Notice of Meeting

HEALTH AND ADULT SERVICES SELECT COMMITTEE

Wednesday, 20 September 2017 - 7:00 pm
Chamber, Town Hall, Barking

Members: Cllr Peter Chand (Lead Member), Cllr Adegboyega Oluwole (Deputy Lead Member), Cllr Sanchia Alasia, Cllr Jane Jones, Cllr Eileen Keller, Cllr Hardial Singh Rai, Cllr Linda Reason, Cllr Chris Rice and Cllr John White

Date of publication: 7 September 2017

Chris Naylor
Chief Executive

Contact Officer: Masuma Ahmed
Tel. 020 8227 2756
E-mail: masuma.ahmed@lbld.gov.uk

AGENDA

1. Apologies for Absence

2. Declaration of Members' Interests

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

3. Minutes - To confirm as correct the minutes of the meeting held on 21 June 2017 (Pages 3 - 9)

4. North East London Foundation Trust's Improvement Journey (Pages 11 - 36)

5. East London Health and Care Partnership: Consultation on Payment Development and Drivers for Change (Pages 37 - 72)

6. Health Checks Performance Update (Pages 73 - 76)
Scrutiny Review on Oral Health in Early Years

7. Scoping Report (Pages 77 - 79)

8. Oral Health in Early Years - Presentation by Public Health (Pages 81 - 99)

Standard Items

9. Results of Inspections Undertaken by the Care Quality Commission on Local Adult Social Care Services in Quarter 1 (Pages 101 - 111)

10. Joint Health Overview & Scrutiny Committee - update (Pages 113 - 115)

11. Health and Wellbeing Board Forward Plan (Pages 117 - 127)

   Members are asked to indicate whether there are items on the Health and Wellbeing Board Forward Plan which may need to be included on the Select Committee’s Work Programme for pre-decision scrutiny.

12. Work Programme (Pages 129 - 130)

13. Any other public items which the Chair decides are urgent

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

   Private Business

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

15. Any other confidential or exempt items which the Chair decides are urgent
Our Vision for Barking and Dagenham

One borough; one community; London’s growth opportunity

Our Priorities

Encouraging civic pride

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

Enabling social responsibility

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

Growing the borough

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

Well run organisation

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

Wednesday, 21 June 2017
(7:00 - 9:05 pm)

Present: Cllr Peter Chand (Chair), Cllr Adegboyega Oluwole (Deputy Chair), Cllr Jane Jones, Cllr Linda Reason and Cllr Chris Rice

Apologies: Cllr Sanchia Alasia, Cllr Eileen Keller, Cllr Hardial Singh Rai and Cllr John White

1. Declaration of Members' Interests

Councillor Oluwole stated that he was employed by Barking, Havering and Redbridge University Hospitals Trust (BHRUT).

2. Minutes - To confirm as correct the minutes of the meeting held on 3 May 2017

The minutes of the meeting held on 3 May 2017 were confirmed as correct.

3. Barking, Havering and Redbridge University Hospitals Trust - Improvement Plan Update

Sarah Tedford, Chief Operating Officer (COO) for Barking, Havering and Redbridge University Trust (BHRUT) stated that the Trust was inspected by the Care Quality Commission (CQC) in September and October 2016. Following the inspection, a ‘Quality Summit’ was held to discuss the inspection report findings and develop a plan of action. The CQC felt that the Trust had made enough improvement to move on from an overall rating of ‘inadequate’ to a rating of ‘requires improvement’, which meant that it could be taken out of special measures. The Trust has demonstrated an encouraging level of improvement and the COO’s presentation would now discuss what was in place to support the Trust to continue its improvement journey to enable it to achieve an overall rating of ‘good’.

The COO’s presentation covered the following areas:

- Where we are:
  - Establishment of an improvement portfolio board with clear lines of reporting and accountability
  - The quality improvement plan, monitored through the improvement portfolio board
  - Importance of joint working with partners
  - Continual external and internal assurance

- Must do actions – March 2017 report
- Governance Structure.

A member asked the COO to update the Committee on the Trust’s current referral to treatment time (RTT) performance and asked whether its performance at the time of the inspection affected the CQC’s findings. The COO stated that the Trust
had drafted a plan alongside the Clinical Commissioning Groups to get to the RTT target by September 2017. She was pleased to report that by the end of the month, the Trust would meet the RTT target for 90 percent of patients (the standard was 92 percent); however, for some specialisms such as trauma, orthopaedics and general surgery, it would take more time to reach RTT targets. RTT performance was being monitored very closely to ensure that patients would not face harm whilst waiting, that waiting times were decreasing at a good rate, and that the Trust was on track to meet RTT targets by September this year.

The Committee asked what the Trust was doing to retain staff, given its high staff turnover and vacancy rate. The COO stated that this was a complex and challenging area for the Trust which it was working hard to address. The Trust had successfully recruited 200 nursing staff who would join soon and had also held an ‘Open Day’ at the weekend which led to the appointment of 50 people. Past recruitment initiatives had not produced this level of response which may be attributed to the Trust’s previous ‘special measures’ status. The Trust still had a large vacancy rate but was starting to see it reduce. With regards to retention, this remained a challenge as many newly qualified staff were still leaving after a year of employment. The Trust was trying to understand the reasons behind this and in response, had put in place rotational opportunities so staff could obtain a variety of experiences and a 10-year career development programme, which had been shared with NHS Improvement, who were keen to share it nationally. In response to a further question, the COO stated that there was regular monitoring of this programme and in approximately six months’ time, the Trust would be able to build a picture of its effectiveness.

In response to a question, the COO stated that she would be able to provide the Committee information on the Trust’s vacancy rate in terms of percentage following the meeting and added that the Trust still relied heavily on agency staff.

In response to questions, the COO stated that the Trust’s Chief Executive held a high level monthly meeting where the ‘five pillars’ of improvement work were considered. There were many other meetings looking at different elements of these pillars which occurred as frequently as weekly. The executive team met with frontline staff regularly. Across all times of the week there were a range of forums where engagement with staff took place to allow significant opportunity for the staff voice to be heard. Senior staff within specialisms met with their own teams regularly also.

A member asked the COO to update the Committee on the Trust’s financial position. The COO stated that the Trust was now in a relatively strong financial position. It was in a £11.9m deficit at the end of the last financial year and the first two months of the current financial year showed a surplus of £1.3m. This was a testament to the hard work of teams across the Trust in finding better ways of working. In response to questions asking whether reducing the deficit over the years had affected residents and the numbers of staff negatively, Ms Tedford stated all the Trust’s plans go through an impact assessment overseen by the Medical Director and Chief Nurse, which would consider carefully the impact on service users and staff. The Trust had found ways to become more efficient resulting a reduction in admissions to hospital, for example. Unlike many other NHS organisations, the Trust has increased staffing levels and most of the savings were down to addressing significant inefficiencies in how the Trust was operating.
A member asked what the Trust was doing to improve the level of resuscitation training as this was an area of concern raised by the CQC. The COO stated that this issue related to the ability to release staff for the training, which had now been resolved. The Trust had started monitoring mandatory training and this action had now been complete.

In response to a question, the COO stated that agency staff were more expensive than permanent staff. The Government had issued regulations regarding the capping of pay for agency staff and it was important that all NHS trusts kept to the cap in order for it to reduce costs across the NHS.

A member asked what the Trust’s main priorities were for achieving an overall rating of ‘good’ by the time of its next CQC inspection, and what the Trust’s target time period was for achieving this. The COO stated that the Trust aimed to achieve an overall rating of ‘good’ by the time of its next CQC inspection, which could be in March 2018 (however, it was usually difficult to change the overall rating unless there was a full CQC inspection, which currently was not known at this stage). In terms of priorities, the Trust had an ‘Improvement Portfolio’ which listed its main priorities. In summary, it aimed to continue to work on administrative and other systems to achieve better services by demonstrating that it was proficient in all the domains CQC would inspect it on.

In response to a question, the COO stated that cost was not stopping the Trust from recruiting the right staff. The Trust had a Workforce Strategy and knew the numbers it needed; for example, it had nine consultants in the Emergency Department but it should have 24. The issue was a national one in that there was a shortage of staff, and there were many other trusts in this position. The Medical Director and Chief Nurse were working with universities to enhance BHRUT’s offer to attract more staff.

A member stated that members had been hearing about plans to close or ‘downgrade’ King George Hospital’s (KGH) A&E department for some time and move services to Queen’s Hospital. She asked whether there was a planned timetable to implement this and how the Trust could be confident that doing this would improve access to emergency care for the borough’s residents. The COO stated that it was correct that there had been numerous discussions regarding the KGH A&E and the best way forward to manage the increase in demand on A&E. Over the past two years the Trust had seen a 20 percent increase; however, much of this increase could be attributed to people attending A&E due to inaccessibility of other services more suited to deal with non-emergency cases. No decision had been made on the future of the A&E at KGH but different models were being looked at as part of the Sustainability and Transformation Plan for this part of London.

A member stated that the CQC inspection found that the Trust was consistently failing to meet NHS waiting time indicators relating to 62-day cancer treatment, and asked the COO to explain to what extent the delay had been decreased. The COO stated that the clinical team were working hard to ensure the service had the right resources to reduce delay. In March 2017, the service had in fact managed to deliver the waiting time target; however, performance slipped back in April and more recently, the NHS cyber-attack occurred, which could potentially affect
performance. The team were aware of this and would be looking seriously at how to reduce the delay so that in June, performance would be on target once again.

In response to a question, the Council’s Strategic Director for Service Development and Integration (SDSDI) stated that the borough had a higher rate of people being diagnosed with cancer at a late stage due low awareness amongst residents of the signs and symptoms of cancer. The Council’s Director of Public Health (DPH) added that there were two screening programmes for breast and bowel cancer in this borough and in Havering and Redbridge, and it was important to improve screening attendance rates so that more people could be diagnosed earlier. There was currently a programme being delivered to target specific communities and work with GPs, which was being overseen by the Cabinet Member for Social Care and Integration. The Chair stated that this Committee had completed a scrutiny review on raising awareness amongst residents of the lifestyle factors that can increase the risk of cancer, the importance of screening, and the symptoms of cancer, which would be presented to the Council’s Health and Wellbeing Board in September 2017.

4. **Barking, Havering and Redbridge University Hospitals Trust - Response to the Parliamentary and Health Service Ombudsman Report on Failures in Discharge from Hospital**

The Council’s Operational Director, Adults’ Care and Support (ODACS) introduced the item by stating that the Parliamentary and Health Service Ombudsman published a report last year entitled ‘Unsafe Discharges from Hospital’. This report was based on investigations that they carried out on 216 complaints and nine cases were used to illustrate the gap they saw between established good practice and people’s actual experience of leaving hospital.

The most serious issues they observed were:
- Patients being discharged before they are clinically ready to leave hospital;
- Patients not being assessed or consulted properly before their discharge;
- Relatives and carers not being told that their loved one had been discharged; and
- Patients being discharged with no home-care plan in place or being kept in hospital due to poor co-ordination across services.

The ODACS added that hospital discharge practice had improved considerably in BHRUT over recent years supported by the creation of the Joint Assessment and Discharge (JAD) Service which had led to a sharp reduction in delays attributable to social care. However, the Council was still aware of discharges that had gone wrong where some of the issues described above were present. This agenda item had been requested to inform members on what systems were in place locally to monitor the numbers of unsafe discharges and what was being done to address problems around practice that may be present locally.

The COO for BHRUT delivered a presentation on ‘Ensuring Discharges are Safe’ which covered:
- How older people can define ‘wellbeing’
- What is a safe discharge?
- Why is safe discharge important?
What we are doing to improve – the flow programme, and
How we will know we have improved?

A member stated that vulnerable people such as those with learning disabilities should have a hospital ‘passport’, which would contain information in it that should help facilitate appropriate discharge from hospital. She asked what the Trust was doing to ensure that such people got home safely as she was aware of a case where despite having a hospital passport, the person did not get home safely from the Emergency Department. The COO stated that she was disappointed to hear this as there were support teams in the A&E departments to ensure people got home safely. She asked the member to provide her with the details of the case outside of the meeting so she could arrange for it to be looked into.

In response to questions from members, the COO stated that:

- The Trust was seeing much closer working between social care staff and its own staff but there was more to be done on this;
- There were arrangements in place to support people with medications at home and some diagnostic tests could also be undertaken in the person’s home;
- The Trust had had some cases of vulnerable people being discharged in the middle of the night on their own and was working to ensure this would not recur. Discharge was now discussed with the patient to ensure they understood what was happening and if there was no support available to enable the person to be discharged at night, there was an ‘observation ward’ where they could stay until morning;
- The Trust has a system in place to record ‘repeat attendees’ and was working with GPs on this. It had also obtained some funding to appoint two individuals to work with such patients to understand why they kept returning to hospital;
- The reasons why some discharges were classed as ‘complex’ varied but usually, it was because the person could not go back to the setting they were in before they came into hospital. The JAD Service had made a big difference to help ensure better discharges for many people;
- Demand for patient beds was still a big challenge for the Trust, particularly during bank holidays and cold winters, for example. However, the Trust’s policy was not to discharge if it was not considered safe to do so;
- There were three meetings a day to consider patient flow so that discharges could be planned. These meetings should lead to better planning around ordering transport for the patient if required. She would be keen to hear examples of where the ‘cut-off’ point for ordering transport had been missed due to poor planning, leading to an extra night’s stay in hospital;
- If the patient was homeless, the Trust would work with the relevant services to ensure the patient had a safe place to go to from hospital. This could sometimes lead to a longer stay in hospital; and
- The Trust no longer ‘rewarded’ teams for discharging patients earlier in the day.

5. Barking, Havering and Redbridge University Hospitals Trust’s Response to the Cyber Attack on the NHS

The COO stated that the recent cyber-attack on the NHS had fortunately not affected BHRUT as badly as it had done some other NHS organisations; however,
the Trust did face some challenges as a result of the attack. In the aftermath of the attack the Trust had to shut down its internet access and external emails, and update its anti-virus software. Some servers were affected but as it had over 400 servers, the impact was not severe. The Trust’s IT service worked with Microsoft to carry out ‘patches’ on affected servers to aid recovery. The Trust did have to declare an internal ‘major incident’ as some data could not be transferred across teams. This meant that staff had to walk back and forth locations to maintain services and because of delays, they had to prioritise some cases above others. Some non-urgent appointments also had to be rescheduled to deal with delays caused by the attack and allow more capacity to deal with emergency patients. Emergency and cancer services were effected. There were some problems with the Trust’s switchboard and some routine blood tests had to be stopped.

A full review was being undertaken on how the Trust dealt with the attack. Some early lessons were that systems should be tested, and patches should be undertaken, regularly.

In response to questions from members, the COO stated that:
- There were no breaches of patient confidentiality;
- No ransoms were paid as a result of the attack; and
- The patches made to servers as a result of the attack did not cost the Trust as they were provided by Microsoft, but the attack did have a cost-in terms of man hours spent on dealing with the impact.

6. Results of Inspections undertaken by the Care Quality Commission on Local Adult Social Care Services in Quarter 4

The Commissioning Director, Adults’ Care and Support (CDACS), outlined a report updating members on results of inspections undertaken by the CQC on local adult social care services in Quarter 4, which was noted by the Committee.

A member asked whether members of the Committee could undertake visits to a selection of providers in the borough and the CDACS stated that he would be happy to facilitate this. The SDSDI stated that previous members of this Committee had been offered such visits after a programme had been produced; however, take up was low and therefore members would need to commit to attend before a programme of visits was drawn up. The Chair asked the Democratic Services Officer to write members to request that they express an interest in taking part in visits.

7. Joint Health Overview & Scrutiny Committee

The Chair asked members to note a report on the Joint Health and Overview Committee (JHOSC), which as well as providing background and information on local joint health scrutiny arrangements between the borough, and the boroughs of Havering, Redbridge and Waltham Forest, asked members to appoint three members of the Committee to the JHOSC.

The Committee agreed to appoint Councillors Chand, Oluwole and Jones to the JHOSC for 2017-18.
8. Draft Work Programme 2017/18

The Committee noted a report on its proposed Work Programme for 2017-18, including a recommendation made at the 3 May 2017 meeting that the Committee undertake a scrutiny review on Oral Health in 2017-18.

Councillor Reason suggested that before taking a decision, the Committee alternatively, consider undertaking a scrutiny review on homeless people’s access to health services, as her experience as a councillor told her that this was an issue that needed investigation. Officers advised that due to the number of Committee meetings remaining in 2017-18, this area would be difficult to scrutinise thoroughly as it would involve a wide remit to address several complex issues. Councillor Reason accepted this and urged members to undertake a scrutiny review on this issue next year (she would not be standing to become a councillor in 2018).

Having confirmed that the Committee agreed to undertake a small-scale scrutiny review on Oral Health in 2017-18, the Chair stated that the Committee would now need to agree upon which aspect of oral health the review would focus on. Officers had laid out three options in the report, as follows:

- Oral health in early years;
- Oral health and special educational needs; or
- Oral health training and the wider professional workforce.

Having taken advice from officers, the Committee agreed that the area of focus for the Oral Health Scrutiny Review should be Early Years.

The Chair asked members whether they felt there were items on the Health and Wellbeing Board Forward Plan which needed pre-decision scrutiny. Members confirmed that at this stage, there were not.

The Committee noted the other suggested items for its Work Programme 2017-18 and the Chair asked members to write to the Democratic Services Officer with any further suggestions.
This page is intentionally left blank
Title: North East London Foundation Trust – Care Quality Commission’s Comprehensive Inspection

Report of North-East London Foundation Trust (NELFT)

Open Report | For Information
---|---
Report Author: Melody Williams, Integrated Care Director | Contact Details: Tel: 0300 555 1201 x65075 E-mail: melody.williams@nelft.nhs.uk
Accountable Director: Melody Williams – Integrated Care Director NELFT
Accountable Strategic Director: Jacqui Van Rossum – Executive Director London NELFT

Summary:
Appended to this cover report is an updated presentation on the actions taken by NELFT following the Care Quality Commission’s inspection outcome for services in Barking and Dagenham Comprehensive Inspection of North East London Foundation Trust (NELFT).

Recommendation(s)
The Health and Adult Services Select Committee (HASSC) is recommended to agree:
(i) Note the progress against the overall CQC judgement rating, and
(ii) Note the NELFT re-inspection framework.

Reason(s)
It is good practice for the HASSC, as the Council’s health scrutiny committee, to be kept updated on the progress of providers following CQC inspections which have found a need for significant improvements, to allow members the opportunity to provide constructive challenge where needed.

1. Introduction and background to presentation update:

1.1 The Care Quality Commission, or CQC, is the independent regulator of health and adult social care services in England. Its purpose is to make sure health and social care services provide people with high-quality care and to encourage care services to improve. The CQC’s role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety these are known as Essential standards of quality and safety.
1.2 NELFT received its first full comprehensive inspection during the week of 4th - 8th April 2016 and the outcome of this inspection was made public on the 27th September 2016.

1.3 Of our 14 core services that were inspected, the CQC rated nine as ‘Good’ and four as ‘Requires Improvement’ and one as ‘Inadequate’. This has led to an overall CQC rating of ‘Requires Improvement’ for the Trust.

1.4 The CQC held a Quality Summit on 14th October 2016 and representatives from all partner organisations, Governors, patient groups and staff attended and a series of development workshops to look at how the partnership can work together to support an improvement plan took place.

1.5 The Trust has developed a quality improvement action plan to address the issues within the CQC report which was presented to the NELFT Board in Part 1 of the Trust Board meeting on the 25th October 2016 and has been monitored and scrutinised for progress on a monthly basis since then.

1.6 Significant progress has been achieved across all areas of ‘Must Do’ and ‘Should Do’ recommendations, as reported to the NELFT Board, Commissioners and partnership forums (see attached presentation)

1.7 Re-inspection programme across End of Life, Well Led and the individual services has commenced in late Summer/Autumn 2017

Background Papers Used in the Preparation of the Report:

Care Quality Commission website listing all reports:

Individual reports and the Summary Report following the comprehensive inspection in April 2016 published Sept 2016
http://www.cqc.org.uk/provider/RAT/reports

Brookside (CAMHS Inpatient Services) Sept 2016 published March 2017
http://www.cqc.org.uk/provider/RAT/inspection-summary#mhadolescent

List of appendices:

Appendix 1 NELFT’s presentation to the HASSC
CQC Improvement Plan Update
Barking & Dagenham HOSC

September 2017

Integrated Care Director: Melody Williams
Hilary Shanahan: Strategic CQC Project Lead
Adjoa Nsiah-Jennings: Strategic CQC Project Manager
Introduction

The Care Quality Commission (CQC) are the national regulators of all healthcare providers, their purpose is to ensure services are provided in a Safe, Effective, Responsive, Caring and Well-led way.

On 4th-8th and 14th April 2016 NELFT received a comprehensive (full) inspection, from which 14 individual core service reports were published plus an overarching NELFT report.

Each domain was given an overarching rating of:-
Safe – Requires improvement
Effective – Requires improvement
Responsive – Requires improvement
Caring – Good
Well-led – Requires improvement
## Ratings for Mental Health Services

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

**Good – September 2017**
### Ratings for Community Health Services

<table>
<thead>
<tr>
<th></th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health services for adults</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Community health services for children, young people and families</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Community health inpatient services</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>End of life care</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Community dental services</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Overall</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
</tbody>
</table>
CQC result by core service (Sept 2017)

10 services received a “Good”

1. CAMHS Brookside
2. CHS in-patients
3. Community MH LD/autism
4. Community MH adults of working age
5. Community MH for older people
6. Forensic in-patients (Morris ward)
7. S136 and crisis
8. Specialist community MH C&YP
9. Wards for people with LD/autism (Moore ward)
10. Long stay rehab (Picasso ward)

4 services received a “Requires Improvement”

1. MH acute wards
2. Community health services for adults
3. Community health services for C&YP
4. Wards for older people with MH problems (Cook, Stage and Woodbury wards)
CQC Improvement Plan

- January 2017: CQC Strategic Project Team in post
- Clinical engagement across all the areas of ‘requiring improvement’
- Additional oversight via the ‘Communities of Practice’ within NELFT
- Plan and response overseen by the Executive Director of Nursing
- Reporting Framework to the Board, commissioners and external partners including B&D HWBB
Strategic CQC Quality Improvement Group

In response to the CQC findings, NELFT set up a Strategic CQC Quality Improvement Group to manage each of the 137 recommendations.

In June 2017, seven Locality CQC Quality Improvement Groups were set up in order to monitor progress, sustainability and mitigate risks at a local level, therefore embedding this as day to day service delivery.

Serious of internal peer review/mick inspections delivered across all services areas
Locality Quality Groups reporting arrangements

Board

Quality & Safety Committee

EMT

Quality SLT

Locality Quality Improvement Groups

A&R Locality Group
WF Locality Group
Redbridge Locality Group
B&D Locality Group
Havering Locality Group
B&B Locality Group
Thurrock Locality Group

Best care by the best people
CQC Recommendation Themes

- Care Planning & Clinical Risk Assessment
- Mandatory Training, Supervision and Appraisal
- Lone working
- Estates
- Ligatures & Restraint
- Access to EPR for temporary staff
- Information Governance – use of paper diaries
- Effective Governance – incident reporting, referral to treatment, lessons learnt
Recommendations affecting services within Barking & Dagenham
Care Planning

• The QI Care Planning Accelerator Programme

• A collaborative approach, using QI methodology, to address the recommendations in the CQC report relating to care planning

• Care planning managed via supervision and team meetings (CRT)

• Task & Finish Group – CHS Adults / RiO & SystmOne
Clinical Risk Assessment

- RiO clinical risk assessment template developed for mental health services
- Clinical risk assessment policy in final stages of development
- Mandatory classroom based clinical risk assessment training delivered
- Online foundation clinical risk assessment training under development
Mandatory Training

- Trust compliance target is at (85) %
- B&D compliance is at 85%+ in all core areas apart from 1
- ATL (AT-Learning) manager access for data scrutiny
- Monthly alerts from ATL to individual staff to remind them
- Monitored at DPQSG’s/LT and the strategic workforce group
- Monthly fall out rates are reviewed and escalated to ICD’s
- Highest levels of MT requirements and completion in comparison to other London Trusts
Supervision & Appraisal

Supervision:
- On line module launched via STARs
- Reporting mechanism by directorate in development
- Localised data is now being monitored

Appraisal:
- Appraisal form on STARS
- Appraisal training rolled out and access to STARS given to business managers
- Detailed review of the 1100 overdue staff and individualised feedback provided
- Video and Frequently Asked Questions (FAQ) on intranet
- NELFT B&D compliance is at 86% (target is 85%)
Lone Working

• Lone working policy reviewed

• Lone working risk assessments completed by staff at an individual and team level

• Health & Safety team have promoted awareness of Lone Working via NELFT communications

• Localised action plans being monitored at Leadership Teams and are supported by the Health & Safety team
Caseload Allocation

- Recommendation refers to specifically to paediatric therapies
- Skill mix in teams reviewed
- Urgency of appointments reviewed and all patients waiting longer than standards are clinically reviewed
- Additional funding for BHR Paediatric therapies is with CCG commissioners for consideration
- Also identified in the Joint SEND inspection and forms part of the SEND joint action plan.
Information Sharing and Incident Reporting & Feedback

- Clinical Portal Programme in development for sharing information across organisations and localities
- Training sessions increased and developed for staff and managers
- Bi-annual Datix newsletter
- Drop-in sessions created
- Localised lessons learning events
  - Shared via locality groups
  - Shared via Community of Practice forums
Information Governance (paper diaries)

- Discontinuation of paper diaries
- Communications sent out
- Infographic circulated
- SNAP audit completed
- September 2017 re-audit
- Three year Agile Working Programme - B&D = 2/3 of staff with agile device
Governance

• Heat Maps being developed to clearly identify areas of concerns/risk

• Process has been agreed at SLT to include referral to treatment waiting times

• Regular meetings with Performance

• Quality Dashboard developed by Chief Nurse for the Board and informs commissioner reporting
Dementia Friendly Environments

- MSNAP Accredited Barking & Dagenham Memory Service:
  - Excellent April 2015-April 2016

- Re-evaluated in Summer of 2017
  - Risk assessment completed on shiny floor covering
  - Rating now changed to pass/fail
  - B&D services assessed by external review team as passed
Re-inspection August 2017

- On 15\textsuperscript{th}-17\textsuperscript{th} August the CQC re-inspected the Acute and Rehabilitation Directorate and EWMHS (Essex)
- Initial feedback from staff overall positive
- Any issues raised dealt with promptly
- Top line feedback from CQC on 21\textsuperscript{st} August 2017
- Formal feedback due in 4-5 weeks
Re-inspection and End of Life Inspection

- CQC Resource Pack & Self-Assessment Tool
- Team Posters in development
- CQC Well-Led Review in October 17
- Re-inspection of core services: two weeks notice
- CQC has proposed revised Key lines of enquiry (KLoEs) which are due to be published post general election – awaiting an update
- End of Life Bench-marking exercise undertaken.
- End of Life Action plan developed and progressing
Mock Inspections & Peer-Led Reviews

- Across June & July all services who were inspected in 2016 by the CQC were re-visited

- Awareness of core service report and recommendations were discussed

- The links between changes within the organisation and the CQC recommendations need to be reinforced

- A programme of mock inspections and peer-led reviews are taking place across July-September 2017

- Mock inspections – Directors of Nursing / operational managers / infection control / safeguarding / communications / health and safety / pharmacy / medics / allied health professionals / frontline nursing staff / NEDs
Conclusion

- Key themes from the April 2016 CQC inspection were identified and a considerable amount of work across the Trust has been completed to address those recommendations at both a ‘Must Do’ and ‘Should Do’ level.

- Locality Quality Improvement Groups have been formed to monitor compliance and ensure the embedding and sustainability of these themes in practice.

- A Well-Led review will take place in October 2017.

- Re-inspections of CAMHS and the Acute and Rehabilitation Services took place in August 2017.

- CQC will also inspect against the End of Life Care standards in 2017.
Title: Response to East London Health & Care Partnership’s Consultation on Payment Mechanisms

Report of the Deputy Chief Executive

<table>
<thead>
<tr>
<th>Open Report</th>
<th>For Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Author:</td>
<td>Contact Details:</td>
</tr>
<tr>
<td>Mark Tyson</td>
<td>020 8227 2785</td>
</tr>
<tr>
<td>Commissioning Director, Adults’ Care &amp; Support</td>
<td><a href="mailto:mark.tyson@lbld.gov.uk">mark.tyson@lbld.gov.uk</a></td>
</tr>
</tbody>
</table>

Accountable Director: Mark Tyson, Commissioning Director, Adults’ Care and Support

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

Summary:

On 11 July 2017, the East London Health & Care Partnership (the new name for the partnership formerly referred to as the Sustainability & Transformation Plan partnership) launched a consultation on future payment mechanisms within the NHS. The document is attached and introduces the need for reform and some of the key considerations. A response is required by 29 September 2017, which is an extended deadline to accommodate this (and other) formal Board meetings.

The Health & Wellbeing Board received a report on 6 September 2017, which set out the points that may be made in response to the consultation from London Borough of Barking & Dagenham. Officers will verbally update the Health & Adult Services Select Committee on the discussions that took place at the Health and Wellbeing Board on 6 September 2017.

The Health & Adult Services Select Committee is invited to further consider the Health & Wellbeing Board report and to add further comments to the response that will be sent from the Council. If there are additional comments, or points of disagreement, then they will be flagged up in the combined response as having been provided by this Committee. To support the Committee in considering the response, the East London Health & Care Partnership will attend the meeting to present the consultation and contribute to the discussion.

The proposals set out by the ELHCP in their consultation document, whilst quite generalised at this stage, are broadly consistent with the work that has been undertaken across Barking & Dagenham, Havering and Redbridge to scope the development of
accountable care approaches. In particular, the Business Case for the development of an Accountable Care Organisation, completed in late 2016, covered much of the same ground in setting out the case for change. Currently organisations in the health and care system are driven by the competing requirements of their commissioners, and therefore new payment arrangements need to drive a focus on the outcomes needed for residents and patients, rather than payments for episodic and unconnected care.

**Recommendation(s)**
The Health and Adult Services Select Committee are recommended to:

- Note the consultation document, and the presentation provided by the East London Health & Care Partnership;

- Note the verbal update on the proposed response of the Health & Wellbeing Board and its discussion from 6 September;

- Provide any further comments and observations that the Committee feels appropriate and delegate to the Chair to approve on its behalf the Select Committee’s contribution to the final response for submission by the deadline of 29 September 2017.

**Reason(s):**
If we are to improve how well the health and care system prevents ill-health, promotes well-being, and joins up the care received by residents, then we will have to make some changes to how individual organisations are contracted and paid. These payments form incentives to behave in certain ways (attracting episodes of care, rather than responding more fully to the needs of an individual, for example). Working across organisational boundaries can only really happen when financial incentives are aligned to the outcomes that are wanted.

**Appendices**

- **Appendix 1:** Health & Wellbeing Board report proposing a draft response and seeking comments.

- **Appendix 2:** East London Health & Care Partnership Consultation Document on New Payment Mechanisms
On 11 July 2017, the East London Health & Care Partnership (the new name for the partnership formerly referred to as the Sustainability & Transformation Plan partnership) launched a consultation on future payment mechanisms within the NHS. The document is attached and introduces the need for reform and some of the key considerations. A response is required by 29 September 2017, which is an extended deadline to accommodate this (and other) formal Board meetings.

The proposals set out by the ELHCP in their consultation document, whilst quite generalised at this stage, are broadly consistent with the work that has been undertaken across Barking & Dagenham, Havering and Redbridge to scope the development of accountable care approaches. In particular, the Business Case for the development of an Accountable Care Organisation, completed in late 2016, covered much of the same ground in setting out the case for change. Currently organisations in the health and care system are driven by the competing requirements of their commissioners, and therefore new payment arrangement need to drive a focus on the outcomes needed for residents and patients, rather than payments for episodic and unconnected care.

The proposed content of a response is included in this report, and the Health & Wellbeing Board is invited to discuss it, make amendments, and ultimately to agree to delegate to the Chair to approve the final text of the submission.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Note the consultation;
Appendix 1

(ii) Review and amend the outline response, and add in any further matters for consideration.

(iii) Delegate authority to the Chair of the Board to approve the final response on its behalf for submission by the deadline of 29 September 2017.

Reason(s):
If we are to improve how well the health and care system prevents ill-health, promotes well-being, and joins up the care received by residents, then we will have to make some changes to how individual organisations are contracted and paid. These payments form incentives to behave in certain ways (attracting episodes of care, rather than responding more fully to the needs of an individual, for example). Working across organisational boundaries can only really happen when financial incentives are aligned to the outcomes that are wanted.

1. Introduction and background

1.1. The Strategic Outline Case that was prepared in November 2016 set out a way forward for health and social care in Barking & Dagenham, Havering and Redbridge, and was submitted to inform the London Devolution Agreement, which is still awaited. Amongst the devolution ‘asks’ was a concise summary of the problems which a reform of payment mechanisms are intended to address:

“Our contracting and commissioning structures are fragmented and do not enable or support integrated working. Currently most of the resource in the system is weighted toward treating people when they become unwell, with significantly lower investment in preventing people from becoming unwell in the first place. Similarly, contracts for services are based on activity rather than outcomes, creating artificial and perverse incentives which pay for services based on the number of people that they treat, as opposed to the experience and outcomes of those that receive them. By changing the way in which we commission and contract for services, and pooling the resources and expertise of commissioners and local authorities, we would be able to utilise greater budgetary flexibility to enable financial incentivisation and prioritisation that more accurately responds to local needs.”

1.2. This is explored in greater detail in the proposals set out by East London Health & Care Partnership. As a local ‘STP’ footprint, the ELHCP has a weight behind it which can carry negotiations with regulators and the NHS centrally, to support the reforms which the local system requires in order to better serve local people. Whilst the shape of local commissioning and payment arrangements will need to be tailored to support the ambitions of the BHR system, it is nonetheless therefore important that ELHCP are part of shaping the options available.

1.3. At this stage, the ELHCP is not proposing any specific options for changes to the way services are contracted or how they receive payment for the services that they provide to residents. It is exploring the need for change, and seeking views on how that change might best serve local needs. At this stage, therefore, much of what the BHR system may want to explore has been set out in general terms in the
Appendix 1

Strategic Outline Case. It is proposed that the response to the consultation from Barking & Dagenham re-emphasises this.

1.4. Given this, and given the work that is underway in BHR on these issues, it is not proposed that the individual questions posed by the consultation be answered in turn.

1.5. It is worth noting, for the sake of clarity, that this is not a consultation about changing how or whether individuals should pay for health and care. It is solely concerned with how the public money to pay for health and care services is packaged up and given to providers in return for the services that they provide to residents.

2. Elements of a proposed response

General recognition of the need for change

2.1. The drivers for change set out by the ELHCP are in accord with those set out in the work to develop the case for an Accountable Care Organisation. Currently a programme is being developed to better align commissioning across the BHR system, as well as providers working together on how to take a greater shared responsibility for achieving what residents need from health and care services. This has been subject to a number of updates to the Board over the past year or so, and it is proposed to refer in the response to ELHCP to this emerging work.

2.2. Fundamentally, there is no disagreement on the principle that tariff-based payment mechanisms, as currently exist, need to change if we are to increase prevention and move away from fragmented and episodic care delivery.

Governance and timing

2.3. The Board may wish to consider taking this opportunity to raise a question about how the consultation has been approached. It is welcome that the borough partners – the Council and CCG – have been invited to respond to the consultation, but this raises a concern that the ‘system’ governance that has been created for BHR has been sidestepped. Given there is a BHR Integrated Care Partnership Board, with democratic and clinical leadership, in time it may be more reasonable to expect partners’ contributions from the BHR patch to be routed through this mechanism. It has been highlighted before that there is a local focus on the BHR system as the means of delivering the shared aims of the ELHCP, and to open up two lines of discussion between individual partners and a level of ‘system governance’ would not be helpful or productive. It is proposed that the consultation response re-emphasises Barking & Dagenham’s commitment to the BHR system for the continuance of these conversations, and encourages ELHCP to engage with the BHR mechanisms accordingly.

2.4. Question 10 asks what elements should be in place to ensure current provider relationships support transformation. It is again proposed that Board identify that current plans in BHR are, in principle, for strengthening joint commissioning and for providers to lead collaborations that prioritise outcomes for residents and patients over the current organisational silos. Therefore, ELHCP may be encouraged to
ensure their own approaches to provider alliances or new commissioning structures should be created to support, not duplicate or shadow, the emerging BHR systems.

**Localities**

2.5. The backbone of the programme for reforming health and care delivery, in Barking & Dagenham and the BHR system more widely, is the integrated locality arrangements. Currently three localities exist, with a fourth to follow in coming years as the population expands. These are the focus for bringing together a range of social care, community health and primary care services, to meet the needs of both the general population and those with higher levels of health and care need. It is suggested that the localities are referred to as a response to those questions seeking to identify priorities for new payment mechanisms. New ‘capitated budget’ approaches have been suggested as ways in which locality partnerships might take greater shared responsibility for driving preventive and joined up care, and therefore payment needs to reflect that this is our shared ambition.

2.6. In particular, question 7 asks about the geographic footprint for payment systems: a restatement of the longstanding agreement about ‘subsidiarity’ would again be appropriate. Payment mechanisms should support locality delivery, maintain borough accountability, and be shaped and drive through the BHR system. Where the ELHCP can add specific additional value, they have a role as part of that delivery chain.

**Services in scope**

2.7. It is suggested that, at this stage, the question about services in scope be deferred until the work being undertaken to support joint commissioning and provider collaboration in BHR is at a more advanced stage. As in that work, the Board may simply wish to respond that nothing should be excluded until there is a case identified for excluding it from any new approaches to paying providers for the services that they deliver.

2.8. One point that it would no doubt be worth absolutely emphasising in any response, is that a payment mechanism must be able to reward preventive activity, rather than continuing to compensate for reactive care processes. This is the fundamental aim of the programme. This will mean, therefore, that traditional views of ‘services’ or ‘pathways’ have to be rethought to identify the opportunities for prevention that are currently missed. Taking it to its furthest conclusion, this may well extend to services that are currently peripheral to the health and care system, but absolutely central to health improvement and the prevention of illness, such as housing, leisure, welfare and employment support.

2.9. A further helpful refinement to the approach may also be to consider not only who is paid, but who pays. The starting assumptions read strongly as NHS system payments. Local authorities and other partners also pay for elements of service (weekly price-based contracts for residential care, for example, or hourly homecare contracting) and there is an opportunity think anew about how to contract such services when purchasing for broader service user outcomes together with health commissioners.
2.10. The question of ‘who pays’ is made more transformational still when the resources are given to the service user or patients as a personal budget or personal health budget, and the market is further opened up to what are currently ‘non-standard’ options. This has the potential to harness or stimulate individuals’ willingness to take control of their own health and wellbeing, including with digital health and wellbeing self-management tools and other alternatives to dependence on current service models.

Questions about data and analytical capacity

2.11. A set of questions at the end of the consultation explore issues of data flows and the capacity to manage any new system of payment.

2.12. In terms of system development, the Local Digital Roadmap has been in on-going development for some time, to shape the data and record management system needs for a more integrated and responsive health and care system. The questions which are raised about data capacity ought to be resolve through that workstream. The Board’s response may be to suggest that this be referred back to the respective leads in each of the health and care systems for their consideration, and for each of them to raise common issues which the ELHCP may be in a position to help resolve.

2.13. On a specific point, it has been noted in a number of forums locally that the East London Information Sharing Agreement is now quite old (dating back to around 2004-2007). Whilst it remains serviceable, and there continues to be Service Specific Information Sharing Arrangements created under its terms, general good practice would suggest that it may be opportune to review it and ensure that it supports the information governance arrangements of the work that all of the health and care systems are doing or planning. That would seem to be a clear example of a piece of work that could usefully be led across ELHCP.

2.14. On the subject of analytical capacity, again the Board may wish to consider whether the response should be to draw the ELHCP into supporting the development of shared analytical capacity within the BHR (and neighbouring) health and care systems, rather than planning the creation of capacity at ELHCP level. The complexities of planning for population health improvement and more outcomes-focused payment mechanisms will require considerable resource, and if it is to be assumed that there is not the available resource to double this up at both BHR and ELHCP level, then the points made above would all suggest that the priority should be on supporting the ambitions laid out in BHR.

3. Mandatory implications

Joint Strategic Needs Assessment

3.1. Currently organisations in the health and care system are driven by the competing requirements of their commissioners. New payment arrangements need to drive a focus on the outcomes needed for residents and patients, rather than payments for episodic and unconnected care. The Board’s response to this consultation can capture this.
Appendix 1

Health and Wellbeing Strategy

3.2. Barking and Dagenham’s Joint Health and Wellbeing Strategy identifies ‘improvement and integration of services’ as a priority theme. The creation of new, effective payment arrangements may forward this priority, and the wider agenda of health and social care integration in Barking and Dagenham.

Integration

3.3. The creation of new payment arrangements could unify the driving motivations behind services, forwarding the ambition of the ELHCP, and delivering further health and social care integration.

Financial Implications – completed by Katherine Heffernan: Group Manager, Service Finance

3.4. There are no financial implications directly arising from this report.

Legal Implications – completed by Dr. Paul Feild Senior Lawyer

3.5. 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. As part of that role it has an expectation that it is consulted on potential changes to health provision within the Council’s area.

3.6. The function of this report is to seek observations on a consultation document on payment mechanisms the East London Health & Care Partnership may adopt for its accountable area. The consultation document is detailed with some complex and interlinked issues. These will need to be fully considered and reflected upon. Furthermore the timescale is short. It is important that the Boards voice is heard and so this report therefore recommends that the Board delegate to the Chair of the Board informed by professional advisors and practitioners, making the Boards response to the consultation.

Safeguarding

3.7. n/a

List of Appendices:

Appendix A: Payment Development Consultation – 11 July 2017
Appendix B: ELHCP General Update – September 2017
Appendix C: Transformation Priorities July 2017
Appendix D: What ELHCP is doing and what it means
Appendix E: ELHCP STP Governance Structure
East London Health and Care Partnership:

Consultation on payment development and drivers for change
Summary

East London Health and Care Partnership (ELHCP) is working towards a new approach to managing health and care across East London, working together in a more integrated way and taking shared accountability for delivering improved outcomes for local populations. As part of this, the three sub-systems within ELHCP (i. City and Hackney; ii. Waltham Forest, Newham and Tower Hamlets; and iii. Barking and Dagenham, Havering and Redbridge) are developing Accountable Care Systems (ACSs) and are keen to use a consistent approach. To support this, it is important to examine current payment mechanisms and consider where changes to payment can support system development in East London.

There is a need to reduce variations in the quality of care and develop care packages that provide a patient-centred and coordinated approach. Alongside this, by the 2020/21 financial year the overall funding gap in East London is projected to be £578 million. We will not be able to rely on external funding to solve these issues. Improvements to services will need to be made and the funding gap will need to be closed using a combination of service redesign and improved productivity. The way the system currently pays for services and works together as organisations make it harder to successfully meet these challenges.

Service design and ways of working will be the primary route to meet system challenges. There are a number of payment options and combinations of payment approaches that may enable incentives within the system to operate in a more coherent way, and more effectively enable the delivery of system objectives. At present in East London there are a variety of contractual payment mechanisms running concurrently depending on the type of organisation.

The diagram below gives an illustration of challenges:

We must ensure a local payment system that enables a focus wellness and what patients want to achieve from care... and enables innovation and increased productivity across the system

- Creates incentives for care to be delivered in less intensive settings, where appropriate
- Aligns incentives - financial and non financial (e.g. staff motivation to help people, measures & targets)
- Encourages best use of resource across the system

Current funding creates mechanisms that cause unintended consequences... and can be at odds with clinical motives, patient wishes and some system targets
As a system we must consider what configuration of payment will most effectively support system objectives. Examples and evidence from other areas, including NHS vanguards, can be drawn on to inform our thinking.

We recognise that, on its own, changing payment will not solve all the system issues. Payment systems can support strategy, but should not drive it. Therefore, new governance arrangements are also needed to ensure ELHCP can deliver genuinely accountable, coordinated care. These arrangements need to be underpinned by improved data collection and use of analytics for strategic commissioning as well as continual improvement to care. New contracting frameworks and payment mechanisms can feed into this and support clinical improvement.

The ELHCP is clear that work to develop payments should not be used (or perceived) as a programme to cut costs. The aims of this work are to ensure the system is maximising use of the resources available to it and to support ELHCP discussions about improving service delivery and prioritising care in a transparent and evidence-based way.
# Table of Contents

1. **Structure and timelines** .................................................................................................................. 5
2. **Context and view of the current payment system** ............................................................................ 7  
   Background and context ......................................................................................................................... 7  
   Specific challenges within East London ................................................................................................. 9  
   Setting objectives and agreeing priorities ............................................................................................ 10
3. **Payment options and considerations** .................................................................................................. 13  
   Overview of payment forms (this list is not exhaustive) ...................................................................... 13  
   Payment approaches widely used within East London Health and Care Partnership ......................... 15  
   Examples of local payment solutions ..................................................................................................... 17  
   Considerations for local payment development .................................................................................... 19
4. **Service model, system organisation and pace of change** ................................................................. 22  
   Options for organisational form ........................................................................................................... 22  
   Considerations for pace of change ........................................................................................................ 24
5. **What else is needed to support system objectives?** ........................................................................ 25  
   Lessons from other health and care systems ......................................................................................... 25  
   Getting the infrastructure right, whatever option is chosen for payment ............................................ 26

**Annex: ELHCP Payment Development Consultation - questions** ...................................................... 28

---

**Summary**

<table>
<thead>
<tr>
<th>Section</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Structure and timelines</td>
<td>Offer a summary of key points in each section</td>
</tr>
<tr>
<td>2. Context and view of the current payment system</td>
<td>Show consultation questions asked in that section</td>
</tr>
<tr>
<td>3. Payment options and considerations</td>
<td></td>
</tr>
<tr>
<td>4. Service model, system organisation and pace of change</td>
<td></td>
</tr>
<tr>
<td>5. What else is needed to support system objectives?</td>
<td></td>
</tr>
</tbody>
</table>

---

To help readers navigate this document the following diagram is located at the front of each section of this document. It will highlight:

- What section the reader is on
- Content and themes covered in that section
- Consultation questions asked in that section
1. Structure and timelines

1.1. This paper considers the strategic objectives for ELHCP and asks: how appropriate are existing payment systems to deliver shared Sustainability and Transformation Plan (STP) objectives? It is broken into five sections.

- Section one provides an overview of the paper structure and content as well as the consultation process

- Section two sets out the challenges faced by health and social care over the coming years, nationally and within East London.

- Section three outlines payment options in use across East London and seeks to describe the benefits and issues with these approaches. It also considers alternative payment options and looks at examples of local health and care payment approaches developed elsewhere.

- Section four considers options for contractual form and scope and scale of service models that payment may cover. It also outlines possible timelines for transitioning to a new payment approach that may be developed.

- Section five notes other workstreams that are needed at an STP level to complement development work around payment design. Without these other components any change in payment will not drive the desired change in the system.

1.2. Throughout this document are thirteen questions. They are clearly labelled at the end of each section and are intended to generate a base understanding of each organisation’s views. An eleven week engagement period will start on Tuesday 11 July 2017. The consultation will take account of both written and verbal feedback. Verbal feedback will be captured through workshops – which will include engagement with providers, commissioners, voluntary sector, front line staff, patients, residents and carers.

1.3. Further to this, each organisation is asked to draft a written response. The eleven-week engagement period has been set to give organisations the opportunity to engage their Board and other leaders in their response. Therefore, feedback should reflect organisational consensus.
1.4. Written and verbal feedback will be consolidated to generate an understanding of areas of consensus and points of difference, and inform next steps. **Written responses should be sent to enquiries@eastlondonhcp.nhs.uk by 18:00 on Friday 29 September 2017.** This is an extension from the original deadline of 4 September. If you have general questions about this document or the consultation process please send them to the email address above or Katie.brennan1@nhs.net.

1.5. For ease of reference, the list of thirteen questions is available in the annex to this document. This is a simple template that can be copied into another document to allow for free text responses.

1.6. Next steps: pending feedback, a working group will be established to develop recommendations.
2. Context and view of the current payment system

Background and context

2.1. Across East London providers and commissioners must meet increased financial pressures and a need to provide more person-centred care. There are practical challenges and barriers that prevent us from achieving this:

- The practicalities of working across team and organisational boundaries are often a major challenge, running contrary to existing cultural and structural characteristics.
- In all sectors, financial pressures and increased workload can have an impact on the ability to innovate and transition to change.
- Some providers face substantial fixed costs, commitments that cannot be shifted within short or medium term time horizons.
- East London faces a total financial gap of £578m in the ‘do nothing’ scenario to reach a break even position by the 2020/21 financial year. Achieving a 1% surplus target for commissioners increases the gap by another £30m to around £610m.

2.2. East London Healthcare Partnership (ELHCP) is comprised of providers, commissioners and local government representatives covering the eight local government footprints. Across the ELHCP, health and care partners have an ambition to develop more effective and coordinated approaches to delivering care across the local health systems. To meet these challenges ELHCP organisations will need to confirm common objectives, agree ways of working, develop governance arrangements and consider service model design. These will be central drivers of change. Payment development and the availability of good quality data and analytics both have an important role to play to support that work and align incentives across the system.

2.3. Historically, the majority of NHS healthcare has been paid for on an activity basis. This was introduced to encourage activity and investment in the system when funding was increasing and waiting times needed to be reduced. The payment approach was initially effective at driving investment and reducing waiting times. However, it has had the unintended consequence of drawing health and care resources towards operational capacity for measurable units of treatment, with insufficient focus on improving the
outcomes and wellbeing patients experience. It also limits the opportunity for targeting investment in a more flexible and effective way.

2.4. Today, our health and care systems face new challenges. The system must deliver improved quality, a more patient-centred approach to care, better support for population health and more effective use of resources.

2.5. The challenges our partnership faces are consistent with the issues described in the Five Year Forward View\(^1\), published in October 2014, and the accompanying ‘Next Steps’\(^2\) document, published in March 2017. They set out objectives for care that is patient-centred, focused on recovery, prevention and early intervention. They also set out the need for a health and care system that makes best use of resource and treats people in the lowest intensity setting - providing care ‘closer to home’ where ever possible. This need is primarily driven by what people say they want and need from health and care services.

2.6. Messages from national bodies have been increasingly consistent when it comes to possible solutions. They are encouraging local health and care systems to adopt a more coordinated approach to find solutions to the challenges they face. Those in prominent national roles have advocated implementation of a capitated payment linked to outcomes as the best way to support needed change. In any case, there is a clear move in national policy to encourage payments linked to person-centred outcome measures. This has been signalled as a desirable direction of travel from NHS England and been enshrined in the tariff. For example, as of April 2017 NHS England and NHS Improvement require mental health providers and commissioners to adopt transparent payment approaches based on capitation or episodic payment, which must be linked to achievement of agreed outcomes. In ELHCP, work is underway to comply with these requirements using existing data and information. Plans to develop improved patient level data for mental health will support this work further in future.

2.7. NHS England and NHS Improvement support development of local solutions that are co-developed and can demonstrate positive impacts on ways of working and system goals. This means local areas have an opportunity to drive their destiny, but they must take active steps to develop a local approach. If not a solution may be imposed by national bodies. Within ELHCP we need to consider and develop the best payment approach for our local system.

---

\(^1\) The Five Year Forward View, NHS England (23 Oct 2014) [https://www.england.nhs.uk/ourwork/futurenhs/](https://www.england.nhs.uk/ourwork/futurenhs/)

Specific challenges within East London

2.8. Often, payment development is perceived to be about transferring risk from one part of the system to another, or from one organisation to another. However, to be successful, payment development must be about enabling new ways of working. This means:
- ensure those in the health and care system with the power to change how care is delivered have the right incentives to do so – and that incentives within the system are aligned with one another;
- remove barriers to organisations and staff working in a more coordinated way;
- a cultural change, so the system works together towards collective, local objectives and system partners are empowered to take a more patient-focused approach to service design; and
- ensure risk is shared across the partnership in the safest way.

2.9. Within London there is a recognition that care needs to change and a desire to innovate. Below are two examples that illustrate issues that are more difficult to address in the context of the current payment structure.

- **Outpatient care:**
  - There is a desire to move to new ways of working for delivery of outpatient care. The way current payment levels are set across the system and payment mechanisms interact can provide a disincentive to coordinate care and develop person-centred service models. For example it makes it more difficult to:
    - increase advice and guidance provided to people and patients to prevent issues arising and allow them to manage their wellbeing;
    - move towards more non-face to face consultations, where appropriate; and
    - make better use of scarce hospital capacity and enable patients to have access to specialist consultation without the inconvenience of an often unnecessary hospital visit.
  - **Other issues include:**
    - The variation between payments received for non-face to face versus face to face is too large;
    - There are no mechanisms for income to reflect fixed costs and stepped costs that may become ‘stranded’; and
    - There is no national tariff guidance or advice about how to address issues identified within ‘pay for activity’ frameworks.

- **End of life care:**
  - Current service provision within the STP footprint is poor overall and only a small proportion of patients currently die at home or at the place of their choosing. Sufficient payment levers are not currently in place across both the health and care system to be able to realign this.
  - There is no incentive for providers from different sectors to work together and provide joined up care.
Existing financial mechanisms are skewed by payment for activity, which has a tendency to incentivise care to take place within a hospital even if that is not in line with the patient’s preference.

2.10. It is clear that the system must adapt to address these pressing challenges.

- Evidence from work in the NHS as well as international examples suggests providers and commissioners need to work more collaboratively and take a system/population view of care and resource use.

- A number of structural and cultural changes are needed to support this:
  - payment development;
  - improved use of data and analytics; and
  - governance arrangements that enable organisations and front line staff to work in a more coordinated way.

2.11. There are a range of ways health and care systems have delivered this type of change in England and abroad (examples include Oxfordshire Mental Health, and see footnote 3 above for international examples). Improved accessibility and use of linked data sets and payment reform have featured as a key part of achieving these goals. An agreed set of objectives and clear vision for the system is also important, the vision for the payment system should be fully in line with the vision for the wider health and care sector. The ELHCP now needs to decide what the right approach is for our populations and health and care economies. Can this be achieved via tweaks to the existing payment system, or is more comprehensive payment development needed?

Setting objectives and agreeing priorities

2.12. Lessons from other health and care systems within the NHS demonstrate the need for a clear vision and set of priorities to mobilise thinking and focus efforts toward common goals. All parties within the health and care sector that want to implement new ways of working need to be clear about what the system is trying to achieve. When setting these objectives it is important to put patient and population needs at their centre. This promotes a patient-centred approach to solutions and aligns system objectives with those of front line staff and the population. It is also important to be

---

3 International examples include:


5 http://www.pwc.co.uk/industries/government-public-sector/healthcare/insights/shifting-to-accountable-care-characteristics-and-capabilities.html:

‘Experience from accountable care organisations operating across the world shows that the successful delivery of accountable care requires capability in eight key areas: 1. Strategy & vision: There is a compelling vision and clear strategy for managing and delivering clinical, patient and service user outcomes. This is shared by all organisations involved in the delivery of health and care.’
open about local opportunities, and challenges that need to be addressed. It is important for payment to be developed and configured in a way that supports agreed system objectives.

2.13. From a patient perspective, the ELHCP\(^6\) sets out areas for improvement:

- Apart from City and Hackney all East London areas are below the national average for success in getting a GP appointment and ‘ease of getting through to someone at a GP surgery on the phone’ (based on patient surveys).
- Address inconsistent patient experience for A&E, inpatients, maternity, and outpatients and for mental health providers (based on Friends and Family Test).
- Many patients do not die in their preferred place (as few as 22-29% in some areas. See example above on end of life care).
- One year survival rate for all cancers is lower across all seven CCGs than survival rates across England.

2.14. In most cases what local people want from their interactions with the health and care service is consistent across geographies – and the list is likely to resonate with each of us as service users. The patient representative group National Voices has set out what service-users say they want and findings from Barking and Dagenham, Havering and Redbridge (BHR) and Tower Hamlets echo these national themes:

- the ability to 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\(^7\).

2.15. To deliver better outcomes for patients and address the strategic system challenges, providers and commissioners across ELHCP will need to focus on the following:

- incentivising early intervention and prevention for whole populations;
- encouraging all providers collectively operate within costs constraints of the system; and
- removing the barriers that currently block care coordination.

---

\(^6\) ELHCP October 2016, apart from the first bullet, which represents updated data (as of 7 July 2017) from the NHSE’s GP Patient Survey [https://gp-patient.co.uk/](https://gp-patient.co.uk/)

2.16. Change will not happen overnight. Improvement processes can be overstretched and become unfocused unless they have clear priorities. It is important that system leaders agree clear system-wide objectives and, given that, decide which areas of work to prioritise. Possible areas to prioritise include:

i. Incentivise better outcomes rather than increased volume of interventions.
ii. Reward delivery of care that enables patients to control decisions regarding their own health and care.
iii. Manage financial risk between organisations.
iv. Manage transformation and the process of transition.
v. Design a contractual framework that aligns providers and commissioners objectives to deliver collective outcomes.
vi. Improve quality-linked patient-level data across the whole system.

Question 1: What are your top five priority areas relating to the payment system to support better outcomes for patients across the system?
3. Payment options and considerations

3.1. Across health and care systems a range of payment approaches are generated using adaptations of a standard set of payment tools: fee for activity, block payment, capitated payment, payment for outcomes, cost and volume arrangements and so on. Drawing on these tools, and using them in combination, there are an infinite number of payment options that may be developed and implemented locally. This section considers system goals that payment needs to support, outlines common payment approaches used in East London, examines a range of payment approaches available and offers real world examples of different local payment approaches.

Overview of payment forms (this list is not exhaustive)

3.2. Payment cannot drive transformation, but it has an important role to play in supporting system change. This section provides an overview of a range of payment forms that can be drawn on when developing local payment approaches. All have benefits and drawbacks. The important thing when designing a payment approach is to ensure that incentives across the system are appropriately aligned to support desired outcomes and reduce the risk of unintended consequences.

3.3. **Block payments** offer a fixed amount of funding to a provider to deliver care to an agreed population over a fixed period of time. This provides a stable source of funding to enable investment and delivery of quality care. It is calculated based on historical expenditure and can be adjusted to reflect expected efficiency gains, trends in patient needs (demographic growth and changes in case mix) and cost uplifts. Non-acute providers using block contracts have a clear awareness of their cost envelope and can organise their service availability to match it. However, since they then have limited capability to flex their staffing they have little incentive to attract additional work. To manage demand they may extend waiting times, take a measured approach to acute discharge and actively move patients on to alternative care settings.

3.4. **Primary care per capita** is payment for core GP services allocated on a per capita basis, using an average payment per patient based on the GP patient list. In principle, this arrangement incentivises GPs to take on new patients. In addition to core services, commissioners provide specific additional payments for items of locally prioritised
activity, for example locally-enhanced services linked to clinical outcomes for specific long term conditions. The bulk of primary care funding and costs, therefore, are relatively predictable, enabling them to remain financially sustainable as providers. GPs provide direct treatment, but they also have a significant role diagnosing and referring patients to alternative care settings. The increasing constraints on GP time and the increase in the number of appointments/contacts they are required to make potentially creates a perverse incentive to avoid risk and refer patients for tests or acute diagnoses rather than undertake measures available out of hospital that might be viable alternatives. The limitation on their resource can also limit their capacity to provide preventative care in the most effective way.

3.5. **Fee for service** means a care provider is paid separately for each component of an interaction with a patient. This means there is a specific price for each individual resource used (ice pack, splint, serum, etc.) and for each care action taken (scan interpretation, drawing blood, physical examination, etc.). Some private insurers in the United States use this approach for payment. Provided fees are set at or above efficient cost levels, it offers remuneration for all activity and resources used to treat a patient, but does not create incentives for early intervention, preventative care or coordination between care providers.

3.6. **Payment by activity** (as per the current national tariff). This is payment by event or episode. It was developed over a decade ago, at a time when the NHS had a specific set of priorities to reduce waiting times and increase acute activity. However, it can limit incentives for coordinated care or care focused on early intervention and recovery. Further limitations of this approach are explored in para 3.10.

3.7. **Cost and Volume payment** is a variant of payment for activity, and often incorporates caps and collars. This payment mechanism helps to manage volume risk. It involves a block element for the core service, allowing for variable costs and/or case adjustment between a threshold and a ceiling. This works particularly well for services that have to be provided come what may, where it is clear what the core service costs for example, A&E services have to be provided 24 hours a day seven days a week. The contract can be set assuming a certain level of patient attendances and acuity, with additional payments up to a ceiling that are flexed if more people attend than expected. This type of approach can be useful to address a specific volume risk in one service, but on its own does not support reduced demand risk or integrated approaches to care.

3.8. **Outcomes based payment** is where organisations link a portion of payment to attainment of agreed objectives. Evidence suggests that outcomes based payment is most effective at supporting transformation when focused on a small set of measures that are aligned to patient and population outcomes rather than more specific and lengthy list of clinical outcomes. It is also more effective when framed as a payment rather than a penalty, and supports innovation best when it accounts for a relatively

---

small share of total payment. If the size of the outcomes-based payment as a share of the total payment is set too high, the agreed metrics are likely to focus on clinical outcomes that can be easily achieved rather than more ambitious person-centred outcomes. Successful outcomes based payments require co-development of appropriate metrics and the existence (or development) of supporting data systems allow agreed outcomes to be measured in a direct way, limiting proxy indicators wherever possible.

3.9. **Gain and loss share arrangements** can give providers an opportunity to have a stake in the success of the system. It can allow them to retain a share of savings they are able to generate for the system or have to absorb a share of losses incurred. They can also be deployed to mitigate financial risk to individual organisations that are due to switching to a new integrated care model, by redistributing changes in revenue from one part of the system to another. In financially constrained health and care systems the ability for gain and loss share arrangements to operate effectively is more limited, as any funds in the pot will need to be held back from funds that may be needed to provide care. In this case it may be more appropriate to have an agreed risk pool across providers and commissioners that is ring-fenced to manage unanticipated changes in demand.

**Payment approaches widely used within East London Health and Care Partnership**

3.10. This section looks at payment forms used within ELHCP and considers the incentives they place on the system. There are a number of smaller scale commissioning arrangements that are experimenting with different payment forms in order to improve incentives within the system. However, at present, the majority commissioning arrangements within ELHCP combine:

- Fee for activity – or Payment by Results in the acute sector; with
- Block payments for community and MH services; and
- Primary care per capita core payments and outcomes payments.
3.11. The structure of the current payment system as outlined in the diagram above supports some objectives desired by the system, but also presents real barriers to realising the changes required.

- **Benefits include:**
  - It encourages providers to clear RTT backlogs in acute care, ensuring payment for units of care provided, enabling activity and reducing backlogs.
  - It allows quality of care per intervention to remain to standard in acute settings, through nationally prescribed reimbursement for each unit of care delivered.
  - It encourages quality coding of data for acute care as payment is linked to it.
  - It enables providers to manage, and be remunerated for, unanticipated surges in demand.
  - It stimulates providers to be internally efficient.

- **Issues include:**
  - It is not designed to promote or support larger scale shifts in care from settings where the prevailing contract form is activity driven, to other settings where care is paid for under a block contract.
  - It is not well suited to promote coordination of a more patient-centred way of delivering care.
  - It provides almost insufficient direct incentive for health promotion and disease prevention at the provider level, locking the vast majority of NHS funding into treating the effects of poor health rather than preventing their occurrence.
  - It does little to support targeted investment of funds to areas that will deliver more effective care, or better efficiency, productivity or innovation across the wider system. I.e. it does not always support allocative efficiency of care across the system.
  - It provides insufficient direct financial incentive for providers to engage in patient flow and demand management programmes across the system. For example, demand pressures may continue to result in activity and referral rates in the acute sector that are above plan. In this case, performance targets may be breached and the cost to the system of acute activity becomes unsustainable.
  - Tariff-based payment rewards delivery of prescribed interventions on a volume basis, which may not always lead to better outcomes for the patient and the system.
  - It can be perceived as complex to understand. This acts as a barrier to engaging staff (in particular clinical staff) to understand the impact the payment system has on care delivery within the local system – this effects the quality of discussions on root cause analysis and solutions when looking to support change.
Where Trusts are under financial pressure, it can create a tension between (i) the draw to meet local needs and coordinate with local partners and (ii) pressure from regulators to maximise funding streams to shore up financial position.

3.12. Clearly the payment system can act to create pressure and impact adversely on both commissioner and provider organisations. Currently, the tools to address issues in the system are not in the hands of those who have the capability to impact change on the ground.

Question 2: In your organisation’s view, how does the current payment system support and inhibit attainment of system objectives?

Examples of local payment solutions

3.13. There is a growing consensus within the English NHS and internationally that having both payment by activity arrangements and block contracts in place does not create the most effective mechanisms to support co-ordinated, patient-centred, prevention-focused and sustainable care. For example, under this payment system funding must flow to acute providers as their activity increases. In a financially constrained system this means funding may need to be found from other areas of the system (e.g. primary and community care), where the system may otherwise wish to invest. Most health systems working toward transformation and increased accountability for patient outcomes have developed their own local payment system to better align incentives.

Examples of systems starting to form accountable care arrangements in UK

<table>
<thead>
<tr>
<th>Type (from most to least formal)</th>
<th>Scope</th>
<th>Scale</th>
<th>Risk</th>
<th>Further details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northumbria ACO: prime provider with full risk share</td>
<td>Health and social care providers (acute, OPE, MH, LA, ambulances)</td>
<td>300,000 people</td>
<td>Rural population</td>
<td>Full transfer of risk and responsibilities from commissioners to non provider org</td>
</tr>
<tr>
<td>Torbay and South Devon NHS FT fully merged with some risk share</td>
<td>Acute, community and social care services</td>
<td>616,000 people</td>
<td>Budgeted £353m</td>
<td>6,000 staff across 2 sites</td>
</tr>
<tr>
<td>Symphony in South Somerset: corporate JV with some risk share (Outcomes 2.5%)</td>
<td>Secondary, community and primary care</td>
<td>Initially 1,000 people with multiple LTCs</td>
<td>Will be expanded to full population of approx. £40m</td>
<td>Proposed at least 2.5% (aligned with CCG/HSN) at risk for delivery outcomes increasing over time. Further risk share plans to be agreed</td>
</tr>
<tr>
<td>Mid-Nottinhamshire Better Together: memo of understanding without risk share</td>
<td>Services in Primary, secondary, community and social care</td>
<td>970,000 people</td>
<td>Budgeted £390m</td>
<td>Combined CQUN to incentivise a joint outcomes framework</td>
</tr>
<tr>
<td>Working Together in South Yorkshire, Mid Yorkshire and North Derbyshire: loose partnership, no risk share</td>
<td>Acute care only</td>
<td>2.7 million and 7 providers</td>
<td>15 hospital sites</td>
<td>Approximately 45,000 staff</td>
</tr>
</tbody>
</table>

Source: built on work from McKinsey & Company, October 2016, but updated to reflect ongoing developments. Many of these schemes are currently being developed and will track their progress, and reflect lessons learned as ELHCP payment development work progresses.
3.14. Within East London, contracts that have developed alternative payment arrangements to support transformation include:

- Tower Hamlets Community Health Services alliance contract, which brings together care across a number of locations, including hospital, community and GP care. Key developments include a new single point of access that is available 24 hours a day, seven days a week; better integration of adult and children services and a single patient record.

- Newham CCG is working closely with the provider based MSK Collaborative to establish a ring fenced contract for MSK activities. The providers will decide how resources are distributed between them. The new contract will provide for incentive payments, risk pools and efficiency savings. Providers have indicated that internal Collaborative transactions will operate on a mixed economy basis - i.e. some components will still comply with National Tariff rules whilst others will be forms that include the potential for block and tolerance type agreement. Providers have the opportunity to minimise risks such as stranded costs via control of a risk pool that will be operated by the Collaborative. There is also an opportunity to link outcomes to this payment arrangement.

3.15. With both NHS and international examples of care transformation, most systems include the following elements as part of their payment systems:

i. Capitated payments\(^{10}\): Most NHS vanguard sites are planning to use capitated contracts with incentives or penalties linked to delivery of outcomes. In addition to the table above, NHS examples include Salford, Dudley, Stockport, Kent and Coastal, Sandwell & West Birmingham CCGs and others. Internationally, systems delivering patient-centred, coordinated care have generally used capitation, whether they be risk adjusted to mirror commissioner allocations or not\(^{11}\).

ii. Outcomes or Incentive based payments:

- Payments linked to patient and population outcomes are a core component of successful systems because they more directly incentivise delivery of desired objectives. This can form a small but important proportion of the overall contract value. Although some areas have developed outcome frameworks, the scope of measures that will be linked to mature contracts has not yet been published by any vanguard area. Some (e.g. Mid-Nottinghamshire Better Together) base contract outcomes on process

\(^9\) The tolerance element relates to elements of growth exceeding expected levels that are driven by higher than expected GP referrals. Further details are TBC as contract negotiations are ongoing.

\(^{10}\) Capitated payment, or capitation, means paying a provider or group of providers to cover the care provided to a specified population across different care settings. The regular payments are calculated as a lump sum per patient. [https://www.gov.uk/guidance/capitation](https://www.gov.uk/guidance/capitation)

measures in the short-term, but will move to patient and population outcomes in time.

- Clinical outcomes, for example the Quality and Outcomes Framework are useful to drive an initial change in behaviour, but can be unsustainable as providers rely on payments to continue that behaviour. Depending on outcomes measured, they can be complex to administer for little long-term gain.

iii. Risk-gain share: This can be used as a component of capitated budgets to manage uncertainty in volumes or flows of patients, or to drive specific changes in provider activity.

iv. Pooled budget arrangements between health and social care (e.g. Section 75\(^\text{12}\)):
These are a useful tool, already in place in most localities. On their own they are not sufficient to align incentives to promote whole population care. However, as part of addressing the wider determinates of health and wellbeing, it is important consider how payment for relevant care can support improved coordination between staff and improve outcomes for people and patients.

3.16. Any development of the payment system that designs incentives needs to take an objective approach to ensure those incentives are placed in the hands of those most capable of making a difference, rather than where it is most expedient. Such work will also need to consider how any payment flows between organisations may be managed appropriately. Alongside payment development evidence shows it is important ensure the relevant governance, reporting and data sharing arrangements are in place.

Considerations for local payment development

3.17. There is no perfect payment system. In practice local systems need to work together to design payment options that work best for their area. Different types of payment are useful to support different system objectives. The table below illustrate the strengths and weaknesses of different approaches explored above.

---
\(^{12}\) Section 75 of the NHS Act 2006 gave PCTs and local authorities legal powers to enter into integrated and lead commissioner arrangements. Where lead commissioning arrangements are in place, commissioning duties are delegated between organisations, and one organisation leads on behalf of the other(s) to achieve a jointly agreed set of aims. The lead commissioner is responsible for commissioning the agreed scope of services, within the relevant budget, and for entering into contracts with providers. Governance of integrated or lead commissioning arrangements are typically set out in a section 75 agreement (along with arrangements for pooled budgets).
Payment for outcomes can apply to any of the above payment types.

It is possible to meet system objectives using the current payment system through local variations to tariff for given services. Local providers and commissioners have already developed a range of ‘work around’ payment and service solutions for specific types of care. However, without a strategic and coordinated approach to payment across a local health and care system there is a risk that special contract agreements and a proliferation of modifications to service models will lead to increasingly fragmented and incoherent incentives across the system as a whole.

Any payment development work will need to consider how to support patient choice as part of its objectives. Contract forms for such arrangements can include (i) the commissioner carving out an amount for patient choice from the whole population budget, which is then used to pay out of area providers; or (ii) the identified amount being managed through a prime provider, sub-contractor arrangement – although the latter would require transparent arrangements to address the potential financial conflict of interest. With either arrangement, the amount would be based on an estimated volume of patients. Overspend could be addressed through a risk pool arrangement, however there would be an incentive for providers to maintain and improve quality to encourage patients to choose their service. Analysis based on Service Level Agreement Monitoring (SLAM) data for 2015/16 shows that 87% of total spend on acute tariff-based services within ELHCP is commissioned from providers within the ELHCP footprint.

Evidence suggests that payment mechanisms that are less complex in structure are easier for all people in the system to understand and react appropriately to. Decisive steps should be taken to minimise complexity, both to enable greater transparency and reduce the bureaucracy associated with a burdensome set of rules and processes.
3.22. Given the challenges the NHS now faces, and the experience of other areas that have implemented reform, there is a strong case to review payment mechanisms to support greater coordination and a patient-centred approach to care.

| Question 3: What does your organisation want out of the payment system? |
| Question 4: What payment elements do you consider are most important to meet agreed ELHC objectives? |
| Question 5: What payment options do you, as partners in ELHCP, want to explore further? |
4. Service model, system organisation and pace of change

Options for organisational form

4.1. This consultation is not about organisational form. However, there is an intrinsic link between organisational form and development of a contract form to support it.

4.2. Successful coordinated systems can operate using a range of contractual forms. An ‘accountable care system’ can operate under one single organisation or, alternatively, governance structures can enable different organisations to operate in a coordinated way. Local partners should consider the local provider landscape and relationships when determining which option is best for their area. Below is a spectrum of options.

<table>
<thead>
<tr>
<th>Options</th>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Care Organisation</td>
<td>Single legal entity</td>
<td>One person (CEO) in charge, with one board, and single accountability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pooled ‘capitated’ budgets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complete risk transfer</td>
</tr>
<tr>
<td>Accountable Care Partnership or System</td>
<td>Partnership</td>
<td>Joint accountability via partner board (or lead provider) alongside organisational governance structures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Some / shadow pooling of budgets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No risk transfer or shared risk</td>
</tr>
<tr>
<td>Collaborative network</td>
<td>Collaboration</td>
<td>Boards and CEOs for separate organisations, individual accountability to commissioner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No pooled budgets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No shared risk</td>
</tr>
</tbody>
</table>
4.3. When considering contract arrangements it will be important to agree the scope and scale of services, as well as what units payment is linked to and what provider(s) payment covers.

4.4. **Scope of payment:** There are two elements to consider

- Setting a ‘whole population’ scope for payment supports a person-centred approach to care, in which no specific condition or disease is singled out. The rationale for this is that it enables a focus on specific segments of the population, not disease pathways, in order to reinforce and encourage integrated working. This offers less complication about when people transition in and out of a pathway and encourages early intervention and management of conditions. Categories could include: Adults with complex needs, children with complex needs, mostly well adults, mostly well children, older adults, under-5 children, etc.

- Setting a condition based approach, for example MSK services or diabetes care can encourage joint working of providers along a limited care pathway. It may not support integrated care for people with multiple conditions.

4.5. **Scale of payment:** A key consideration for payment development is around geographic scale. Scale could be set in a way that is coterminous with local authorities, i.e. at a CCG level, this would support integration with social care. If the focus is to enable better integration between acute and community services, a wider scale footprint may be more appropriate, for example across i) Waltham Forest, Newham and Tower Hamlets; ii) Barking Havering and Redbridge, and iii) City and Hackney. For some care needs it may be appropriate to consider a single payment approach for the whole ELHCP footprint. This can enable discussions about service configurations across geographies to make the most of resources and capabilities across provider organisations.

**Question 6:** Is it best for payment to cover populations based on a person-centred approach or disease/condition specific approach?

**Question 7:** What geographic footprint is appropriate for payment: CCG level; City and Hackney/Waltham Forest, Newham and Tower Hamlets/Barking and Dagenham, Havering and Redbridge; or across the ELHCP footprint?

**Question 8:** What services would be included in a new payment approach?
Considerations for pace of change

4.6. The move to a new way of paying for care does not need to happen via a ‘big bang’. Most areas that have introduced changes to payment system have done so via an incremental approach, and taken an evidenced based approach to selecting and testing options. A key first stage will be to get data and information in place – outline what type of data is needed (both the minimum needed to support our objectives, and ideally what data we would like to have).

4.7. System partners work together to understand and improve baseline data, and consider evidence about (i) opportunities for service development and/or improve use of resource within existing services; and (ii) implications on the system of different payment methodologies.

4.8. Experience from other areas shows that this initial stage is a vital step toward achieving transformation. This also shows that the relationships and ways of working established when organisations are committed to the process can be as important a lever for change in local systems as the payment, contracting and governance mechanisms that are developed out of that work. However, that development stage requires real commitment and leadership from all partners as well as continual active cooperation in the development process.

Question 9: What steps are needed to secure this type of buy-in and practical engagement among all ELHCP member organisations?
5. What else is needed to support system objectives?

Lessons from other health and care systems

5.1. A number of components are needed to support and enable change within the health and care system. A common vision, good quality data and information (one version of the truth) and structures that allow people in the system to work together to solve collective problems are all essential.

5.2. Experience from other health and care systems show the following elements are needed:

- **An understanding of patient and population needs.** For example, in Somerset the Symphony project Accountable Care Organisation acts as the ‘engine room’, providing data analytics to inform population segmentation, carry out risk stratification (in terms of need and cost), and inform service redesign.

- **Good quality data and information** to inform system-wide decision-making as well as provider actions and the activity of front line staff. Practical examples of where this has worked include Northumberland Tyne and Wear NHS Foundation Trust and Group Health, who operate a closed insurer and provider system in the USA. In both cases, they invested in developing data over time and used this to inform services and care, understand their impact on patients and support continuous improvement using data in an active dialogue led by clinicians.

- **Patient and public feeding into goal-setting and decision-making.** For example, commissioners and providers in Oxfordshire developed an outcomes based commissioning model for adult mental health, which was co-developed with experts-by-experience and third party sector partners. The framework is based on a capitated payment approach linked to outcome measures.
• **Governance assurance tools for cross-boundary working** for safe, high quality care. These give public and providers assurance that safety and quality will not be compromised, and could include:
  - monitoring progress of system goals;
  - monitoring performance of organisations within the accountable care system;
  - infrastructure and planning to raise issues early to deliver services more effectively;
  - aligning assurance across health and social care; and
  - links with others outside the local system (e.g. London Borough Councils, voluntary sector, housing authorities and the education sector if they are not formally part of the accountable care system).

• **Professional working arrangements** across organisational boundaries. This includes setting out routes to develop innovations in care pathways using new technology, skill mix and care delivery.

• **Escalation and dispute resolution routes.** Lessons from Hudson Headwaters Health Network in the US suggest it is important to acknowledge that partnership working is challenging. This includes identifying issues that may arise in a partnership environment, and having mechanisms set up in advance to manage quality issues and disputes.

• **Funding flows that reduce barriers** to front line staff being able to deliver efficient care in a person-centred way. This needs to be supported by complementary organisational structures. It means avoiding overcomplicated management and payment forms. Supporting teams and giving permission to be more innovative and have a greater degree of ownership and using mechanisms that reduce patterns of behaviour that add limited value.

26

---

**Question 10:** What elements are needed to ensure current provider relationships and partnership arrangements support transformation?

**Question 11:** What skills, capacity and resources would need to be transferred between acute and primary care to support better collaborative working?

Getting the infrastructure right, whatever option is chosen for payment

5.3. Based on the evidence above, it is clear that further investment and development is needed to support a system-wide data and analytic function in ELHCP. The aim of this function is to:

a. **Support clinical decision making** - enable continual improvement and best use of resource from front line staff (e.g. adoption of a learning system approach)
b. **Support providers** to manage and monitor performance and resource-use as well as identify (and act on) opportunities to improve care. To do this, providers need to understand outcomes for people in their care, their activity and costs at a granular level and how these relate to resource utilisation.

c. **Enable system management** and improved strategic commissioning to support health and wellbeing across health and care systems - including constructive, evidenced-based discussions on care and quality improvement

5.4. Learning from successful transformation work shows these elements are needed to support analytics and system intelligence:

- **Patient level data** is key to supporting sophisticated system intelligence and clinical decision making. It enables us to track people through care pathways and understand the impact of their interactions with the health and care system.

- **One version of the truth**, where all organisations have access to consistent data and analytic outputs and have the same understanding of where issues and opportunities lie.

- **Use of advanced statistics and analytics** help us understand patterns and correlations. Retail and other sectors have used this for years and it is time for health organisations to make better use of the information we have. NHS England has kicked off a tender process for common specifications and procurement of business intelligence and analytics across London. Data and analytics is a critical part of the work to develop payments and support system development. Therefore, comments on analytic needs are sought as part of this engagement process, which will help inform ELHCP analytic development as well as any London-wide efforts.

- **Patient and population engagement at scale.** As commissioners and providers, we need to complement the data and information within the health and care system with patient and population voices via the appropriate forums and representative groups. This will add depth and understanding to data outputs and offer input to shape analysis undertaken.

- **Patients and carers able to readily access and enter their own details**, to support public engagement and people’s ownership of their care. People are used to this with other services and will increasingly demand this from health and care, it also provides valuable information to inform diagnosis and care13.

---

**Question 12:** What do ELHCP partners need to do to build data and analytic capacity within the STP?

**Question 13:** What can be done to support provider understanding of their Service Line Reporting?

---

Annex: ELHCP Payment Development Consultation - questions

Below are the thirteen questions asked in this consultation document. This list allows easy access to all questions in a single place and can be copied into another document to help frame your organisation’s written response to this consultation. The deadline for written responses is 18:00 Friday 29 September 2017. This has been extended from the original deadline of 4 September.

Consultation questions

1. What are your top five priority areas relating to the payment system to support better outcomes for patients across the system?

2. In your organisation’s view, how does the current payment system support and inhibit attainment of system objectives?

3. What does your organisation want out of the payment system?

4. What payment elements do you consider are most important to meet agreed ELHCP objectives?

5. What payment options do you, as partners in ELHCP, want to explore further?

6. Is it best for payment to cover populations based on a person-centred approach or disease/condition specific approach?

7. What geographic footprint is appropriate for payment: CCG level; City and Hackney/Waltham Forest, Newham and Tower Hamlets/Barking and Dagenham, Havering and Redbridge; or across the ELHCP footprint?

8. What services would be included in a new payment approach?

9. What steps are needed to secure this type of buy-in and practical engagement among all ELHCP member organisations?

10. What elements are needed to ensure current provider relationships and partnership arrangements support transformation?

11. What skills, capacity and resources would need to be transferred between acute and primary care to support better collaborative working?

12. What do ELHCP partners need to do to build data and analytic capacity within the STP?

13. What can be done to support provider understanding of their Service Line Reporting?
Health and Adult Services Select Committee

20 September 2017

Title: Health Checks Performance - Update report

Report of the Director of Public Health

Open Report

Report Authors:
Mary Knower, Public Health Strategist

Contact Details:
Tel: 020 8227 2998
e-mail: mary.knower@lbbd.gov.uk

Accountable Director: Matthew Cole, Director of Public Health

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

Summary:
This is an update of a report that was presented to HASSC in May of this year, about the performance of the NHS Health Checks Programme.

The May paper highlighted the successes and issues with the programme as it runs in the borough. These issues need to be resolved if we are to address quality of life problems and health inequalities in Barking and Dagenham.

This paper is an update on the May 2017 report and provides an update on the progress as to how the problems of both quantity and quality might be addressed.

Recommendation(s)

The HASSC is recommended to note:

(i) The proposals to reduce variability in health checks delivery in both quantity and quality, and
(ii) Progress of the Health Checks Improvement Plan.

Reason(s)

If performance is improved and variability reduced, there will be better equity of access which means that the programme will meet the corporate objectives of living well through the life course and will help address the Council health priorities for obesity, smoking reduction, prevention, and better mental health, as well as reducing health inequalities. It will also contribute to better partnership working between primary care and lifestyle services.

1. NHS Health Checks Introduction

1.1 For the 2016/17-year 5,177 health checks were delivered in Barking and Dagenham; this is an improvement on 2015-16 when 4,844 health checks were delivered.
The number of health checks completed is comparable with London but the number of referrals for support to other services is low. For Q1 of the 2017/18, 1,179 health checks were delivered in Barking and Dagenham. Of the above number,

- 293 residents were identified as smokers and given advice, though only 4 were formally referred to services and 11 signposted to services.
- With physical activity, 230 residents had an intervention, 155 were signposted and 20 were formally referred to services.
- With weight management, 263 were given advice, 147 signposted to services and 8 were formally referred.

1.2 Also of concern that there is a large variation between practices in the number of health checks being done. Details are provided in the HASSC paper of 3 May 2017 and can be accesses via the link below [http://moderngov.barking-dagenham.gov.uk/documents/g9025/Public%20reports%20pack%20Wednesday%2003-May-2017%20Health%20and%20Adult%20Services%20Select%20Committee.pdf?T=10](http://moderngov.barking-dagenham.gov.uk/documents/g9025/Public%20reports%20pack%20Wednesday%2003-May-2017%20Health%20and%20Adult%20Services%20Select%20Committee.pdf?T=10)

1.3 Trend data does show that there are some consistently poor performers, however two of the practices currently in the worst performing list were not in the group of worst performers at 16/17-year end.

1.4 Given the emerging concerns about the overall delivery of Health Checks in the borough the Cabinet Member for Adult Social Services and Health supported by Officers met with the CCG Chair Dr Mohi and the Accountable officer, Conor Burke to discuss how performance could be improved.

2. Improvement Plan

2.1 Proposals to improve the Health Checks programme, with partners are summarised below: more detail on the progress against the actions in point 2.2.

- Introduce a stepped audit & systematic monitoring of outcomes.
- Support sharing and implementation of good practice between GP practices and localities.
- Put in place compliance monitoring that better tracks underperformance
- Improve the patient journey from health check to lifestyle services.
- To promote healthy lifestyle services as a route to supporting residents to develop a healthier lifestyle.
- To link Health Checks to the healthy weight behaviour change approach
- Potentially centralising the sending out of Health Check invitations

2.2 Progress against Proposals

A detailed and robust improvement plan is in place which includes the following:

- GP practices are currently completing an audit which will run till the first week in August – this will give LBBD and CCG baseline information about how they are delivering their health checks
- An agreed specification has been written and shared with the GP Federation to host a nurse specialist for Health Checks; the project will run for one
calendar year and will support struggling practices to improve their performance.

- An operational work book to aid practices has been put together that will provide detailed and step by step guidance for practices in how to complete the health check fully and correctly, including follow up processes.
- Public Health has engaged GPs in network meetings, where practice performance has been raised on a regular basis, and through which the network and CCG will support performance improvement.
- Health checks is included in the performance dashboard developed by Public Health that incorporates other prevention indicators like immunisation and which will encourage activity to prevent long term conditions.
- A partnership steering group with GPs and Primary Care meets on a regular basis to oversee and monitor progress with each of the actions.
- The steering group is working through each stage of the patient pathway, identifying issues and formulating actions to redress the problems.
- Visits to GP practices by the Primary Care Engagement Officer to address issues improvement locally are on-going.

3. Financial Implications

Implications completed by: Katherine Heffernan, Group Manager - Finance

3.1 The Public Health Grant provides funding for the NHS Health Check Programme. The 2016-17 Public Health budget includes £350,000 for the NHS Health Check Programme. Primary care providers are paid on a performance basis, with payments based on activity levels. The proposals for the health check programme in this report aim to provide a more effective and value for money service that will improve links healthy lifestyle services and promote these services as a route to developing a healthier lifestyle. The health check budget for 2017-18 is £350,000. It is anticipated that expenditure for this service will not exceed the budget for 2017-18.

4. Legal Implications

Implications completed by: Dr. Paul Feild Senior Governance Solicitor

4.1 There are no direct legal implications arising from this report.

5. Other Implications

5.1 Risk Management

The Council is working closely with the CCG in order to manage its relationship with Primary Care positively and to continue to foster the good relationships that have existed between it and Public Health.

5.2 Contractual Issues: The current contract with Primary Care is not due to finish until March 2019, by which time a procurement process will have been undertaken to award a contract going forward.
5.3 **Safeguarding Children:** No direct link with safeguarding children but through practitioners using their training in safeguarding they have the skills to detect an issue which needs querying or raising with families.

5.4 **Crime and Disorder Issues:** impacted by alcohol brief interventions (as part of the Health Check) Practitioners are required to discuss alcohol intake with patients and depending on the patient’s response, they give brief advice or may need to signpost the patient to dependency services.

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


Report to HASSC on 3 May 2017

**List of appendices:**

None.
**Oral Health in Early Years Scrutiny Review – Proposed Scope**

**Report of the Director of Public Health**

<table>
<thead>
<tr>
<th>Open report</th>
<th>For decision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report author:</strong></td>
<td><strong>Contact Details:</strong></td>
</tr>
<tr>
<td>Mary Knower, Public Health Strategist</td>
<td>Tel: 020 8227 2998</td>
</tr>
<tr>
<td>Masuma Ahmed, Democratic Services</td>
<td>E-mail: <a href="mailto:mary.knower@lbld.gov.uk">mary.knower@lbld.gov.uk</a></td>
</tr>
<tr>
<td></td>
<td>Tel: 020 8227 2756</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:masuma.ahmed@lbld.gov.uk">masuma.ahmed@lbld.gov.uk</a></td>
</tr>
</tbody>
</table>

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

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

**Summary:**

The Health and Adult Services Select Committee (HASSC), at its last meeting on 21 June 2017, agreed to undertake a small-scale scrutiny review on Oral Health in 2017-18. The Committee considered three options for areas of particular focus for the review and after discussion agreed to focus on Oral Health in Early Years (Option 1). The Options Paper can be accessed via this link (see Appendix 2 of item 8): [http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=585&MId=9515&Ver=4](http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=585&MId=9515&Ver=4)

The aim of the Review would be to target the most deprived communities populated with young families which will offer the best opportunity to tackle dental disease in children and where the greatest difference can be made.

As requested by the HASSC on 21 June, this briefing proposes the scope of the Review in terms of questions to be answered and a work plan that outlines a time-line for the evidence sessions members will take part in and the production of the end report with recommendations to improve outcomes and practice.

**Recommendation(s)**

The HASSC is recommended to review and agree the proposed scope and work plan for this Scrutiny Review.

**Reason(s)**

It is best practice to produce a scoping report prior to commencing a scrutiny review so that members and officers can give direction to the review, consider what evidence will form the basis of recommendations and have a time-line for completion. The topic of Oral Health in Early Years relates to the Council’s priority to ‘Enable Social Responsibility’ and the objectives of ensuring that everyone can access good quality healthcare, including dental care, when they need it’, as well as narrowing the gap in attainment and realise high aspirations for every child.
1. **Issues**

1.1 In 2012/13 dental extraction was the highest cause of hospital admissions for children in London. In Barking and Dagenham 310 children were admitted to hospital for dental extractions with 40% in the 5-9-year age group. This represented 0.5% of the 0-19-year-old population, similar to that for London.

1.2 In 2013 Barking and Dagenham participated in a national oral health survey of 3-year-old children. Though results showed that oral health had improved compared to the 2010 survey, Barking and Dagenham still had worse oral health than the London and England averages.

- 18% of Barking and Dagenham children had experienced dental disease, compared with figures of 13.6% for London and 11.7% for England;
- Barking and Dagenham children had on average 3.49 decayed, missing or filled teeth compared to 3.11 for London and 3.08 for England;
- There were higher rates of dental abscess amongst Barking and Dagenham children at 1.9% compared to 0.5% for London; and

1.3 Based on the above data, members agreed that Oral health in Early Years was an issue where the Committee could potentially add value by reviewing the reasons for poor oral health in early years, considering the quality of services available to residents to improve and treat oral health and considering what further could be done to get the right messages out to parents and children about looking after children’s oral health.

2. **Terms of Reference (ToR) for the Scrutiny Review**

i. What are the reasons for young children in Barking and Dagenham having poor oral health?

ii. What is the quality of services that are available to residents and what do they deliver to improve oral health?

iii. What are the best ways of getting the right messages out to parents about looking after their children’s oral health?

3. **Proposed Work Plan for the Scrutiny Review**

<table>
<thead>
<tr>
<th>Date of HASSC session</th>
<th>Activity</th>
<th>ToR questions covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 September 2017 (HASSC meeting)</td>
<td>Presentation on the local context of oral health in early years</td>
<td>1, 2</td>
</tr>
<tr>
<td>6 October 2017 (tbc)</td>
<td>Members to meet parents of young children and professionals at Gascoigne Children’s centre</td>
<td>1, 2 &amp; 3</td>
</tr>
<tr>
<td>20 October 2017 (tbc)</td>
<td>Members meet staff at pre-school</td>
<td>1, 2 &amp; 3</td>
</tr>
<tr>
<td>Nov – (tbc)</td>
<td>Members to visit a community dentist</td>
<td>1, 2 &amp; 3</td>
</tr>
<tr>
<td>11 Dec 2017</td>
<td>Draft report and recommendations circulated</td>
<td>1, 2 &amp; 3</td>
</tr>
<tr>
<td>10 Jan 2018 (HASSC meeting)</td>
<td>Members to provide comments on draft report</td>
<td>1, 2 &amp; 3</td>
</tr>
<tr>
<td>21 February 2018 (HASSC meeting)</td>
<td>Final report</td>
<td>1, 2 &amp; 3</td>
</tr>
</tbody>
</table>
3.1 The Local Dental Committee has been invited to participate in this Review and has agreed to be involved which will provide an expert source of advice and recommendations for improving oral health in young children. Officers will endeavour to ensure they are represented at the above sessions.

4. Financial Implications

4.1 The costs for undertaking this scrutiny review will need to be met from existing Scrutiny and Public Health budgets.

5. Legal Implications

Implications completed by: Paul Feild, Senior Lawyer, Law and Governance

5.1 The Health and Social Care Act (2012) conferred the responsibility for health improvement, including oral health improvement to local authorities. This Select Committee’s terms of reference establish its function to scrutinise any matter relating to the planning, provision and operation of the health services in the borough. The proposals are in keeping with this Committee’s function.

6. Background information

6.1 Members are recommended to familiarise themselves with the reading materials listed below under background papers which will be referred to throughout the preparation of the scrutiny report.

Background Papers Used in the Preparation of this briefing:


This page is intentionally left blank
One borough; one community; London’s growth opportunity

Encouraging civic pride

Enabling social responsibility

Growing the borough

For more information visit lbbd.gov.uk/visionandpriorities
Oral health in young children

Matthew Cole: Director of Public Health
Mary Knower: Public Health Strategist
Terms of Reference

In reference to the data presented around poor oral health in the Borough it is proposed that the review consider the following:

1. What are the reasons for young children in Barking and Dagenham having poor oral health?

2. What is the quality of services that are available to residents and what do they deliver to improve oral health?

3. What are the best ways of getting the right messages out to parents about looking after their children’s oral health?
## HASSC work plan

<table>
<thead>
<tr>
<th>Date of HASSC session</th>
<th>Activity</th>
<th>Terms of reference questions covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 September 2017 (HASSC meeting)</td>
<td>Presentation on the local context of oral health in early years</td>
<td>1, 2</td>
</tr>
<tr>
<td>6 October 2017 (tbc)</td>
<td>Members to meet parents of young children and professionals at Gascoigne Children’s centre</td>
<td>1, 2 &amp; 3</td>
</tr>
<tr>
<td>20 October 2017 (tbc)</td>
<td>Members meet staff at pre-school</td>
<td>1, 2 &amp; 3</td>
</tr>
<tr>
<td>Nov – (tbc)</td>
<td>Members to visit a community dentist</td>
<td></td>
</tr>
<tr>
<td>11 Dec 2017</td>
<td>Draft report and recommendations circulated</td>
<td>1, 2 &amp; 3</td>
</tr>
<tr>
<td>10 Jan 2018 (HASSC meeting)</td>
<td>Members to provide comments on draft report</td>
<td>1, 2 &amp; 3</td>
</tr>
<tr>
<td>21 February 2018 (HASSC meeting)</td>
<td>Final report</td>
<td>1, 2 &amp; 3</td>
</tr>
</tbody>
</table>
2010 oral health survey
3 and 4 year olds
Barking and Dagenham

Almost 3 in 10 (28%) had experienced dental disease and almost all of this (91%) was untreated.

Around 1 in 10 children (9%) had experienced pain in the teeth, mouth or jaws.

4 in 10 (41%) of those with decay had visited a dentist in the previous 12 months.
2010 oral health survey
3- and 4-year-olds
Barking and Dagenham

There were marked inequalities among ethnic groups, with high rates of decay and untreated disease in Asian children.

Asian children were less likely to have their teeth brushed twice a day than White or Black children.

Approximately 14% of parents reported at least one oral health-related impact on their child’s quality of life (occasionally or more often) (Marcenes, Muirhead and Fortune, 2010)
Though results showed that oral health had improved compared to the 2010 survey, Barking and Dagenham still had poorer oral health than the London and England average.

18% of Barking and Dagenham children had experienced dental disease, compared with 13.6% across London and 11.7% in England.

For those with disease, Barking and Dagenham children had on average 2.49 decayed, missing or filled teeth compared with 3.11 for London and 3.07 for England.
A national dental survey in 2015 found that almost one-third (31.4%) of five-year-olds had tooth decay in Barking and Dagenham. This is significantly higher than England (24.7%), but not London (27.2%). Based on 2016 mid-year population estimates, this would equate to around **1,200 five-year-olds** in Barking and Dagenham (95% confidence interval 1,000 to 1,400) having dental decay, if the proportion has remained constant since the survey.
% of 5-year-olds with experience of decay in NE London

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2015
% of 3- and 5-year-olds with experience of decay

3-year-olds surveyed in 2013; 5-year-olds surveyed in 2015

Dental services

Barking and Dagenham has 57 dentists per 100,000 population, more than both London and England.

There are also more units of dental activity (UDA)* per 100,000 population (168,123) compared with London (142,365) and England (158,977).

* a way of measuring the amount of dental work undertaken

There are 27 dental practices including community/special care dental clinics.

Dental access

45.5% of children resident in Barking and Dagenham accessed dental services in the 12 months to March 2017. This figure is similar to London.
% children accessing dental services
12 months to March 2017; London boroughs

Source: NHS Digital, 2017
% children accessing dental services by age
12 months to March 2017

Source: NHS Digital, 2017
% children accessing dental services by ward
12 months to March 2017; ages 0–9

Source: NHS Digital, 2017
In 2015/16, there were 301 hospital episodes for dental extractions among Barking and Dagenham children.

- 50% of these were in the 5–9 year age group.
- This represents 0.5% of the 0–19 year old population, similar to that for London (0.6%)

Source: HES, analysed by PHE Dental Public Health Epidemiology Team

In 2015/16, dental extraction was the most common hospital procedure among 5–9-year-olds across England.

Source: HES, analysed by Royal College of Surgeons
Preventing dental decay in young children

- Reducing the amount of sugary food and drinks in their diet

- Twice daily supervised tooth-brushing with fluoride toothpaste

- Regular visits to the dentist, beginning when the child gets their first tooth

- Decayed incisors are associated with long-term bottle use with sugar-sweetened drinks, especially when given overnight or for long periods of the day.

  - 9.9% of 5-year-olds in Barking and Dagenham (compared with 8.2% in London and 5.6% in England) experience this aggressive form of dental decay (2015 oral health survey)
Reviews of clinical effectiveness by NICE (PH55) and PHE (Commissioning Better Oral Health for Children and Young People, 2014) have found that the following programmes effectively reduced tooth decay in 5 year olds:

<table>
<thead>
<tr>
<th>Programme</th>
<th>Cost After 5 Years</th>
<th>Cost After 10 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Targeted supervised tooth brushing programme</td>
<td>£1 spent = £3.06</td>
<td>£1 spent = £3.66</td>
</tr>
<tr>
<td>A targeted fluoride varnish programme</td>
<td>£1 spent = £2.29</td>
<td>£1 spent = £2.74</td>
</tr>
<tr>
<td>Water fluoridation providing a universal programme</td>
<td>£1 spent = £21.71</td>
<td>£1 spent = £21.98</td>
</tr>
<tr>
<td>Targeted provision of toothbrushes and paste by post</td>
<td>£1 spent = £1.03</td>
<td>£1 spent = £1.54</td>
</tr>
<tr>
<td>Targeted provision of toothbrushes and paste by post and by health visitors</td>
<td>£1 spent = £4.89</td>
<td>£1 spent = £7.34</td>
</tr>
</tbody>
</table>
What is Barking and Dagenham doing?

The ‘Teeth for Life’ project – commencing Autumn 2017

- Targeted supervised tooth brushing project
- Involving approximately 7000 children under 5 years
- Settings include day nurseries, pre-schools and school nurseries
- Community dental team will provide oral health training for staff
Oral health in young children

Matthew Cole: Director of Public Health
Mary Knower: Public Health Strategist
Title: **Results of inspections undertaken by the Care Quality Commission on local adult social care services in Quarter 1, 2017/2018**

**Report of the Commissioning Director, Adults' Care and Support**

<table>
<thead>
<tr>
<th>Open Report</th>
<th>For Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Author:</strong></td>
<td><strong>Contact Details:</strong></td>
</tr>
<tr>
<td>Julie Aduwa, Statutory Compliance Manager</td>
<td>Tel: 020 8227 2965</td>
</tr>
<tr>
<td></td>
<td>E-mail: <a href="mailto:julie.aduwa@lbld.gov.uk">julie.aduwa@lbld.gov.uk</a></td>
</tr>
</tbody>
</table>

**Accountable Director:** Mark Tyson, Commissioning Director, Adults’ Care and Support

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

**Summary:**

This report is an overview of CQC inspection reports, published during Quarter 1 of 2017: (1 April – 30 June 2017). The following report provides an overview of the inspections as well as the actions that have been taken as a result of inspections where improvements are required. The report covers CQC inspection reports on providers in the Borough or those who provide services to our residents outside the Borough.

Links to the CQC inspection reports themselves and a summary of the findings can be found in Appendix 1.

**Recommendation(s)**

Members of the Select Committee are recommended to review the document and to comment on the CQC findings and the actions taken as a result.

**Reason(s)**

The Council has a responsibility for ensuring the quality and sufficiency of adult social care provision in the borough. The Care Quality Commission is the quality regulator for social care and inspects local services. It is important that local people have confidence in the social care services that are provided in the borough, and part of the approach to ensuring confidence is to provide an opportunity for Elected Members to review accounts of performance. This is one such opportunity.
1. Introduction and Background

1.1 The Care Quality Commission (CQC) are responsible for inspecting all health and social care providers that fall under their regulatory remit. The ratings ask five key questions of the services that CQC inspect:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

1.2 Each question has a number of lines of enquiry to guide the inspection. The results of each category then enable an overall rating to be achieved for each provider:

- Outstanding
  *The service is performing exceptionally well.*
- Good
  *The service is performing well and meeting our expectations.*
- Requires improvement
  *The service isn't performing as well as it should and we have told the service how it must improve.*
- Inadequate
  *The service is performing badly and we've taken action against the person or organisation that runs it.*

1.3 Alternatively, a provider may be given no rating where the outcome is under appeal, their business is suspended or there was only one person using the service at the time of the inspection. There are no services locally where this has been the case.

1.4 The Council’s commissioning function uses the results of CQC inspections, together with its own intelligence about how services perform, to shape its own approach to quality assuring social care services. Similarly, we are in regular dialogue with the Care Quality Commission based on our experience of local services and they use our information to inform their approach to inspections.

2. CQC Findings Quarter 1 2017/2018

2.1 Of the 6 providers inspected, two met the requirement for an overall rating of ‘good’, two providers were rated as ‘requires improvement’ and two were rated as inadequate.

2.2 The two providers rated ‘good’ and the date on which they were inspected were:

- **Bennetts Castle** – Bennetts Castle is a 64 bedded nursing home that provides nursing and residential care to adults and older people living with dementia, mental health, learning and physical disabilities including respite accommodation. Bennetts Castle is a spot provider based on individual referrals. LBBD currently have 19 people placed in the home. The service was inspected on 1 and 2 February 2017 and the inspection report was published 19 April 2017.

- **Hart Lodge** – Hart Lodge is a nursing care home that provides accommodation, nursing care, rehabilitation and personal care including 24
hours support to a maximum of 11 adults who are restricted under the mental health Act, dementia, eating disorders, mental health conditions and substance misuse. Hart Lodge is Health funded accommodation and LBBD has one placement funded by LBBD Mental Health. The service was inspected on 26 and 27 April 2017 and the inspection report was published 25 May 2017.

3. **Providers requiring improvement (Quarter 1)**

**Hanbury Court**
Rating – Requires Improvement

3.1 Hanbury Court is a 34-bedded nursing home that provides nursing, residential and respite care to adults and older people living with dementia, end of life care and physical disabilities. Hanbury Court is a spot provider and LBBD have 16 people placed in the home.

3.2 The CQC inspection was undertaken on 31 January and 1 February 2017 and the report was published 28 June 2017. The inspection found that three areas (Safe, Responsive and Well-Led) required improvement.

- Safe (requires improvement) – Concerns were raised around medicine not always recorded appropriately.
- Responsive (requires improvement) – the CQC gave a required improvement rating because care plans did not always contain information to guide staff and people’s assessments were not always properly recorded.
- Well-Led (requires improvement) – the CQC found that effective systems were not in place to monitor quality assurance and this area was rated as requires improvement.

3.3 Quality Assurance (QA) carried out an unannounced visit on 16 March 2017 and the concern regarding staffing levels was addressed immediately. A Safeguarding Strategy meeting was held with Hanbury Court on 11 May 2017 regarding the unexplained death of a resident. A service improvement plan was developed and is now been monitored by the Quality Assurance team. Hanbury Courts action plan to meet the CQC’s requirements has been received from them and QA will be monitoring the CQC action plan in the coming months.

**Sahara Parkside**
Rating – Requires Improvement

3.4 Sahara Parkside is a residential home that provides residential accommodation and respite for people with learning and physical disabilities, autism, mental health and people with multiple diagnoses. LBBD currently have one placement in the home.

3.5 The service was inspected by CQC on 12 and 13 April 2017 and the report was published on 10 June 2017. The service was rated as ‘requires improvement’ in all five areas:

- Safe (requires improvement) – the CQC was told that there were not enough staff and recruitment did not reflect best practice.
- Effective (requires improvement) – the CQC report found that people were deprived of their liberty under the Mental Capacity Act 2005. Staff had not received specialist training to enable them to carry out their role.
Caring (requires improvement) – the CQC found that some people did not feel they were treated with respect and preferences were not taken into account.

Responsive (requires improvement) – the CQC found that people were not supported to attend activities and the level of details on the support plan varied

Well-led (requires improvement) – The home quality assurance system did not address concerns. Some people including staff did not find management approachable.

3.6 QA carried out a visit on the 31 May 2017 to review the CQC Service Improvement Plan before the inspection report was published in June 2017. Sahara Parkside management had actioned all the points raised during the inspection. The safeguarding concern raised by the home regarding one other residents had been downgraded to casework by the Safeguarding Adult Manager overseeing the safeguarding enquiry. A follow up announced QA has been arranged for 7 August 2017. The QA team will continue to work in partnership with the home to achieve and maintain the required fundamental standards.

4. Providers rated as inadequate (Quarter 1)

Bond Care - Alexander Court
Rating – Inadequate

4.1 Alexander Court (formally managed by Lifestyle 2011 now owned by Bond Care) is a nursing home that provides nursing and residential care including respite care and support to adults and older people living with dementia, mental health, physical and learning disabilities, brain injuries, end of life/palliative care and people with multiple diagnosis. This service is located in Rainham Road, Dagenham. LBBD have 17 funded placements with Alexander Court placed on an individual spot purchase basis. Alexander Court was inspected by CQC on 28/29 November 2016 and 5 December 2016 and the proposal to remove the home and the home managers registration was relayed to the Local Authority in January 2017. The CQC has now withdrawn its proposal to remove the managers and the homes registration. A further CQC inspection was carried out in May 2017 and the service was rated ‘inadequate’ in four areas and ‘requires improvement’ in one.

- Safe: Inadequate – the CQC found that medicines were not always administered safely. There was no guidance for risk assessments and not enough staff to meet people’s need.
- Effective: Inadequate – the CQC found that the service was not working within the principals of the Mental Capacity Act 2005. The service was not always proactive to ensure that people had access to health and social care services. Staff were not always supported to receive training to enhance their roles.
- Caring: Requires improvement – the CQC found that the service did not always maintain the dignity of people who use the service.
- Responsive: Inadequate – People’s support needs were not reflected in their care records and they were not able to take part in preferred activities that meet their needs
- Well-led: Inadequate – the CQC found that there was no system in place to monitor the quality of service.
4.2 LBBD Quality Assurance and CCG have been working in partnership with Alexander Court to ensure that the quality standard or services delivered are maintained.

4.3 **Reline Care Limited – Reline Care**
Rating: Inadequate

4.4 Reline Care is located at the Barking Enterprise Centre in Barking. Reline Care is a large domiciliary care service providing personal care to people in their own homes. This provider is not on the LBBD providers’ framework and LBBD do not have anyone placed with them, although services are provided to service users in the London Boroughs of Newham, Waltham Forest and Redbridge. The CQC inspected the service on 1, 2 and 5 December 2016 and published their report on 25 May 2017. The service was rated as the following:

- Safe: Inadequate – the CQC found that instances of neglect and abuse were not raised as safeguarding issues and staff did not identify neglect as a type of abuse. Risk assessments were not robust and did not contain sufficient measures to mitigate risks faced by people receiving a service.
- Effective: Inadequate – the CQC found that staff training was not effective at ensuring staff had the knowledge required to perform their roles.
- Caring: Requires Improvement – the CQC found that care plans were not robust and did not contain enough information about the service user’s personal histories.
- Responsive: Inadequate – the CQC found that care plans were task focussed and did not contain information about people’s preferences.
- Well-led: Inadequate – the CQC found that Reline was not submitting notifications to CQC.

4.5 Barking and Dagenham undertook a joint unannounced visit with Newham Council in December 2016 and contacted the other Boroughs for their concerns regarding the provider. Waltham Forest and Redbridge had few concerns, although Newham had concerns and were working closely with the provider to monitor improvements against the improvement plan. Newham formally reviewed the progress made against the improvement plan in January and February 2017 with the provider and a joint meeting between Barking and Dagenham, Newham, Redbridge and Waltham Forest was held in February 2017 where it was confirmed that the provider was continuing to show improvements. Improvements were further confirmed by the Barking and Dagenham Quality Assurance team via a joint visit with Newham in April 2017. The provider will continue to work through the service improvement plan with Newham Council and the Barking and Dagenham QA team is in regular communication with the provider and the other local authorities to ensure that improvements are sustained. A joint visit with Newham was carried out on the 31 May 2017 and it was agreed that there was continuous improvement. Voluntary suspension has been lifted and Redbridge has resumed placements. LBBD, Newham, Redbridge and Waltham Forest continue to work to support the provider in maintaining quality of service.

5. **Consultation**

5.1 There are no consultation requirements associated with this report, since it is presented for information and comment. In conducting their inspections, CQC consult with the Council as the host borough, and with residents and their carers.
6. **Implications**

**Risk Management**

6.1 The provision of social care services by providers who fail to meet the minimum CQC inspection rating of ‘Good’ are subject to increased monitoring both the Council’s commissioning function and CQC. This feeds into a wider approach to risk-based quality assurance which the Council uses to prioritise its work with local social care services.

6.2 Where problems are identified, quality assurance staff will work with the provider to plan and deliver improvements, including where necessary the actions contained in the CQC action plan and exchange intelligence regarding progress with CQC. The main priority is to ensure that the service is safe for service users and the quality of the delivery meets expectations.

6.3 For those providers who do not adequately comply with the action plan recommendations within the timeframe, CQC will issue a warning notice which is in the public domain and alert other authorities using that provider to use caution when commissioning services from them. There is considerable impact for the provider if this course of action is taken. Ultimately, CQC have the option available to them to suspend the provider’s registration or take legal action.

7. **Customer Impact**

7.1 Ensuring that services are safe and effective is a critical role for the Council in the provision of social care services and the management of the local market in social care. This ensures not only basic safety but that there remains a meaningful choice in services to meet diverse needs.

**Safeguarding Children and Vulnerable Adults**

7.2 Safeguarding vulnerable people – both children and adults – is the prime motivation for ensuring a robust system of inspection, quality assurance and regulation. This report presents one key element of that approach, led by CQC.

**Health Issues**

7.3 Effective regulation of services is important to ensure that they support people to achieve their desired outcomes, including maintaining and improving their health and wellbeing.

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

Information on the regulation approach taken by CQC, on the website at: www.cqc.org.uk.

**List of appendices:**

Appendix 1: Quarter 1 2017/2018 CQC Report
<table>
<thead>
<tr>
<th>Provider name</th>
<th>Location</th>
<th>Link to report</th>
<th>Report date</th>
<th>Inspection date</th>
<th>Rating</th>
<th>Comments/Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>MNS Care Plc</td>
<td>Hanbury Court</td>
<td><a href="http://www.cqc.org.uk/location/1-119099319">http://www.cqc.org.uk/location/1-119099319</a></td>
<td>28 June 2017</td>
<td>31 January &amp; 1 February 2017</td>
<td>Requires Improvement</td>
<td>CQC rated required improvement after an inspection on 31 January &amp; 1 February 2017 as:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Safe: Requires Improvement</strong> - Concerns were raised around medicine not always recorded appropriately</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Effective: Good</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Caring: Good</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Responsive: Requires Improvement</strong> - Care plan did not always contain information to guide staff and people’s assessments were not always properly recorded</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Well-led: Requires Improvement</strong> - There were no systems in place to monitor the quality of service.</td>
</tr>
<tr>
<td>Sahara Parkside ltd</td>
<td>Sahara Parkside</td>
<td><a href="http://www.cqc.org.uk/location/1-164893164">http://www.cqc.org.uk/location/1-164893164</a></td>
<td>10 June 2017</td>
<td>12 &amp; 13 April 2017</td>
<td>Requires Improvement</td>
<td>CQC rated required improvement after the inspection on 12 &amp; 13 April 2017 as:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Safe: Requires Improvement</strong> - There were not enough staff and recruitment did not reflect best practice.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Effective: Requires</strong></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Inadequate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Safe: Inadequate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medicines were not always</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>administered safely. There was no</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>guidance for risk assessments and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>not enough staff to meet people’s</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>need.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Effective: Inadequate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The service was not working within</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>the principals of the Mental</td>
<td></td>
</tr>
</tbody>
</table>

 Improvement
People were deprived of their liberty under the Mental Capacity Act 2005. Staff had not received specialist training to enable them carryout their role.
Caring: Requires Improvement
People did not feel they were treated with respect and preferences were not considered
Caring: Good
Responsive: Requires Improvement
People were not supported to attend activities and the level of details on the support plan varied
Well-led: Requires Improvement
Quality assurance and monitoring systems in place were not always effective and management were not approachable.
Action: Quality Assurance and Commissioning have worked with the provider through a number of monitoring visits and meetings. There have been improvements in many areas. Further QA monitoring visit 7 August 2017 to confirm continuous improvements.
Appendix 1

<table>
<thead>
<tr>
<th>Provider</th>
<th>Action</th>
<th>Date Handled</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reline Care Ltd</td>
<td>Inadequate</td>
<td>25 May 2017</td>
<td>1, 2, 5</td>
</tr>
<tr>
<td>Reline Care</td>
<td><a href="http://www.cqc.org.uk/sites/default/files/new_reports/INS2-2343573207.pdf">http://www.cqc.org.uk/sites/default/files/new_reports/INS2-2343573207.pdf</a></td>
<td>December 2016</td>
<td>Inadequate</td>
</tr>
</tbody>
</table>

Capacity Act 2005. The service was not always proactive to ensure that people had access to health and social care services. Staff were not always supported to receive training to enhance their roles.

**Caring: Requires improvement**
The service did not always maintain the dignity of people who use the service.

**Responsive: Inadequate**
People’s support needs were not reflected in their care records and they were not able to take part in preferred activities that meet their needs

**Well-led: Inadequate**
There was no system in place to monitor the quality of service.

**Action:**
CQC rated Inadequate after a 3 day inspection in December 2016 and with the report published 25 May 2017 as:

**Safe: Inadequate**
Instances of neglect and abuse were not raised as safeguarding issues and staff did not identify neglect as a type of abuse. Risk assessments were not robust and did not contain sufficient measures to mitigate risks faced by people receiving a service. Recruitment was not completed in line with the provider's policy and discrepancies in staff applications were not explored. Medicines were not managed or recorded in a safe way.
Appendix 1

**Effective: Inadequate**
Staff training was not effective at ensuring staff had the knowledge required to perform their roles. The service was not working in line with legislation and guidance regarding consent and care for people who lacked capacity. Care plans did not contain information about people’s dietary needs and preferences. People were not consistently supported to eat and drink or to maintain a balanced diet. People’s healthcare diagnoses were included in their care plans. However, there was limited information about the impact people’s health had on their care.

**Caring: Requires Improvement**
Care plans contained brief personal histories with information about people’s pasts and significant relationships.

**Responsive: Inadequate**
Care plans were task focussed and did not contain information about people’s preferences. Records did not show that people’s care plans were followed.

**Well-led: Inadequate**
Audits were completed, but they were not effective as they had not identified issues with the quality of records and plans found during the inspection. Quality complaints were dealt with on an individual basis and lessons learned were not applied to the overall quality of the service. The service was not submitting notifications to CQC as...
Appendix 1

required.

**Action:**
No LBBD service users with the provider. Joint visit with Newham in December 2016. Service improvement plan in place. Review of Service Improvement Plan by Newham in January and February 2017. Joint meeting with Newham, Redbridge and Waltham Forest in February 2017. Joint visit with Newham in April 2017 confirmed improvements and continuing to monitor to ensure that improvements sustained. Joint visit with Newham 31 May 2017 to go through the Service Improvement Plan. LBBD, Redbridge, Newham and Waltham Forest continue to work with Reline to maintain the quality of service delivered.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
<th>Inspection Dates</th>
<th>Inspection Dates</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bennetts Castle Ltd</td>
<td><a href="http://www.cqc.org.uk/location/1-117294310">http://www.cqc.org.uk/location/1-117294310</a></td>
<td>19 April 2017</td>
<td>1-2 February 2017</td>
<td>Good</td>
</tr>
<tr>
<td>Hart Care Ltd</td>
<td><a href="http://www.cqc.org.uk/location/1-127130055">http://www.cqc.org.uk/location/1-127130055</a></td>
<td>25 May 2017</td>
<td>26-27 April 2017</td>
<td>Good</td>
</tr>
</tbody>
</table>
## Joint Health Overview and Scrutiny Committee: Update

### Report of the Director of Law and Governance

**Open Report** | **For information**
--- | ---
**Report Author:** Masuma Ahmed, Democratic Services Officer, Scrutiny
**Contact Details:**
Tel: 020 8227 2756
E-mail: masuma.ahmed@lbbd.gov.uk

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

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

### Summary:

This report updates the Health and Adult Services Select Committee (HASSC) on the issues that were discussed at the last meeting of the Joint Health Overview and Scrutiny Committee (JHOSC), held on 18 July 2017, at Barking Town Hall.

### Recommendations

The HASSC is recommended to note the update.

### Reason

To keep the HASSC updated on issues discussed at JHOSC meetings.

### 1. Introduction and background

1.1 The Outer North-East London JHOSC is a discretionary joint committee made up of three health scrutiny members of the following local authorities to scrutinise health matters that cross local authority boundaries:

- Barking & Dagenham
- Havering
- Redbridge and
- Waltham Forest.

(The Essex County Council Health Overview and Scrutiny Committee is permitted to appoint one member to the JHOSC).

1.2 As agreed by the HASSC at its meeting on 21 June 2017, the London Borough of Barking and Dagenham’s representatives on the JHOSC for 2016/17 are Councillors Chand, Oluwole and Jones.

1.3 Four JHOSC meetings are usually held per municipal year and are chaired and hosted by each constituent authority on a rota basis. This report covers the matters that were discussed at the first meeting of this municipal year, on 18 July 2017. The next meeting will be held at 4.00pm on Tuesday 10 October 2017 at Redbridge Town Hall.
2. Matters discussed at the last meeting of the JHOSC

2.1 The last JHOSC meeting was held on 18 July 2017 at Barking Town Hall and was chaired by Councillor Chand. An outline of the matters discussed at the meeting is provided below.

2.2 Barking, Havering and Redbridge University Trust (BHRUT) - Update on Safety of Services

2.2.1 The Chief Nurse at BHRUT advised that the Trust was now above the national average for incident reporting – an indication of a healthy organisation. Few of the reported incidents were serious or harmful in nature. All complaint responses were reviewed by the Chief Nurse, complaints were now more focussed on specific issues and the Trust welcomed the chance to meet face to face with complainants. The Trust had recently received its first Regulation 28 report from a coroner in 18 months concerning a patient who had died following a liver biopsy. One maternal death had recently been reported by the Trust, the first such occurrence for two years, although two terminally ill mothers who had given birth were also required to be included in the statistics.

2.3 North East London Foundation Trust (NELFT) - Future Plans

2.3.1 The NELFT representative stated that the Brookside unit for young people had been rated as inadequate by the Care Quality Commission in 2016 and concerns had been raised over care planning and risk assessment on mental health inpatient wards. The Unit had been closed for a period in response and a new model of service had now been agreed with the commissioners, NHS England. The CQC had revisited the refurbished Unit in October 2016 and was now happy with the services, although it was still closely monitored.

2.3.2 A shortage of adolescent mental health beds nationally meant there had been pressure on the Unit to admit patients from elsewhere. This had improved however, and patients were mainly from the Outer North-East London boroughs. Improvement work was under way to address the CQC findings around care planning and risk assessments. Work to eliminate ligature risks in would be completed by spring 2018 and the Unit would be closed while this work was carried out. The CQC would carry out a further inspection on the ‘well led’ domain in October 2017 when some other areas that had previously been found to need improvement, would also be assessed.

2.3.3 A ward at Goodmayes that catered for patients with learning disabilities had originally been closed due to the presence of a very challenging patient on the ward, leading to safety issues for other patients. This unit was now open to admissions but a written response would be provided.

2.3.4 The CQC report had made a total of 137 recommendations covering NELFT as a whole and 106 of these had now been completed.

2.4 Great Ormond Street Hospital - Great Ormond Street Hospital had to send apologies as it could not send a representative to the meeting.
2.5 Healthwatch Havering - Reports

2.5.1 The Chair of Havering Healthwatch explained that the organisation had received a number of complaints about meals at Queen’s Hospital which led to enter and view visits being undertaken to three wards in October 2016. These found that the overall standard of food on Bluebell A and B wards were good but the standard on Sunrise B ward, which catered for patients suffering from dementia, was much lower (it was accepted by Healthwatch Havering that staff on the ward were under significant pressure). In response, the BHRUT Chief Nurse, who confirmed that she was aware of the problems on Sunrise B ward prior to Healthwatch’s intervention, welcomed the report and described the work undertaken to improve the position.

2.5.2 Havering Healthwatch also presented a report on NELFT’s Street Triage Service. Healthwatch was very supportive of this service, which was operated by NELFT, the Metropolitan Police and the British Transport Police with the aim of being able to intervene with people having a mental health crisis in a public area without their being criminalised and avoid people being taken to a police station or to A & E. As a result of their report, Healthwatch made a number of recommendations to the commissioners and providers of the service. The local CCGs had confirmed the scheme was a priority area in the East London Health and Care Partnership and that options to invest in the service were being looked at. It was noted that no response to the report had been received from the Metropolitan Police (Havering’s Crime & Disorder Scrutiny Committee would be seeking a response). No response had been received from Waltham Forest CCG to the report yet.

2.6 Committee’s Work Plan

2.6.1 It was agreed that a standing item should be put on the agenda for future meetings for an update on developments with the East London Health & Care Partnership. In addition to the proposed workplan submitted, it was agreed that the following issues should be scrutinised, if possible, by the Joint Committee during the municipal year:

- Problems with supply of oxygen to patients
- Local delivery of chemotherapy treatments
- A Healthwatch Redbridge report on the discharge pathway
- An update on maternity services to cover responses to recent CQC reports and progress since the closure of the maternity unit at King George Hospital
- Clarification over which boroughs (if any) had formally signed a memorandum of understanding re the East London Health and Care Partnership.
- Procurement issues across the local NHS
- An update on performance of the Health 1000 project
- It was also agreed that a visit to Whipps Cross Hospital should be arranged.

3. Implications

3.1 There are no legal or financial implications arising directly from this information report.

Background Papers Used in the Preparation of the Report:
Minutes of the JHOSC meeting held on 18 July 2017:

List of appendices: None.
This page is intentionally left blank
THE FORWARD PLAN

Explanatory note:

Key decisions in respect of health-related matters are made by the Health and Wellbeing Board. Key decisions in respect of other Council activities are made by the Council’s Cabinet (the main executive decision-making body) or the Assembly (full Council) and can be viewed on the Council’s website at http://moderngov.barking-dagenham.gov.uk/mgLstPlans.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@lbld.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:

<table>
<thead>
<tr>
<th>Edition</th>
<th>Publication date</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2017 edition</td>
<td>8 August 2017</td>
</tr>
<tr>
<td>November 2017 edition</td>
<td>9 October 2017</td>
</tr>
<tr>
<td>January 2018 edition</td>
<td>18 December 2017</td>
</tr>
<tr>
<td>March 2018 edition</td>
<td>12 February 2018</td>
</tr>
<tr>
<td>June 2018 edition</td>
<td>14 May 2018</td>
</tr>
</tbody>
</table>
Confidential or Exempt Information

Whilst the majority of the Health and Wellbeing Board’s business will be open to the public and media organisations to attend, there will inevitably be some business to be considered that contains, for example, confidential, commercially sensitive or personal information.

This is formal notice under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 that part of the meetings listed in this Forward Plan may be held in private because the agenda and reports for the meeting will contain exempt information under Part 1 of Schedule 12A to the Local Government Act 1972 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it. Representations may be made to the Council about why a particular decision should be open to the public. Any such representations should be made to Alan Dawson, Democratic Services Manager, Civic Centre, Dagenham, Essex RM10 7BN (telephone: 020 8227 2348, email: committees@lbbd.gov.uk).

Key to the table

Column 1 shows the projected date when the decision will be taken and who will be taking it. However, an item shown on the Forward Plan may, for a variety of reasons, be deferred or delayed.

It is suggested, therefore, that anyone with an interest in a particular item, especially if he/she wishes to attend the meeting at which the item is scheduled to be considered, should check within 7 days of the meeting that the item is included on the agenda for that meeting, either by going to http://moderngov.barking-dagenham.gov.uk/ieListMeetings.aspx?CId=669&Year=0 or by contacting contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@lbbd.gov.uk).

Column 2 sets out the title of the report or subject matter and the nature of the decision being sought. For ‘key decision’ items the title is shown in bold type - for all other items the title is shown in normal type. Column 2 also lists the ward(s) in the Borough that the issue relates to.

Column 3 shows whether the issue is expected to be considered in the open part of the meeting or whether it may, in whole or in part, be considered in private and, if so, the reason(s) why.

Column 4 gives the details of the lead officer and / or Board Member who is the sponsor for that item.
<table>
<thead>
<tr>
<th>Decision taker/Projected Date</th>
<th>Subject Matter</th>
<th>Open / Private (and reason if all / part is private)</th>
<th>Sponsor and Lead officer / report author</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
<td>Open / Private</td>
<td>Mark Tyson, Commissioning Director, Adults' Care &amp; Support (Tel: 020 8227 2875) (<a href="mailto:mark.tyson@lbbd.gov.uk">mark.tyson@lbbd.gov.uk</a>)</td>
</tr>
<tr>
<td></td>
<td>The Board will be asked to agree the recommendations made to it and oversee the other recommendations.</td>
<td>Open / Private</td>
<td>Mark Tyson, Commissioning Director, Adults' Care &amp; Support (Tel: 020 8227 2875) (<a href="mailto:mark.tyson@lbbd.gov.uk">mark.tyson@lbbd.gov.uk</a>)</td>
</tr>
<tr>
<td></td>
<td>- Wards Directly Affected: All Wards</td>
<td>Open / Private</td>
<td>Mark Tyson, Commissioning Director, Adults' Care &amp; Support (Tel: 020 8227 2875) (<a href="mailto:mark.tyson@lbbd.gov.uk">mark.tyson@lbbd.gov.uk</a>)</td>
</tr>
<tr>
<td>Health and Wellbeing Board: 6.9.17</td>
<td>Integration and Better Care Fund: Update and Discussion</td>
<td>Open</td>
<td>Mark Tyson, Commissioning Director, Adults' Care &amp; Support (Tel: 020 8227 2875) (<a href="mailto:mark.tyson@lbbd.gov.uk">mark.tyson@lbbd.gov.uk</a>)</td>
</tr>
<tr>
<td></td>
<td>In July 2017 the Board was updated on the development of the Plan for the 2017-19 Integration and Better Care Fund (BCF), and delegated authority to approve the Plan.</td>
<td>Open / Private</td>
<td>Mark Tyson, Commissioning Director, Adults' Care &amp; Support (Tel: 020 8227 2875) (<a href="mailto:mark.tyson@lbbd.gov.uk">mark.tyson@lbbd.gov.uk</a>)</td>
</tr>
<tr>
<td></td>
<td>Following the publication of policy guidance for the BCF, this report will update the Board on the further developments to the local BCF Plan, and seek the opinion and discussion of the Board.</td>
<td>Open / Private</td>
<td>Mark Tyson, Commissioning Director, Adults' Care &amp; Support (Tel: 020 8227 2875) (<a href="mailto:mark.tyson@lbbd.gov.uk">mark.tyson@lbbd.gov.uk</a>)</td>
</tr>
<tr>
<td></td>
<td>- Wards Directly Affected: All Wards</td>
<td>Open / Private</td>
<td>Mark Tyson, Commissioning Director, Adults' Care &amp; Support (Tel: 020 8227 2875) (<a href="mailto:mark.tyson@lbbd.gov.uk">mark.tyson@lbbd.gov.uk</a>)</td>
</tr>
</tbody>
</table>

Page 121
The East London Health and Care Partnership (ELHCP) are currently running a consultation on the payment mechanism between those organisations within ELHCP holding budgets for services and those organisations providing them. The consultation opened on 11 July and closes on 29 September, and the ELHCP are inviting written responses from all organisations in the ELHCP as well as clinicians, other health and care professionals and front line staff, finance managers, councils, patients and the public.

The Board will be asked to comment.

- **Wards Directly Affected:** All Wards

---

Further to the July Board report, this report will introduce and append a narrative detailing the history of health and social care service integration in Barking and Dagenham.

The Board will be asked to approve the narrative, as well as the consequent integration principles that it will outline.

- **Wards Directly Affected:** All Wards
<table>
<thead>
<tr>
<th>Health and Wellbeing Board: 6.9.17</th>
<th>Reports for information</th>
</tr>
</thead>
<tbody>
<tr>
<td>• London Ambulance Service – Update</td>
<td></td>
</tr>
<tr>
<td>• East London Health and Care Partnership – Update</td>
<td></td>
</tr>
<tr>
<td>• Local Account 2016/17</td>
<td></td>
</tr>
<tr>
<td>• Two Annual Safeguarding Reports</td>
<td></td>
</tr>
<tr>
<td>• Wards Directly Affected: All Wards</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health and Wellbeing Board: 6.9.17</th>
<th>London Borough of Barking &amp; Dagenham Tobacco Control Strategy: Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Board will be presented with the London Borough of Barking &amp; Dagenham Tobacco Control Strategy. The strategy sets out approaches to reduce the smoking prevalence in the Borough and keys aspects of Tobacco control by preventing people from becoming smokers and protecting everyone from tobacco related harms. The report has been written in accordance to the aims &amp; objectives of national Tobacco Control Strategy.</td>
<td></td>
</tr>
<tr>
<td>The Board will be asked to agree the Borough’s Tobacco Control Strategy.</td>
<td></td>
</tr>
<tr>
<td>• Wards Directly Affected: All Wards</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health and Wellbeing Board: 8.11.17</th>
<th>Domestic and Sexual Abuse Strategy: Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>The report will present the Board with the draft Domestic and Sexual Abuse Strategy.</td>
<td></td>
</tr>
<tr>
<td>The Board will be asked to discuss and approve the Domestic and Sexual Abuse Strategy.</td>
<td></td>
</tr>
<tr>
<td>• Wards Directly Affected: All Wards</td>
<td></td>
</tr>
<tr>
<td>Health and Wellbeing Board: 8.11.17</td>
<td>Older People’s Housing Strategy - Discussion</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>The Board will be asked to consider and discuss the Older People’s Housing Strategy.</td>
<td></td>
</tr>
<tr>
<td>• Wards Directly Affected: All Wards</td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>Mark Tyson, Commissioning Director, Adults’ Care &amp; Support (Tel: 020 8227 2875) (<a href="mailto:mark.tyson@lbld.gov.uk">mark.tyson@lbld.gov.uk</a>)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health and Wellbeing Board: 8.11.17</th>
<th>Contract: Public Health Primary Care Service - Procurement Strategy: Financial</th>
</tr>
</thead>
<tbody>
<tr>
<td>The current contract for the Public Health Primary Care service will expire on 31 March 2018.</td>
<td></td>
</tr>
<tr>
<td>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 contract.</td>
<td></td>
</tr>
<tr>
<td>• Wards Directly Affected: All Wards</td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (<a href="mailto:matthew.cole@lbld.gov.uk">matthew.cole@lbld.gov.uk</a>)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health and Wellbeing Board: 8.11.17</th>
<th>Sustainability and Transformation Plan Update and Partnership Agreement All Issue Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>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).</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>• Wards Directly Affected: All Wards</td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>Mark Tyson, Commissioning Director, Adults’ Care &amp; Support (Tel: 020 8227 2875) (<a href="mailto:mark.tyson@lbld.gov.uk">mark.tyson@lbld.gov.uk</a>)</td>
</tr>
<tr>
<td>Health and Wellbeing Board: 8.11.17</td>
<td>London Health Devolution Agreement</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>• Wards Directly Affected: All Wards</td>
</tr>
<tr>
<td></td>
<td>Open</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health and Wellbeing Board: 16.1.18</th>
<th>Suicide Prevention Strategy: Community</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In November 2016, a Mental Health Strategy for LBBD was agreed. Since then LBBD and Havering have partnered in the development of a suicide prevention strategy and localised action plans.</td>
</tr>
<tr>
<td></td>
<td>The Board will be asked to approve the Suicide Prevention Strategy.</td>
</tr>
<tr>
<td></td>
<td>• Wards Directly Affected: All Wards</td>
</tr>
<tr>
<td></td>
<td>Open</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

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)

The HWB will be asked to sign-off the final PNA upon its completion.

- Wards Directly Affected: All Wards
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)
Interim LBBD Borough Commander (Metropolitan Police)
Ceri Jacob, Director Commissioning Operations NCEL (NHS England - London Region) (non-voting Board Member)
<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Agenda items</th>
<th>Officer/ Presenter</th>
<th>Deadline for drafts for Chair's pre-meeting</th>
<th>Chair’s pre-meeting date</th>
<th>Deadline for final versions</th>
<th>Relevant Cabinet Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon 23 Oct (provisional)</td>
<td><em>Meeting CANCELLED as the Community Urgent Care Consultation proposals are not likely to be ready until November. See below.</em></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Mon 13 November</td>
<td>BHRCCGs’ Community Urgent Care Proposals&lt;br&gt;Update on decisions arising from Spending NHS Money Wisely (phase 1) consultation&lt;br&gt;JHOSCC Update</td>
<td>TBC, BHRCCGs</td>
<td>Mon 16 Oct</td>
<td>Mon 23 Oct</td>
<td>Mon 30 Oct</td>
<td>Cllr Worby</td>
</tr>
<tr>
<td>Weds 10 January</td>
<td>The Challenges in Adult Social Care&lt;br&gt;Sustainability and Transformation Plans and Accountable Care Partnership - updates (MOVED from November meeting)&lt;br&gt;Primary Care Update</td>
<td>Commissioning Director, Adults’ Care &amp; Support&lt;br&gt;CCG and Commissioning Director Adults’ Care &amp; Support, LBBD&lt;br&gt;BDCCG</td>
<td>Mon 27 Nov</td>
<td>Mon 4 Dec</td>
<td>Mon 11 Dec</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 3

**Notes:**
There are HASSC member sessions in addition to the meetings above in relation to the mini scrutiny review on Oral Health in Early Years. Please contact Democratic Services for more information.

<table>
<thead>
<tr>
<th>Date</th>
<th>Agenda Item</th>
<th>Presenter</th>
<th>Mon 22 Jan</th>
<th>Mon 29 Jan</th>
<th>Mon 5 Feb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weds 21</td>
<td>Draft Report - Oral Health in Early Years Scrutiny</td>
<td>Healthwatch</td>
<td>TBC</td>
<td>TBC, BHRUT</td>
<td>BHRUT</td>
</tr>
<tr>
<td>February</td>
<td>Results of Inspections undertaken by the Care Quality Commission on Local</td>
<td>Commissioning Director,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adult Social Care Services – Quarter 2</td>
<td>Adults’ Care &amp; Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Heathwatch update</td>
<td>Healthwatch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Mental Health Provision in Barking and Dagenham</strong></td>
<td>TBC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Update from BHRUT on referral to treatment times and A&amp;E performance</td>
<td>TBC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(MOVED from November meeting)</td>
<td>TBC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>**Monitoring report – Cancer Scrutiny Recommendations and Progress of</td>
<td>TBC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Action Plan**</td>
<td>TBC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>**Results of Inspections undertaken by the Care Quality Commission on Local</td>
<td>Commissioning Director,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adult Social Care Services – Quarter 3</td>
<td>Adults’ Care &amp; Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Final report – Oral Health in Early Years Scrutiny Review</strong></td>
<td>Chair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>JHOSC update</strong></td>
<td>Chair</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>