available to provide legal advice during this tender process.

**Public Background Papers Used in the Preparation of the Report: None**

**List of appendices:**

**Appendix 1 – Risk Assessment**



## Risk Assessment

Risk	Likelihood	Impact	Risk Category	Mitigation
Delay to/ failed procurement process leading to having no contract in place from 1st October 2018 and a negative impact on the sexual health of the local population and Councils reputation damaged	Medium	Medium	High	Set and follow a realistic timetable. Councils to negotiate short term contract with current provider in case of a delay or failed procurement
Financial risk- bidders' prices higher than available budget	Low	High	High	Service specification to be realistic and have flexibility on requirements from providers. Negotiation procedure is used for this process to allow dialogue with bidders to achieve a cost-effective service for the partnership
Reduced budget due to change from PH Grant to 100% business retention scheme	Low	High	Medium	Provision of sexual health service is mandated for the Council to provide so budget will remain the same even with changes to funding stream. The contract will have a break clause allowing notice to be given by either party for termination. This allows increased flexibility should a significant change in service provision be required.
Contract award decision challenged by an unsuccessful provider	Low	High	Medium	Procure contract in line with Council's contract rules and EU regulation ensuring right process is followed. Liaise with legal and corporate procurement departments at all stages and ensure documentation is kept.

The three boroughs unable to agree a joint vision for services across the sub region and one or more partner boroughs pull out of process	Low	High	Medium	Project group with representatives from the 3 boroughs to meet regularly and agree on service specification and budget at an early stage. Memorandum of Understanding in place setting out withdrawal/ exit arrangement agreed and signed by all 3 boroughs.
TUPE costs prevents providers from tendering for service	Low	High	Medium	Gather TUPE information early in project; get expert advice from legal services. Make information clear in ITT documents. Negotiate new short contract with current provider as contingency plan for no tenders received
No tender received, leading to increased service cost by current provider	Low	High	Medium	Clear service budget identified and new short term contract negotiated with current provider
Potential bidders do not identify appropriate premises for delivery of the service and therefore do not bid	Low	High	Medium	Project group working with NHS Estate to identify appropriate premises for service delivery across BHR
Inadequate officer capacity to take forward the actions required/ sudden loss of officer	Low	High	Medium	Affected borough to send a replacement as soon as possible. In the case of the project manager, Elevate East London to provide replacement as soon as possible
Commissioning plan not approved by necessary boards/groups.	Low	High	Medium	Provision of sexual health service is a mandated requirement for local authorities, individual boroughs to follow due process and request for approval to conduct procurement and award contract to the successful bidder before the start of the

				procurement process
Provider fail to meet contractual obligations	Low	High	Medium	<p>Clear set of outcomes set out in service specification and agreed with provider.</p> <p>Detailed mobilisation period with sufficient time included in procurement plan.</p> <p>Financial and Robust and regular performance monitoring procedures, performance indicators and consequences of failure to meet them set out in service contract.</p>

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## HEALTH AND WELLBEING BOARD

5 July 2017

<b>Title:</b>	<b>Integrated Care Partnership Board - Update</b>	
<b>Report of the Deputy Chief Executive and Strategic Director for Service Development and Integration</b>		
<b>Open Report</b>	<b>For Information</b>	
<b>Wards Affected:</b> None	<b>Key Decision:</b> No	
<b>Report Author:</b> Rhys Clyne: National Management Trainee, LBBD.	<b>Contact Details:</b> Tel: 020 8227 3033 E-mail: rhys.clyne@lbbd.gov.uk	
<b>Sponsor:</b> Anne Bristow, Deputy Chief Executive and Strategic Director for Service Development and Integration, LBBD		
<b>Summary</b>  This report updates the Board on the work undertaken by the Barking and Dagenham, Havering and Redbridge (BHR) Integrated Care Partnership Board (ICPB) since the last meeting of the Health and Wellbeing Board. It appends the reports of the ICPB meetings on 24 April and 31 May 2017.		
<b>Recommendation(s)</b>  The Health and Wellbeing Board is recommended to note and discuss the reports of the Integrated Care Partnership Board.		

**List of Appendices****Appendix A:** Report of the Integrated Care Partnership Board – 24 April 2017**Appendix B:** Report of the Integrated Care Partnership Board – 31 May 2017

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## ACTION NOTES

**Meeting:** Integrated Care Partnership Board

**Date:** Monday 24 April 2017

<b>Attendees:</b>	Joe Fielder <b>(Chair)</b>	<b>JF</b>	NELFT
	Conor Burke	<b>CB</b>	BHR CCGs
	Anne Bristow	<b>AB</b>	London Borough of Barking and Dagenham
	Cllr Wendy Brice-Thompson	<b>WBT</b>	London Borough of Havering
	Cllr Roger Ramsey	<b>RR</b>	London Borough of Havering
	Cllr Mark Santos	<b>MS</b>	London Borough of Redbridge
	Vicky Hobart	<b>VH</b>	London Borough of Redbridge
	John Brouder	<b>JB</b>	NELFT
	Eric Sorensen	<b>ES</b>	BHRUT
	Andrew Blake-Herbert	<b>ABH</b>	London Borough of Havering
	Kash Pandya	<b>KP</b>	BHR CCGs
	Barbara Nicholls	<b>BN</b>	London Borough of Havering
Stephen O'Connor	<b>SOC</b>	NELFT	

**In attendance:** Jane Gateley, Rowan Taylor, Mark Tyson

**Apologies:** Cllr Maureen Worby , Cllr Jas Athwal, Cllr Darren Rodwell, Dr Nadeem Moghal, Dr Atul Aggrawal, Matthew Hopkins, Maureen Dalziel, Caroline Allum, Dr W Mohi, Richard Coleman, Dr Anil Mehta, Caroline Maclean.

Agenda item	Summary
<b>Welcome, introductions and apologies</b>	Introductions and apologies noted as above.
<b>Notes from the previous meeting</b>	<p>Notes agreed subject to the following amendments:</p> <p>Matters arising:</p> <ul style="list-style-type: none"> <li>• Members requested a summary paper which outlines all the PIDs, JG agreed to send this out.</li> <li>• Cllr MS raised concerns that the notes from previous meetings did not fully reflect his comments. Although he may have referenced the journey to localities , this was expressed more widely in terms of the vision to achieve greater health and care integration with a focus on prevention and also the development of strategic commissioning. AB endorsed this.</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Page 260</p> <p><b>System Delivery and Performance Board</b></p>	<p><u>Latest System Delivery Plan position</u></p> <p>JB outlined the significant progress on BHR’s system delivery plan, referring to the slide deck enclosed in the meeting pack. There was recognition of the overall challenges each scheme will have on the system, however JB reiterated the importance of keeping all parties engaged in progressing the work.</p> <p>JB confirmed that the SDPB had asked BHRUT to bring back Business Cases to the SDPB to access counting and coding monies of £4.8m. This was to allow the Board to assure itself on behalf of the system, that investment was target to transformational change that delivered in year savings.</p> <p>JF sought clarity in regards to the tracker and the progress to some PIDs to date. CB advised that as well as identifying schemes there is also requirement for CCGs to review all their commitments against investments. Members were reminded that the CCGs have been given legal direction and are required by regulators to balance their budgets.</p> <p>CB informed members on the recent national process put in place across the NHS called the ‘Capped Expenditure Programme’ (CEP) initiated for all challenged health economies. This effectively means the whole system should take a zero based target budget approach. This programme is being rolled out nationally and BHR are anticipating to be part of the second cohort as part of a phased roll out. The work that is currently underway supported by PwC should contribute to this process rather than duplicate it.</p> <p>JF raised issues around NHS parity of esteem/parity of funding linked to physical and mental health. There was a broader question to commissioners to outline the general parity of funding. CB relayed that commissioners are consistently working to meet the challenges in the</p>



<p>Page 261</p>	<p>changing demands and are meeting constitutional, national, local requirements alongside meeting the legal direction posed. There would be ongoing dialogue with regulators. JF asked that the CCG and all parties continue to lobby regulators and those at the centre for an accelerated parity of funding outcome.</p> <p>ABH highlighted there may be a need to re-address the funding challenges from local authorities. Members agreed there needs to be a piece of work carried out that maps out system wide issues and consideration given to a more proactive approach to lobbying for fair share funding alongside a clear determination of what is possible.</p> <p><u>Clinical Engagement Plan update</u></p> <p>JB outlined there has been a lot of clinical engagement although there had been a reported delay in establishing the clinical cabinet. Sarah See was progressing this with clinical leads.</p> <p><u>Communication and engagement plan update</u></p> <p>RT updated the progress on the “spending NHS money wisely” consultation currently in its fifth week of the process. It was noted the consultation has had very good response rate from the public so far.</p> <p>Members discussed the impact of consultations following the announcement of the forthcoming election. RT advised the Communications team are in close liaison with NHSE in seeking advice.</p>
<p><b>Joint Commissioning Board</b></p>	<p>CB informed members that limited progress has been made on the JCB, currently work is being undertaken to set up a date. CB is in discussions with Adrian Loades.</p> <p>CB informed members that a meeting has been set up between Local authorities and CCGs to discuss the Five Year Forward View and ACS development this week. Representatives include Chief Executives and Chief Finance Officers. The focus of the meeting will be discussions around collaboration and joint commissioning. Outputs with recommendations from the meeting will be produced and will be shared at the next meeting.</p>
<p><b>London Devolution Programme Board</b></p>	<p>ABH advised members that the Devolution announcement has been postponed until election period is over.</p>

<p><b>CEO update</b></p>	<p>ABH/CB advised the CEO's met on 21.04.17.</p> <p>CEOs agreed in principle the vision and approach to integrate data to support the work on place based care. A drafted proposal with clear governance arrangement needs to be presented at this meeting. Members expressed the importance of having the clinical cabinet supporting this approach. JF advised there is existing knowledge available on the technology requirements regarding the 'Internet of Everything', the suggestion was made to potentially tap into NELFT and BHRUT boards who have ready access to more information.</p> <p>CEOs also agreed Liz Sargeant would now take forward new discharge arrangements across the system.</p> <p>Members noted the Estates forum new ToRs had been approved.</p> <p>Members noted there were discussions around the challenges faced around communications. CEOs will keep under review.</p>
<p>Page 262 <b>Sustainability and Transformation Plan</b></p>	<p>CB advised that the STP MOU was received setting out the governance arrangement for approval. It was noted Local Authority colleagues had not yet received the MOU causing concern that the messaging is not being cascaded across the STP footprint appropriately.</p> <p>ABH said he would pick up and continue to chase a response from Rob Whiteman.</p> <p>JF stated there had also been concerns expressed about the degree of governance and independent scrutiny within the STP framework going forward.</p>
<p><b>Time of next meeting</b></p>	<p>31 May 2017 – 4.30 - 6pm – Becketts House</p>
<p><b>AOB</b></p>	<p>VH advised members that Redbridge is producing their health and wellbeing strategy. Members agreed they would be happy to input their comments and feedback. VH to circulate to members of ICPB.</p>

## ACS – Integrated Care Partnership Board- action log

	<b><i>Action 27 March 2017</i></b>	<b><i>Responsible</i></b>	<b><i>Due date</i></b>	<b><i>Status</i></b>
3	Joint Commissioning Board to be establish from April 2017	CB/AL	April 2017	In progress
	<b><i>Action 24 April 2017</i></b>			
1	Summary paper which outlines all PIDs to be produced and sent out to members	JG	28/4/17	Complete
2	Outputs with recommendations from the meeting between Local Authorities and CCGs will be shared at the next meeting	ABH	31/5/17	Covered under agenda item 4
3	ABH said he would pick up and continue to chase a response from Rob Whiteman	ABH	31/5/17	Complete
4	Redbridge health and wellbeing strategy to be circulated to ICPB members to feedback any comments	VH	15/5/17	Attached for info

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## DRAFT ACTION NOTES

**Meeting:** Integrated Care Partnership Board

**Date:** Wednesday 31 May 2017

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<b>Attendees:</b>			
Maureen Worby (Chair)	<b>MW</b>		London Borough of Barking and Dagenham
Conor Burke	<b>CB</b>		BHR CCGs
Dr Atul Aggrawal	<b>AA</b>		Havering CCG
Dr Anil Mehta	<b>AM</b>		Redbridge CCG
Kash Pandya	<b>KP</b>		BHR CCGs
Anne Bristow	<b>AB</b>		London Borough of Barking and Dagenham
Barbara Nicholls	<b>BN</b>		London Borough of Havering
Cllr Wendy Brice-Thompson	<b>WBT</b>		London Borough of Havering
Cllr Mark Santos	<b>MS</b>		London Borough of Redbridge
Adrian Loades	<b>AL</b>		London Borough of Redbridge
John Brouder	<b>JB</b>		NELFT
Joe Fielder	<b>JF</b>		NELFT
Caroline Allum	<b>CA</b>		NELFT
DR Magda Smith (for Dr Moghal)	<b>MS</b>		BHRUT

**In attendance:** Rowan Taylor, James Gregory, Mark Tyson

**Apologies:** Cllr Jas Athwal, Cllr Darren Rodwell, Dr Nadeem Moghal, Matthew Hopkins, Maureen Dalziel, Richard Coleman, Dr Waseem Mohi, Caroline Maclean, Eric Sorensen, Andrew Blake-Herbert

Agenda item	Summary
<b>Welcome, introductions and apologies</b>	Introductions and apologies noted as above.
<b>Notes from the previous meeting</b>	Notes agreed with no alterations
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Page 266</p> <p><b>CEO update</b></p>	<p>CB gave the update from the CEOs meeting. Key points were:</p> <ul style="list-style-type: none"> <li>• Outlining next steps from the NHS Five Year Forward View</li> <li>• Summarising proposed changes to the Strategic Commissioning arrangements across the STP footprint, including the appointment of one Accountable Officer across the STP. It was noted that changes at the STP level were not expected to negatively impact the work of the ICPB, with the view that development of the BHR ACS would work in parallel and form part of the overall STP structure.</li> <li>• It was noted that development of ACS models would likely be progressed at pace at the National and London levels. A pipeline of areas, who would be supported in development of ACS models, would likely be developed in the coming months. This was a potential opportunity for the BHR system.</li> <li>• Discussions were taking place regarding potential moves away from PBR, which were likely to be supported by policy changes following the election. The ongoing PWC work could support the commissioners and providers in achieving this.</li> </ul> <p>MW highlighted the need to maintain momentum on development of the ACS system, and sought commitment from all parties on how this work was progressed, pending conclusion of the election period. CB noted that there was a need to discuss this in more detail at the next ICPB, seeking agreement to progress at pace from all parties (28<sup>th</sup> of June), this would then support a detailed planning discussion in July. JF responded that all parties needed to be fully engaged, and represented, in the development of the optimum model for delivery, raising the issues of provider representation on the Joint Commissioning Board. CB and MW responded that current arrangements were interim and it was the intention of the ICPB to ensure that all parties were fully involved in the development of all areas.</p>

<p><b>Joint Commissioning Board update</b></p>	<p>AL outlined current progress against development of the Joint Commissioning Board. AL summarised the notes from the second meeting of the JCB, stating that the ambition of the group was to define the appetite for commissioners to move towards integrated strategic commissioning.</p> <p>The group discussed the TOR for the JCB. AB requested updating the TOR to reflect that DPH were part of the LA structure. JF raised that Provider organisations were not currently included on the TOR. CB responded that development of the JCB was a journey and that the group would continue to evolve and develop, and that the intention was not to exclude providers from development of the BHR ACS landscape. No further issues were raised in relation to the TOR, and the group agreed the document.</p>
<p>Page 267</p> <p><b>System Delivery and Performance Board</b></p>	<p>JB summarised the outputs from the May SDPB, highlighting that the meeting was helpful. The group reviewed a case for the investment of the £4.8m counting and coding monies as part of the BHRCCGs/BHRUT 17/18 contract agreement. The SDPB did not agree the paper at this time, and sought further development of a case that supported transformation change across the system, however the SDPB did note that there was a further need to ensure the system worked differently to support delivery of business as usual activities. JB also noted the significant progress that had been made on developing the system recovery plan, and the efforts of all parties in achieving this. JB stated that further engagement would be required, including open and honest discussion on parties underlying financial position, in order to maintain momentum. MW queried NELFT involvement in the ongoing PWC review work between BHRUT and CCGs, JB responded that he, CB and Jeff Buggle would meet on the 1<sup>st</sup> of June to discuss how this is progressed.</p> <p>AB asked for an update on the CCGs consultation (“Spending NHS money wisely”), RT summarised the process to date, highlighting that the consultation had now closed, and a findings document would be produced following clinical led reviews of the consultation responses. AB noted the example of the Sterilisation proposal, which would impact on LA spending, and queried how the ICPB could support avoiding moving costs around the system. CB responded that in future the intention was that these types of discussions would take place at the JCB but due to timing and development status of both groups this was not possible for this consultation exercise. JB noted that proposals had been reviewed by the SDPB.</p> <p>CA updated the group on the development of the Clinical Cabinet. The membership met in May, topics for discussion included:</p> <ul style="list-style-type: none"> <li>• How to support clinicians to free up time to attend Cabinet meetings</li> <li>• Engagement across the wider clinical body</li> <li>• Use of enablers such as interoperable IT to bridge gaps between Acute and Primary Care clinicians</li> <li>• Examples of how other systems had developed their Cabinets</li> </ul> <p>CA stated that it was important to identify and deliver “quick wins” which could be used to build momentum for further development of the cabinet. AA and AM discussed the approach taken in Tower Hamlets which has put in place ambition targets for Clinicians to own and deliver which</p>

**APPENDIX B**

	has fostered ownership of the transformational change agenda. AM also noted the need to communicate areas where we had delivered, as the system did not currently do this well enough.
<b>AOB</b>	None raised  MS noted the Redbridge Health and Wellbeing development work underway with the borough, and welcomed comments from all parties.
<b>Time of next meeting</b>	28 June 2017 – 11.00 – 12.30 – Boardroom, barking and Dagenham CCG, Ground floor, Maritime House, 1 Linton Road, barking

**ACS – Integrated Care Partnership Board- action log**

Page 268	<b><i>Action 31 May 2017</i></b>			
	1.	CEOs to discuss momentum of the development of ACS system at the next ICP Exec on 19 June	CEOs	19/6/17



## HEALTH AND WELLBEING BOARD

5 July 2017

<b>Title:</b>	<b>Sub-Group Reports</b>	
<b>Report of the Chair of the Health and Wellbeing Board</b>		
<b>Open Report</b>	<b>For Information</b>	
<b>Wards Affected:</b> None	<b>Key Decision:</b> No	
<b>Report Author:</b> Rhys Clyne: National Management Trainee, LBBD	<b>Contact Details:</b> Tel: 020 8227 3033 E-mail: rhys.clyne@lbbd.gov.uk	
<b>Sponsor:</b> Councillor Maureen Worby, Chair of the Health and Wellbeing Board		
<b>Summary</b>		
<p>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.</p> <p>Please note that the Public Health Programmes Board, and the Children and Maternity Group have not met since the last meeting of the Health and Wellbeing Board, so there are no updates for these groups.</p>		
<b>Recommendation(s)</b>		
<p>The Health and Wellbeing Board is recommended to note and discuss the contents of the sub-group reports set out in the appendices.</p>		

**List of Appendices:****Appendix A:** Mental Health Sub-Group – 15 May 2017**Appendix B:** Integrated Care Steering Group – 12 June 2017**Appendix C:** Learning Disability Partnership Board – 17 January/ 22 March 2017

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**London Borough of Barking & Dagenham (LBBD) Health & Wellbeing Board  
 Mental Health Sub-Group  
 15<sup>th</sup> May 2017 - 1.30pm – 3.30pm  
 Pink Room, Care City Offices**

Attendees

Kevin Sole	(KS)	Assistant Director MH Services ( Chair)
Susan Lloyd	(SL)	Consultant in Public Health
Anthony Maher	(AM)	Service User
Dr Raj Kumar	(RK)	
Nicholas Hurst	(NH)	Non-Executive Director
Stasha Jan	(SJ)	
Vivien Okoh	(VO)	
Julie Allen	(JA)	PA to Assistant Director MHS (Note Taker)

1.	<b>Apologies and Introductions</b>	<b>Action to be completed by</b>
	Apologies received from Melody Williams, Baljeet Nagra, Christine Brand, Michael Fenn, Lorraine Goldberg, Richard Vann, Lewis Sheldrake	
2.	<b>Minutes of Last Meeting &amp; Matters Arising</b>	
	<p>Minutes of the meeting held on 20<sup>th</sup> March agreed as accurate.</p> <p>Minutes of the meeting held on 23<sup>rd</sup> January 2017 agreed with the following amendment.</p> <p>Section 7 – should read “<i>LS advised that MHS strategy will on the agenda bi-monthly reflecting groups ownership</i>”</p>	
3.	<b>Matters Arising</b>	
	MW reviewed the membership outside of the meeting to include clinical and CAMHS staff. JA invited Matt Henshaw and Vivien Okoh to the meeting.	
4	<b>Terms of reference</b>	
	Item carried forward to next meeting 19.06.17	
5	<b>Feedback from MH service Users Group &amp; carers forum</b>	
	<p>AM – People are still having difficulty accessing the advocacy services. Item to be discussed at the next meeting 19.06.17.</p> <p>VO – will gain an update from Matt Henshaw.</p> <p>AM - advised that at the IPEP meeting it was discussed the importance of the services at Sunflowers Court. Street Triage which has now been expended. Forward planning needs to be considered due to the healthy town. NELFT will publicise on twitter and Facebook.</p> <p>The Recovery College is no longer running in the original format of the pilot which was previously run. Each locality is now running local adaptations of the Recovery</p>	

	<p>College within mainstream secondary care mental health services, such as groups and recovery focused interventions. Barbara Tombs is leading on this and has previously given a talk at the MHSG. She will be invited back later in the year to update on progress.</p> <p>Discussion took place around the Smoking ban at Sunflowers Court and patients having to go on the street to smoke. The group all acknowledged that this was across all of NELFT sites.</p> <p>KS updated the group that Physical &amp; Mental health mindfulness sessions were held recently in Care City, as part of Mental Health Awareness Week, Talking Therapies (IAPT) were also out and about around Barking Market handing out leaflets, talking to the general public and advising on how to look after your mental health and where to seek support.</p>	
<b>6</b>	<b>Transformation Plan for B &amp; D</b>	
	<p>VO gave a verbal update that Tier 2 &amp; 3 will be merged. There will be 4 x Band 4 support workers child development practitioner. These members of staff will be 3 days at University for one year and 2 days of the week within the team, to offer support to young people coming into the service.</p> <p>Clarification is needed as to whether this is across the 4 boroughs.</p> <p><b>Action: VO and Dr Kumar will discuss once the session is commenced.</b></p>	
<b>8</b>	<b>MHS Dashboard</b>	
	<p>The dashboard was received and the following noted.</p> <p>Qtr. 4 data for dementia diagnosis is slightly down. SJ advised that they are trying to ensure that it does not fall below 68% .</p> <p>We have one going up, but 3 going down.</p> <p>AM enquired of SL as to whether the data that needs to be reviewed can be highlighted, enabling easier viewing.</p>	
<b>9</b>	<b>Psychological Services in B &amp; D</b>	
	<p>KS advised the group on as to the services that fall under him. All psychological services are back to borough</p> <p>MHS have two services</p> <ul style="list-style-type: none"> <li>• Psychosis – BCH</li> <li>• Mood Anxiety &amp; Personality Services MAP.</li> </ul> <p>Lindsey Royan leads on</p> <ul style="list-style-type: none"> <li>• IMPART</li> <li>• Anger Management services – central</li> <li>• Eating disorders</li> <li>• Perinatal</li> <li>• Learning disabilities.</li> </ul> <p>Discussion took place as to specific services not on offer. KS advised that usually a tertiary referral is considered if NELFT are not able to provide a particular type of therapy of service.</p>	

	<p>Dr Kumar enquired as to sexual health service is there anywhere specific to go too. Advised that Sexual Health is not a service which is provided by NELFT locally as this is provided by BHRUT. Counselling psychology is sometimes provided within Sexual Health, such a HIV+ Counselling, however this is not something which NELFT are involved with locally. Agreed that if any condition is affecting a person's psychological wellbeing, referrals should be made to either Talking Therapies (IAPT) or Secondary Care Psychology, depending upon severity.</p>	
<b>10</b>	<b>Suicide Prevention Strategy</b>	
	<p>SL more needs to be on the MH strategy. There has been lots of activity over the last two months and on 21<sup>st</sup> March workshop was held.</p> <p>NH asked as to whether this could be repeated. SL advised that partnership group with Redbridge &amp; B &amp; D strategy.</p> <p>SL paper to Councillor Worby. B &amp; D strategy will sit within this group. Agreed that this will be owned here and SL will bring to group towards the end of the year.</p>	
<b>11</b>	<b>Training &amp; Development opportunities around Mental Health</b>	
	<p>KS suicide masterclass was well received. SL will send to JA the presentations for onward dissemination.</p> <p>KS learning lessons from SI. Think family agenda is being taken forward. Physical &amp; mental health forums being held within B &amp; D. Capacity assessments masterclass has also been delivered in this forum. Staff have also been receiving in-house training in order to deliver the Physical Health CQUIN.</p> <p>Chelle Farnan is holding sessions with actors on MCA &amp; DoLS in May, staff to register.</p> <p>CAMHS consultation ongoing for tier 2 &amp; 3</p> <p>NH raised a question as to the process when a child is born to a MH patient. KS advised that this process would be held in perinatal services for one year from conception with a link to all other relevant services, depending upon the person's individual need.</p>	
	<b>Any other Business</b>	
	<p>Ks updated the group on the Cyber-attack which took place over the weekend. KS happy to report that NELFT systems were not affected, but assistance was given to other areas who were.</p> <p>NH – Sunflowers Court up and running successfully.</p> <p>AM – Mental Health day in October, can be added to the next agenda.</p>	

**Date of next meeting –  
1.30pm – 3.30pm 19<sup>th</sup> June 2017 , Care City offices.**

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**Integrated Care Steering Group – 12<sup>th</sup> June 2017**

Chair: Sharon Morrow

<p><b>Items to be escalated to the Health &amp; Wellbeing Board</b></p> <p>(a) None</p>
<p><b>Performance</b></p> <p>N/A</p>
<p><b>Meeting Attendance</b></p> <p>Members:</p> <ul style="list-style-type: none"> <li>▪ Sharon Morrow, B&amp;D CCG</li> <li>▪ Dr J. John, B&amp;D CCG Clinical Director</li> <li>▪ Dr R Goriparthi, B&amp;D CCG Clinical Director</li> <li>▪ Simon Clarke, Primary Care Transformation, B&amp;D CCG</li> <li>▪ Melody Williams, NELFT</li> <li>▪ Tudur Williams, LBBD Adult Social Care</li> <li>▪ Ann Graham, LBBD</li> </ul> <p>Attendees:</p> <ul style="list-style-type: none"> <li>▪ Sarah D’Souza, B&amp;D CCG</li> </ul>
<p><b>Action(s) since last report to the Health and Wellbeing Board</b></p> <p>NELFT shared their proposed structure for locality working, which they will be consulting on with staff over the next 6-8 weeks. LBBD provided an update on their new structure and the impact on locality working. The GP leads reported on the development of GP networks and appointment of GP network leads. The group discussed the opportunities for locality working as teams are established and agreed to review the model for integrated case management at the next meeting.</p> <p>An update was given on the health strategy plan for Barking Riverside development and members informed of forthcoming workshops to develop the model further for the new healthcare development.</p>
<p><b>Action and Priorities for the coming period</b></p> <p>(a) NELFT and LBBD to assess impact on all age disability service and disaggregation of the S75 for mental health.</p> <p>(b) GP network leads to be engaged in the ICSG agenda</p> <p>(c) A review of the integrated case management service to be planned for the meeting on 10 July.</p>

**Contact:** Sharon Morrow, Programme Director mental health and Learning Disabilities  
BHR CCGs

**Tel:** 0203 1823302; **Email:** Sharon.morrow2@nhs.net

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## Learning Disability Partnership Board

Chair: Mark Tyson, Commissioning Director Adults' Care & Support

<p><b>Items to be escalated to the Health &amp; Wellbeing Board</b></p> <p>None.</p>
<p><b>Attendance:</b></p> <p>17 January 2017 &amp; 22 March 2017 – 88% (16 out of 18) members attended.</p>
<p><b>Performance issues.</b></p> <p>The LDPB are concerned that the number of health checks have declined to low levels again following the intensive work that was undertaken last year and have escalated this issue to the CCG. Please see commentary below.</p>
<p><b>Action(s) since last report to the Board</b></p> <p>(a) The Council is developing a new Equality and Diversity Strategy to replace the Single Equalities Scheme which expired in 2016. We must do this to meet our duties under the Equality Act 2010. The Strategy will set a new vision for equality and diversity for the Council to aspire to, and set priorities for where we want to make an impact over the next few years. At the LDPB held on 17 January, members were consulted on the draft document and full discussion was facilitated. The LDPB accepted the proposals of the Equality and Diversity Strategy, however the LDPB did have comments on why it felt learning disabilities should have a greater priority than other vulnerable groups.</p> <p>(b) The Direct Enhanced Scheme (DES) for Learning Disability is designed to encourage practices to identify all patients aged 14 and over with learning disabilities, to maintain a learning disabilities 'health check' register and offer them an annual health check, which will include producing a health action plan. This will continue at a higher value for 2017/18. The reporting of health checks to the Board for people with a learning disability are inclusive of patients aged 14 plus since 1 April 2017. Previous improvements within Adults' Services over the past year has slipped to 31% in January. This is disappointingly low considering the efforts made to raise awareness and improve the number of annual health checks. This issue has been escalated to the CCG who holds the contracts with GPs. The CCG are facilitating the programme to raise awareness again and provide training to GP surgeries. The CCG are working with primary care leads to identify how we can get most value out of this devolved responsibility. The CCG are also keen to explore service user and carer experience.</p> <p>(c) The LDPB meeting held on 14 March received an update on the new Disability</p>

Service. The LDPB welcomed the more inclusive service, and particularly how it will ensure that transition into adulthood becomes more seamless. However, members of the LDPB made comments requesting that health services are equally included in the new Disability Service.

- (d) The LDPB has begun planning events for Learning Disability week, which is now confirmed for 3 – 7 July 2017. Alongside the more traditional fun events that service users enjoy, the week will focus on employment and health checks and anti-bullying. Members of the Board, and particularly service users, are looking forward to visiting Dagenham Police Station during the week. A report on the week will be shared after the event.

**Action and Priorities for the coming period**

- (a) Update and approval of the implementation of the Learning Disability Strategic Delivery plan.

**Contact:** Karel Stevens-Lee, Integrated Commissioning Manager – Learning Disabilities

**Tel:** 020 8227 2476 **Email:** karel.stevens-lee@lbbd.gov.uk

## HEALTH AND WELLBEING BOARD

5 July 2017

<b>Title:</b>	<b>Chair's Report</b>	
<b>Report of the Chair of the Health and Wellbeing Board</b>		
<b>Open Report</b>	<b>For Information</b>	
<b>Wards Affected:</b> None	<b>Key Decision:</b> No	
<b>Report Author:</b> Rhys Clyne: National Management Trainee, LBBB.	<b>Contact Details:</b> Tel: 020 8227 3033 E-mail: <a href="mailto:rhys.clyne@lbbd.gov.uk">rhys.clyne@lbbd.gov.uk</a>	
<b>Sponsor:</b> Councillor Maureen Worby, Chair of the Health and Wellbeing Board		
<b>Summary</b>  The Chair's Report is attached at Appendix A.		
<b>Recommendation(s)</b>  The Health and Wellbeing Board is recommended to note the contents of the Chair's Report and comment on any item covered should they wish to do so.		

**List of Appendices:****Appendix A: Chair's Report**

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*In this edition of my Chair's Report, I talk about the General Election, the cancer scrutiny review, the THRIVE London initiative and the LGBT Needs Assessment. 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*

## The General Election

Whatever you think of the general election campaign and (lack of) result, it was refreshing to see health and social care take centre-stage in the debate. Every major party put forward their suggestions to resolve the health and care crisis we face today, and how we fund social care in particular proved an emotive and urgent issue for the electorate.

While the Government's proposals would bring a modest increase in funding to both the NHS and social care services in the short-term, they do not answer the long-term question of how we build sustainable solutions to the rapidly increasing pressures and demands that we face. Furthermore, the lack of a clear majority for the Conservatives means it is unclear what action will be taken at all by this unstable Parliament.

The election also drowned out the coverage of the publication of the Government's draft plan for air pollution, following a successful lawsuit from ClientEarth. James Thornton, Chief Executive of ClientEarth, commented that 'these are plans for more plans, what we need are plans for action'. Each year in London approximately 40,000 people die prematurely due to air pollution, making this a public health crisis in need of decisive action from both central and local government.

## Thrive

Thrive London is a citywide movement for mental health, supported by the Mayor of London and the London Health Board, whose aim is to bring together agencies and communities to improve mental health services, prevent illness and promote community cohesion. Evidence for the effectiveness of Thrive's interventions can be seen by the Mental Health Foundation's work, including Young Mums Together, peer work with children and young people, and tackling the isolation of older people.

Thamesview in Barking and Dagenham has been identified as a potential pilot site for Thrive – albeit potentially in phase 2 of the project – meaning in the coming months:

- The Mental Health Foundation will offer a training session to Councillors and officers on mental health prevention and provide a Borough-wide development session on mental health, bringing together stakeholders.
- The Mental Health Foundation will put forward a plan for carrying out an initial consultation session with the residents of Thamesview, including an initial walkabout of the Estate.
- The Mental Health Foundation will seek out longer term funding for potential work in Barking and Dagenham.

## Cancer scrutiny review

At the start of 2015/16, the Health & Adult Services Select Committee agreed to undertake an in-depth scrutiny review into cancer prevention, awareness, and early detection. The review aims to raise the profile of cancer awareness in the borough and, as a result, early detection and intervention. The review answers the following 3 questions:

1. Why are residents of Barking and Dagenham more likely to develop cancer and less likely to survive cancer than residents in other London boroughs?
2. What is the reason that residents are less likely to respond to requests to screen for cancer than in other London boroughs?
3. What is the reason that residents are not as aware of the signs and symptoms of cancer as residents in other London boroughs?

The full report and resulting action plan will be brought to the next Board, in September 2017. However, it makes 12 key recommendations:

1. The Health and Wellbeing Board acts to reduce the prevalence of smokers in the borough, to levels comparable with London;
2. The Board sets out to the HASSC what action it is taking to reduce the number of overweight and obese individuals in the borough, to levels comparable with London;
3. The Board acts to increase residents' awareness of the how lifestyle, including exposure to the sun, can affect the likelihood of developing cancer, the signs and symptoms of cancer and the importance of early diagnosis, and screening;
4. The National Awareness and Early Detection Initiative informs the commissioners on what action it is taking to target specific 'at risk' groups;
5. The Barking & Dagenham Clinical Commissioning Group (BDCCG) ensures that GPs are auditing and acting on audit information to ensure that patients enter the cancer pathway appropriately, and cancer is diagnosed at as early a stage as possible;
6. The BDCCG, in partnership with Macmillan and Cancer Research UK, acts to increase the proportion of residents returning bowel cancer screening kits, within the next year;
7. The Board, along with MacMillan and Cancer Research UK, acts to raise awareness of the importance of screening and to increase uptake of breast and bowel screening in the borough to a level comparable with England within the next year;
8. The Board, along with MacMillan and Cancer Research UK, acts to raise awareness of the importance of screening and reduce the variation in cervical screening uptake between GP practices within the next year;
9. The Committee urges NHS England to make the Cancer Dashboard available within one year;
10. The Board acts to raise awareness of the importance of the Health Check and reduce the variation in Health Check uptake between GP practices;
11. NHS England provides assurance to it that residents will continue to have in-borough access to breast screening; and
12. The BDCCG, working through the North-East London Cancer Commissioning Board, assures the Committee of the action it is taking to increase awareness of the signs and symptoms of cancer.

## **LGBT+ Needs Assessment**

Barking and Dagenham's LGBT+ population face a range of health and wellbeing challenges and inequalities as a result of homophobic prejudice. The LGBT+ community is disproportionately impacted by issues such as mental health – including depression, self-harm and suicide – sexually transmitted infections, smoking and problematic drug and alcohol use. Public bodies also face difficulties in collecting LGBT+-specific evidence, due to an historic lack of data collection, and under-reporting where data is collected. Last year a Community Engagement Survey highlighted some of the service delivery difficulties related to the LGBT+ population in this Borough. 42.57% of respondents rated the extent to which the Council takes into account their views, experiences and concerns as 'poor' or 'dreadful'. 80% and 94% of respondents claimed to have never reported an incident of homophobia, transphobia or domestic abuse to the police or Council respectively.

It is for these reasons we are now conducting an LGBT+ Needs Assessment. Our recently established Steering Group will lead development of this assessment through consultation and analysis, and the end result will enable a robust understanding of the health and wellbeing needs and assets of the LGBT+ population. This assessment will then be able to form the foundation of further, targeted and co-produced action to improve the health and wellbeing of LGBT+ individuals in Barking and Dagenham.

## **The 2016-17 Local Account**

We are putting the finishing touches to this year's Local Account – the Council's annual message to the community on the state of adult's care and support in Barking and Dagenham – and a draft will be circulated to members of the Board within the next week.

This year we have sought to ensure the Local Account is as accessible and useful as possible, shortening and simplifying the messages to make sure the most importance changes, challenges and achievements come through loud and clear.

We are keen to echo the views and priorities of the Board wherever possible, to strengthen our unified voice. We would therefore welcome any and all comments and suggestions on the draft Local Account, before it is brought to the September Board for final approval.

## **Future dates of the Health and Wellbeing Board**

The Board will meet on the following dates:

- 6 September 2017
- 8 November 2017
- 16 January 2018
- 13 February 2018
- 12 April 2018

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## HEALTH AND WELLBEING BOARD

5 July 2017

<b>Title:</b>	<b>Forward Plan</b>		
<b>Report of the Chief Executive</b>			
<b>Open</b>	<b>For Comment</b>		
<b>Wards Affected:</b> None	<b>Key Decision:</b> NO		
<b>Report Authors:</b> Tina Robinson, Democratic Services, Law and Governance	<b>Contact Details:</b> Telephone: 020 8227 3285 E-mail: <a href="mailto:tina.robinson@lbbd.gov.uk">tina.robinson@lbbd.gov.uk</a>		
<b>Sponsor:</b> Cllr Worby, Chair of the Health and Wellbeing Board			
<b>Summary:</b>  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 <b>Appendix A</b> 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.			
<b>Recommendation(s)</b>  The Health and Wellbeing Board is asked to:  a) Note the draft Health and Wellbeing Board Forward Plan and that partners need to advise 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.			

**Public Background Papers Used in the Preparation of the Report:** None

**List of Appendices**

**Appendix A** – Draft Forward Plan

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# **HEALTH and WELLBEING BOARD FORWARD PLAN**

Draft September 2017 Edition

Publication Date: 7 August 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](mailto: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:

<b>Edition</b>	<b>Publication date</b>
September 2017 edition	7 August 2017
November 2017 edition	9 October 2017
January 2018 edition	18 December 2017
March 2018 edition	12 February 2018
June 2018 edition	14 May 2018

## 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](mailto: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](mailto: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
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<b>Health and Wellbeing Board: 6.9.17</b>	<p><b>Domestic and Sexual Abuse Strategy</b> : Community</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"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)
<b>Health and Wellbeing Board: 6.9.17</b>	<p><b>Contract: Healthy Child Programme (0-19) - Procurement Strategy</b> : Financial</p> <p>The contracts for the 0-5 and 5-19 Healthy Child Programmes (HCP) respectively are due to expire on 30 September 2017.</p> <p>This Board will be asked to approve the procurement strategy for the competitive procurement of these services as an integrated 0-19 HCP and to delegate authority to award a contract to the successful provider.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	Christopher Bush, Interim Commissioning Director, Children's Care and Support (Tel: 020 8227 3188) (christopher.bush@lbbd.gov.uk)

<b>Health and Wellbeing Board:</b> <b>6.9.17</b>	<p><b>Contract: Public Health Primary Care Service - Procurement Strategy :</b>  Financial</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"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
<b>Health and Wellbeing Board:</b> <b>6.9.17</b>	<p><b>Sustainability and Transformation Plan Update and Partnership Agreement All Issue Categories</b></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> <p>The Board will be asked to approve the Partnership Agreement for the East London Health and Care Partnership, and to authorise delegated authority for its signing to the Strategic Director of Service Development and Integration and Deputy Chief Executive and Director of Law and Governance.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)
<b>Health and Wellbeing Board:</b> <b>6.9.17</b>	<p><b>Barking, Havering and Redbridge Transformation Programmes and Governance</b></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"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)



<b>Health and Wellbeing Board: 6.9.17</b>	<p>London Health Devolution Agreement</p> <p>The Board will be presented with a report setting out the agreed London Health Devolution Agreement, including potential opportunities for Barking &amp; Dagenham and the BHR system to use some of the devolved powers and responsibilities.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	<p>Mark Tyson, Commissioning Director, Adults' Care &amp; Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)</p>
<b>Health and Wellbeing Board: 6.9.17</b>	<p>The Cancer Prevention, Awareness, and Early Detection Scrutiny Review 2016/17</p> <p>The Health and Adult Services Select Committee (HASSC) undertook a scrutiny review on 'Cancer Prevention, Awareness, and Early Detection' as Councillors were concerned that there needed to be more public awareness around the importance of early intervention in tackling cancer so that residents access the right services, in a timely manner, to have the best possible outcome. As a result of the review the HASSC made twelve recommendations, which if accepted, will help increase the number of people in LBBD who are aware of the lifestyle factors which may affect the risk of developing cancer, the signs and symptoms of cancer, and the importance of attending cancer screening requests.</p> <p>The Board will be asked to agree the recommendations made to it and oversee the other recommendations.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	<p>Sue Lloyd, Public Health Consultant  (sue.lloyd@lbbd.gov.uk)</p>
<b>Health and Wellbeing Board: 6.9.17</b>	<p>Annual Reports</p> <p>The Board will be presented with the following annual reports for discussion and noting:</p> <p>(i) Annual Complaints Report</p> <p>(ii) Local Account 2016/17</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	<p>Rhys Clyne, National Management Trainee (Tel: 020 8227 3033) (rhys.clyne@lbbd.gov.uk)</p>

<b>Health and Wellbeing Board:</b> <b>8.11.17</b>	<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"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	<p>Mark Tyson, Commissioning Director, Adults' Care &amp; Support  (Tel: 020 8227 2875)  (mark.tyson@lbbd.gov.uk)</p>
<b>Health and Wellbeing Board:</b> <b>13.3.18</b>	<p><b>Barking and Dagenham Pharmaceutical Needs Assessment (PNA) :</b>  Community</p> <p>The Pharmaceutical Needs Assessment (PNA) is a statutory document required to be produced by every local authority's Health and Wellbeing Boards (HWB) every three years. The PNA assesses the pharmacy needs of the local population and provides a framework to enable the strategic development and commissioning of community pharmacy services to help meet the needs of the local individual population.</p> <p>The London Boroughs of Barking and Dagenham (LBBD), Havering (LBH) and Redbridge (LBR) have recently (May 2017) awarded the contract for the production of three PNA's to PHAST CIC (one for each borough)</p> <p>The HWB will be asked to sign-off the final PNA upon its completion.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	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 M. 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)  
(to be confirmed), Metropolitan Police  
Ceri Jacob, Director Commissioning Operations NCEL (NHS England - London Region) (non-voting Board Member)

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